Anti-Retroviral Treatment and Access to Services (ARTAS)

An individual-level, multi-session intervention for people who are recently diagnosed with HIV

Implementation Manual

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Important Information for Users

This intervention is intended to be used with persons who are recently diagnosed with HIV and who are voluntarily participating in the intervention. The materials in this intervention package are not intended for general audiences.

The intervention package includes an implementation manual, training and technical assistance materials, and other items used in intervention delivery. Also included in the package are: (1) the Centers for Disease Control and Prevention (CDC) fact sheet on male latex condoms; (2) the CDC Statement on Study Results of Products Containing Nonoxynol-9; (3) the Morbidity and Mortality Weekly Report (MMRW) article "Nonoxynol-9, Spermicide Contraction Use – United States, 1999;" (4) the ABC's of Smart Behavior; and (5) the CDC guidelines on the content of HIV educational materials prepared or purchased by CDC grantees (Content of AIDS-related Written Materials, Pictorials, Audiovisuals, Questionnaires, Survey Instruments, and Educational Sessions in CDC Assistance Programs).

Before conducting this intervention in your community, all materials must be approved by your community HIV review panel for acceptability in your project area. Once approved, the intervention package materials are to be used by trained facilitators when implementing the intervention.

ACKNOWLEDGMENTS

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TABLE OF CONTENTS

INTRODUCTION

Overview of Implementation Manual
The ARTAS intervention is intended to be implemented by agencies that conduct case management services for persons living with HIV/AIDS or are engaged in linking persons who are recently diagnosed with HIV to primary care providers and/or ancillary support services. This manual can be used by agencies such as health departments, AIDS service providers, HIV testing sites, Ryan White case management programs, drug treatment programs, or community-based organizations involved in HIV prevention.

The manual consists of the following sections: Getting Started, Pre-Implementation, Implementation, Client Session Guide, Maintenance, Adaptation, and Appendices. Following is a brief overview of each section of the manual.

Getting Started
The Getting Started section addresses what to consider when becoming familiar with Anti-Retroviral Treatment and Access to Services (ARTAS) and when deciding whether or not to implement the intervention. The section includes an overview of the intervention, the benefits of linking recently diagnosed individuals to care, the theoretical basis for ARTAS, the Core Elements and Key Characteristics, and four "getting started" activities. This section also contains various checklists and tools staff can use when deciding if ARTAS is right for the agency.

Pre-Implementation
The Pre-Implementation section prepares the implementing agency to conduct the intervention once the decision is made that ARTAS is right for the agency and target population. During this period, the agency makes any necessary changes, plans for the necessary human and monetary resources, builds relationships with community partners, creates a marketing plan, and develops a monitoring and evaluation plan. This section also contains various tools, checklists, and helpful reminders the staff can use during the Pre-Implementation phase.

Implementation
The Implementation section addresses the issues that the implementing agency staff will focus on while implementing ARTAS. The section also includes information on specific staff skills needed to implement ARTAS and ideas for maintaining relationships with community partners.

Client Session Guide
The Client Session Guide includes a step-by-step guide for facilitating each of the five client sessions and the session-related forms needed for ARTAS.

Maintenance
The Maintenance section contains guidance for integrating ARTAS into the implementing agency's existing services. This phase involves continuous work to adapt, monitor, and evaluate the intervention, as well as to make any necessary changes within the implementing agency. Process and outcome monitoring data are collected and analyzed during this phase. These sets of data will assist in adapting the intervention to meet the needs of the target populations and in measuring success.

Adaptation
The Adaptation section provides a brief overview of ways to adapt ARTAS and examples of past adaptations.

Appendices
This manual contains nine appendices:
- **Appendix A** is the Linkage Coordinator (LC) Supervisor Guide, which provides the LC Supervisor with guidance for the implementation of ARTAS and supervision of LCs. The appendix also contains relevant forms for LC Supervisors.
- Appendices B, C, and D contain materials that are discussed in the Pre-Implementation Section. **Appendix B** provides a Memorandum of Agreement (MOA) Template that will guide the development of MOAs. **Appendix C** contains the National Standards on Culturally and Linguistically Appropriate Services (CLAS), which LCs should review to implement ARTAS in a culturally competent way. **Appendix D** provides a sample Community Mapping Tool that will assist with formative research related to community partners.
- **Appendix E** relates to the Implementation Section and contains a Responsive Listening Self-Assessment tool that LCs can use to assess their listening skills.
- Appendices F and G relate to the Maintenance Section. **Appendix F** contains the performance process indicators that will assist in tracking the LC's interactions with clients. **Appendix G** contains the recruitment process indicators that will assist in tracking LC and agency contact with partners.
- **Appendix H** contains copies of the original research articles on ARTAS I and II.
- **Appendix I** contains the following CDC documents: (1) the CDC's fact sheet on male latex condoms; (2) the CDC Statement on Study Results of Products Containing Nonoxynol-9; (3) the Morbidity and Mortality Weekly Report (MMRW) article "Nonoxynol-9, Spermicide Contraction Use – United State, 1999;" (4) the ABC's of Smart Behavior; and (5) the CDC guidelines on the content of HIV educational materials prepared or purchased by CDC grantees (Content of AIDS-related Written Materials, Pictorials, Audiovisuals, Questionnaires, Survey Instruments, and Educational Sessions in CDC Assistance Programs).

<u>Acronyms</u>

Following is a reference list of some common acronyms that will be used throughout the manual.

ADAP	AIDS Drugs Assistance Program
AED	Academy for Educational Development
ARTAS	Anti-Retroviral Treatment and Access to Services (formerly Antiretroviral Treatment Access Study)
ASO	AIDS Service Organization
CBA	Capacity Building Assistance
CBO	Community-Based Organization
CDC	Centers for Disease Control and Prevention
CITAR	Center for Interventions, Treatment, and Addictions Research
CLAS	National Standards on Culturally and Linguistically Appropriate Services
CM	Case Manager
COACH	Center on AIDS & Community Health
CPG	Community Planning Group
CRCS	Comprehensive Risk Counseling and Services
DEBI	Diffusion of Effective Behavioral Interventions Project
IRB	Institutional Review Board
LC	Linkage Coordinator
M&E	Monitoring and Evaluation
MOA	Memoranda of Agreement
PLWHA	People living with HIV/AIDS
PTSD	Post-traumatic stress disorder
SBCM	Strengths-Based Case Management
SMART	Specific, Measurable, Achievable, Relevant, and Time-bound

GETTING STARTED
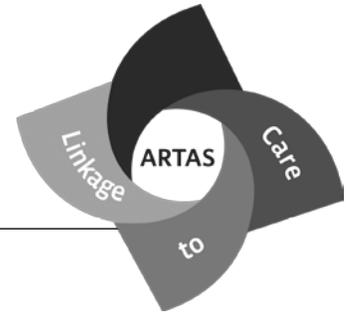
The Getting Started section of the manual addresses what to consider when becoming familiar with Anti-Retroviral Treatment and Access to Services (ARTAS) and when deciding whether or not to implement the intervention. This section also contains various checklists and templates to use when deciding if ARTAS is right for the agency and target population. Below is a full a list of topics covered:

I. What is ARTAS Linkage Case Management?
II. Benefits of Linking Recently Diagnosed Individuals to Care
III. Theoretical basis for ARTAS
IV. Core Elements and Key Characteristics
V. Agency Assessment and Readiness Activities
VI. Intervention Logic Model

I. What is ARTAS?

Anti-Retroviral Treatment and Access to Services (ARTAS) is an individual-level, multi-session, time-limited intervention to link individuals who have been recently diagnosed with HIV to medical care. ARTAS is based on the Strengths-Based Case Management (SBCM) model, which is rooted in Social Cognitive Theory (especially the concept of Self-Efficacy) and Humanistic Psychology. SBCM is a case management model that encourages the client to identify and use personal strengths; create goals for himself/herself; and establish an effective, working relationship with the Linkage Coordinator (LC). The SBCM model views the community as a resource for the client; client sessions take place outside the office.

ARTAS consists of up to five client sessions conducted over a 90 day period or until the client links to medical care – whichever comes first. Eligible clients should be within 6– 12 months of receiving an HIV-positive diagnosis. During the client sessions, the Linkage Coordinator builds a relationship with the client. The client, focusing on his/her self-identified strengths, creates an action plan (known as the ARTAS Session Plan) with specific goals, including linking to medical care. Not every client will move sequentially through the five sessions nor will every client complete all five sessions. For those who complete all five, the sessions will be structured as follows:

- ► The 1st session will consist of building a trusting, effective relationship between the client and the LC, and identifying the client's strengths, needs, and barriers to accessing medical care.
- ► The 2nd and 3rd sessions will focus primarily on goal-setting and creating the ARTAS Session Plan, which identifies and emphasizes the client's strengths,

assets, and abilities. The ARTAS Session Plan lists specific actions to be taken by the client to overcome personal and systemic barriers.

► The 4th session will consist of reviewing progress made in the previous sessions, while continuing to emphasize the client's strengths.

► The 5th session may involve accompanying the client to his/her medical appointment or transition activities if the client linked to medical care.

Following the final session with the LC, the client may be linked to a long-term/Ryan White case manager and/or another service delivery system to address his/her longer term barriers to remaining in care, i.e., those beyond linkage to medical care such as substance use treatment, or mental health services.

At any point, if the client successfully links to medical care, the LC does not need to continue with the remaining sessions. However, implementing agencies may find it useful to hold the last session (transition) and introduce the client to his/her new case manager, if that has not already been done in a previous session.

A. Target Population

The target population for ARTAS is *any* individual who is recently diagnosed with HIV (typically defined as within 6–12 months) and willing to participate in the intervention. During the research stage, the criteria to participate were that the client must:

► Have been 18 years of age or older

► Have received an HIV-positive diagnosis within 6 or 12 months

► Not have been on antiretroviral treatment

► Not received case management or social work services for HIV-related needs

► Have been interested in participating in the intervention

► Not have visited an HIV care provider more than once

The above criteria should serve as guidance for implementing agencies. To best address the needs of the community, implementing agencies should adjust the criteria as appropriate and/or as allowable by the funding agency.

B. The Need for ARTAS

While the benefits of early entry into medical care are well-documented, over one-third of people living with HIV/AIDS (PLWHA), who know their serostatus, are not linked to medical care.[1] Nearly 39 percent delay entry into care by 12 months, and 32 percent delay entry for more than two years.[2] People do not link to medical care following an HIV-positive diagnosis for a variety of reasons. These may include, but are not limited to: personal barriers such as unemployment, lack of health insurance, fear, stigma, substance use, mental health issues, lack of transportation, homelessness, and/or not having the required forms of identification to receive services. People do not seek medical care due to system-level barriers as well, such as a lack of personnel and health care providers, culturally appropriate interventions, and multilingual personnel. Other system-level barriers include wait lists for services and/or medications, and complex, confusing administrative processes. Rarely do people face only one barrier to accessing medical care.

The ARTAS intervention has proven to be successful in helping clients make changes because it emphasizes one's *abilities* to address barriers rather than one's *inabilities* to do so. The goal-setting is client-driven and determined by the person who must implement the changes as opposed to being dictated to the client by a third party, e.g., a case manager or health care provider. Finally, because the relationship between the client and LC is based on mutual respect and cooperation, the client feels supported in his/her efforts to implement changes and overcome barriers.

C. History of the Intervention and the Original Research

Anti-Retroviral Treatment and Access to Services (ARTAS) was developed by the Center for Interventions, Treatment, and Addictions Research (CITAR) at Wright State University Boonshoft School of Medicine, Department of Community Health in Dayton, Ohio. ARTAS is based on a Strengths-Based Case Management (SBCM) model created at the University of Kansas' School of Social Welfare.[3] The strengths-based approach used in ARTAS helps the client do the following:

► Develop an acceptance of his/her HIV-positive status.
► Identify both individual- and system-level barriers to accessing medical care.
► Identify personal strengths to effectively overcome these barriers.
► Create and execute a plan to overcome barriers to accessing medical care.

In conjunction with the Centers for Disease Control and Prevention (CDC) and CITAR, four sites implemented and evaluated a randomized controlled trial, known as the Antiretroviral Treatment Access Study (ARTAS-I). In the original study, 316 participants were randomly assigned to either the ARTAS Linkage Case Management group (N=136) or the standard of care group (N=137). The standard of care group received only HIV information and a paper referral to a local HIV health care provider. The results showed a higher proportion of successful linkage to medical care among the intervention participants (78%) than the standard of care participants (60%) within 6 months. Successful linkage was defined as attending at least one appointment with an HIV health care provider within a six-month period. Among intervention participants, a higher percentage had attended at least 2 appointments within 12 months than the standard of care group (64% versus 49%). Individuals over the age of 40, Hispanic participants, individuals enrolled within 6 months of an HIV seropositive test result, and participants without recent crack cocaine use were all significantly more likely to have gone to 2 medical visits.[4]

From 2005-2006, ten urban and rural demonstration sites – health departments and community-based organizations (CBOs) – within the U.S. tested the ARTAS intervention in real world settings. In this study, ARTAS-II, the results showed that 79 percent of the participants (497 out of 626) attended at least 1 HIV medical care appointment in the first 6 months of enrollment. These results are the same as the previous study (ARTAS-I), which strongly suggests the intervention is replicable in real world settings. Nearly all of the enrollees (96%) had been diagnosed with HIV within 6 months, and 89 percent had no previous encounters with HIV medical care services.

The following is a list of characteristics of intervention participants who were two to three times more likely to be linked to medical care:

● Attended two or more sessions with the LC

- 26 years of age or older
- Hispanic (compared to black, non-Hispanic)
- Had stable housing
- Had not recently used non-injected drugs
- Recruited at a site where the case management services and HIV medical care were co-located[5]

The median number of sessions with a client was 2 (mean=2.3 sessions), and the median time spent on all activities per client was 5.8 hours (mean=7.2 hours, with a range of 0-36.7 hours per client).

The results of the original research discussed above and the experiences of the study and demonstration sites serve as the basis for the information provided in this manual.

II. Benefits of Linking Recently Diagnosed Individuals to Medical Care

Interventions, such as ARTAS, that link people to medical care soon after receiving a positive test result are important because delays in seeking care can result in a negative treatment prognosis and contribute to the spread of the disease.[4] Early treatment has many benefits for HIV-positive individuals, such as improved health outcomes, additional opportunities for risk-reduction interventions, and costs savings.

- Early entrance into medical care improves the disease progression and health outcomes.[6] Individuals entering care early in their disease benefit more from antiretroviral therapy,[7] which decreases morbidity and has been hypothesized to reduce infectivity and transmission of the disease. Individuals linked to medical care also benefit from other therapeutic treatments.[2]

- Medical care provides additional opportunities for risk-reduction interventions with clients.[8] Healthcare providers can educate patients about appropriate behaviors as they provide medical treatment, possibly decreasing risk behaviors and transmission. Medical providers can also provide referrals for individuals to other social services.[2]

- Early linkage to care results in cost savings to individuals and the health care system. Direct care costs in the year following HIV diagnosis were more than 200 percent lower for patients who received treatment early.[7]

III. Theoretical Basis for ARTAS

ARTAS is a theory-based intervention. The three defining features of the intervention are: (1) building effective, working relationships between the client and LC, and between the LC and community partners; (2) focusing on the client's strengths rather than weaknesses; and (3) maintaining a client-driven approach. As noted earlier, ARTAS is based on the Strengths-Based Case Management model with some modifications. As such, ARTAS borrows from Social Cognitive Theory.

A brief description of each supporting theory or model is summarized below.

A. Strengths-based Case Management

ARTAS is based on Strengths-based Case Management. It incorporates a strengths-based approach into the primary functions of case management:

- **Assessment:** the practice of obtaining relevant information from the client's presenting needs, internal and external resources, and desires and proposed outcomes of their participation.
- **Planning:** the process of mutually agreeing on goals and objectives, planning activities to address the clients' needs, and developing strategies that help the client help themselves.
- **Linkage:** the process of actively connecting clients to needed services and resources to address clients' needs.
- **Monitoring:** the practice of systematically assessing how well clients are meeting their objectives and reaching their goals within the timeline proposed in the plan.
- **Advocacy:** provide the client support that encourages and influences desired change.

The strengths-based approach is commonly used in social work and has a strong theoretical foundation as an effective strategy to build an individual's success. Strengths-based practice emphasizes the client's self-determination and strengths. Strengths based practice is client led, with a focus on future outcomes and strengths that the client brings to a problem or crisis.

The strengths approach is based on the belief that individuals have abilities and inner capacities to successfully cope with their own challenges and perceived and existing barriers to meeting their goals and objectives.[9] The strength-based approach uses an asset identification, as opposed to a deficit, approach. Instead of focusing on what is going wrong with the client, the counselor helps the client reframe his or her thinking to consider what is right.

Strengths-based practice has four basic assumptions:

- People have an inner capacity to effectively cope and fix their own personal challenges
- People must be active participants in their own change
- People have personal and environmental assets
- Most people have untapped strengths and are unaware of their personal or environmental strengths

Strengths-based Case Management is a specific implementation of the strengths perspective, through the process of facilitating desired change in individuals. It adds the technique of focusing on client strengths to the primary principles of case management, which are:

- Encourage clients to identify and use their strengths, abilities, and assets to accomplish goals
- Recognize and support client control over goal-setting and the search for needed resources
- Establish an effective working relationship with the client

- View the community as a resource and identify information sources of support
- Conduct case management as an active, community-based activity[10]

B.   Social Cognitive Theory[11]

Behavior change is not simple, and many factors affect a person's ability to change. Social Cognitive Theory considers that behavior is a continuous, reciprocal interaction between personal (attitudes and beliefs), behavioral, and environmental influences.[12] Reciprocal determinism explains the interaction and relationship between the person, the person's behavior, and the person's environment. Hence, one's environment can influence behavior, but behavior can also influence one's environment. People are capable of re-evaluating their behavior, the impact of that behavior on their environment, and the impact of the environment on them and on their behavior. **See Figure 1 for a visual representation of this concept.**

Figure 1: Reciprocal Determinism [13]
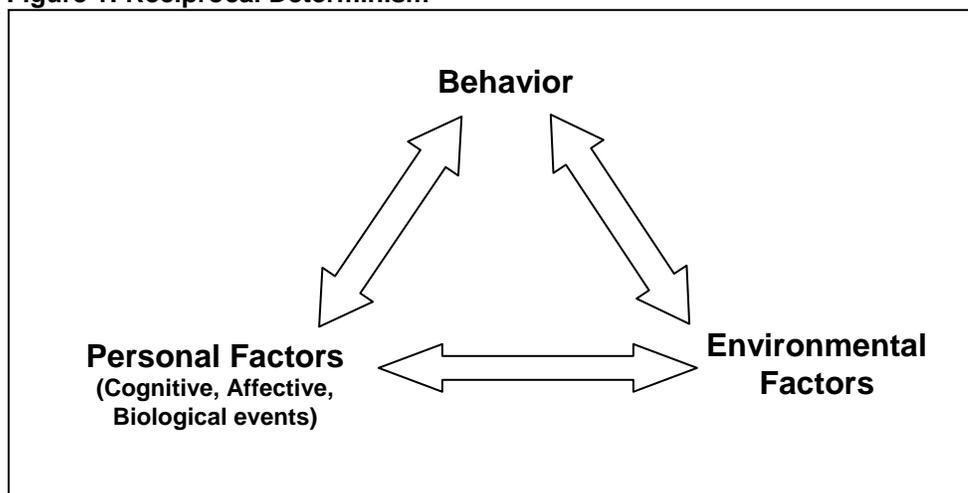
Therefore, behavior change is influenced by:[14]

Information: Awareness of risk and knowledge of techniques for coping with the environment.

Self-efficacy: Belief in one's ability to control his/her motivations, thoughts, emotions, and specific behaviors.

Outcome expectations: Belief that good things will happen as a result of the new behavior.

Outcome expectancies: Belief that the results of the new behavior are valuable and important.

Social skills within interpersonal relationships: The ability to communicate effectively, negotiate with others, and resist pressures from others.

Self-regulating skills: The ability to motivate, guide, and encourage oneself and to problem-solve.

Reinforcement value: Reinforcements are the responses to a person's behavior that increase or decrease the likelihood of reoccurrence. Reinforcement value emphasizes the benefits (rewards) produced by adopting a new behavior, instead of the focusing on what is being given up (costs) by adopting a new behavior.

According to Social Cognitive Theory, successful behavior change can be achieved by:
Learning new information from others
Discussing strategies with others
Having guided practice or rehearsal of new behaviors and skills
Receiving corrective feedback on one's performance of the new behaviors
or skills
Acquiring personal experience with new behaviors and skills
Receiving social support for the new behavior
Hearing the positive outcomes of other people who adapted the new behaviors
Observing new behaviors being modeled
Observing other people's behaviors and experiences

In ARTAS, the Linkage Coordinator helps the client learn new information, such as the benefits of accessing medical care, and discuss strategies to achieve the client's goals. During sessions, the LC may discuss strategies to overcome barriers to visiting an HIV care provider. The LC and client may practice or role-play interactions between the doctor and patient, if that is helpful to the client. These activities help a client's self-efficacy and increase his/her belief in the positive outcomes of visiting an HIV care provider or linking to medical care.

When implementing ARTAS it is important to remember these theoretical constructs and models as they are believed to give ARTAS its efficacy.

IV. Core Elements and Key Characteristics

A. Core Elements
Core Elements are the components that are central features of an intervention's intent and design and that are thought be responsible for its effectiveness. The Core Elements are derived from components of the behavioral theories and/or the experience of implementing the intervention. ARTAS has four Core Elements, most of which are based on the principles of SBCM.

The Core Elements are as follows:
1. Build an effective, working relationship between the Linkage Coordinator and each client.

2. Focus on the client's strengths by:
    a. Conducting a strengths-based assessment
    b. Encouraging each client to identify and use his/her strengths, abilities, and skills to link to medical care and accomplish other goals

3. Facilitate the client's ability to:
    a. Identify and pursue his/her own goals
    b. Develop a step-by-step plan to accomplish those goals using the ARTAS Session Plan

4. Maintain a client-driven approach by:
    a. Conducting between one and five structured sessions with each client

b. Conducting active, community-based case management by meeting each client in his/her environment and outside the office, whenever possible
c. 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
d. Advocating on each client's behalf, as needed, to link him/her to medical care and/or other needed services

These four Core Elements must be maintained without alteration to ensure *fidelity* **to the intervention and its effectiveness.** *Fidelity* refers to conducting and continuing an intervention by following the Core Elements, protocols, procedures, and content set by the research study that determined the intervention's effectiveness. Although the Core Elements cannot be altered in any way, implementing agencies can adapt Key Characteristics.

B. Key Characteristics
Key Characteristics are activities and delivery methods for conducting an intervention that are of great value to the intervention but can be altered without changing the outcome or effectiveness of ARTAS.

The Key Characteristics identified from the original research and during the implementation of ARTAS are as follows:
- Build and maintain effective relationships with community partners, and, whenever possible, sign a Memorandum of Agreement (MOA) between the implementing agency and community partners to facilitate the referral process.
- Conduct a client session with two LCs if the LC is uncomfortable with the client-selected location. The client should agree to this arrangement in advance.
- Implement a strengths-based approach to supervision. This will allow the Supervisor to model a "strengths attitude" for his/her employees.
- Provide transportation to and from the client sessions and/or medical appointment. This can be in the form of taxi or public transportation reimbursement or transportation in the LC's personal vehicle.
- Provide incentives such as gift cards or food vouchers during the five client sessions and/or for completing evaluation forms.
- Attend medical and other appointments with the client if requested.

V. Agency Assessment and Readiness Activities
When deciding if ARTAS is a good fit for the agency and community, it is important to examine the agency's readiness and capacity, identify potential barriers to implementation and solutions to these barriers, obtain internal and external buy-in for ARTAS, and develop a budget. These are the four activities to help an agency make the decision whether or not to implement the intervention. It is important to note that these activities do not necessarily happen in the order in which they appear below. The activities may occur simultaneously. In addition, the activities below are intended to provide guidance when deciding to implement ARTAS. The specifics of each activity should be adjusted to meet the agency's needs – unless the activity is linked to a Core Element of ARTAS. For example, the staff positions are guidelines to assist in the

planning process. They should not be viewed as required staff positions or levels of effort.

A. Getting Started Activity #1: Examine Agency Capacity and Readiness

The first Getting Started activity is to examine the agency's capacity and readiness to implement ARTAS. The recommended agency capacities include an ability to provide case management and the existence of strong relationships with community partners.

These capacities should be considered when assessing whether the ARTAS intervention is right for the agency. While not required, they were identified by the demonstration sites as beneficial to make the implementation of ARTAS easier and more efficient. Examining the agency's capacity will help in developing a budget (e.g., to determine if additional resources need to be allocated for training, staffing).

Recommended Agency Capacities

► **Experience providing case management services:** The successful implementation of ARTAS will be achieved best by an agency with experience providing case management services, or by contracting with an agency with strong case management capacity. Not only will agencies with this capacity already have the existing structures in place that are necessary to implement ARTAS – such as case staffing supervision, experienced staff, related policies on confidentiality, and boundaries – these agencies will also have existing relationships with AIDS service organizations (ASOs), community-based organizations (CBOs) providing HIV services, and other service delivery organizations. If these structures are already in place, they will reduce the amount of time needed for program start-up and assist in the creation of referral networks.

► **Existing strong relationships with community partners**: It is beneficial to have pre-existing relationships with key community partners before implementing ARTAS to reduce the time and effort needed for program start-up. If a community partner has an existing and strong relationship with the agency, then the community partner will likely be more receptive to learning about and participating in the intervention. In addition, where networks are already established, ARTAS can simply be folded into the existing system of referrals to get clients into the ARTAS intervention and to link them to medical care and other needed services.

► **Technological capacity:** Agencies should have the technological capacity to maintain data collection and management systems for monitoring and evaluation purposes, particularly if the funding agency requires evaluation activities. Staff should be proficient in the use of common computer software. The funding agency may have specific requirements, but software to consider includes Microsoft Excel™, Microsoft Access™, and/or SPSS.

► **Staffing:** The following are staffing guidelines to be considered by a CBO when deciding to implement ARTAS. Note: Except for the LC, these are not full-time positions.

- *Program Director/Manager*: The Program Director/Manager is responsible for the overall implementation and management of ARTAS. The Program

Director/Manager should have experience with program management, including budgeting, staffing, marketing, and reporting. If desired, the Program Director/Manager may also serve as the Evaluator, as long as s/he has evaluation experience.

- *Evaluator*: The Evaluator designs the monitoring and evaluation plan and oversees monitoring-related activities including data collection, developing instruments, and reporting results. Data entry may be included in the Evaluator's role, or performed by the LC. The Evaluator position may be filled by an agency staff person or consultant with experience designing and executing monitoring and evaluation plans. Note: This position may or may not be required by the funding agency. Regardless, conducting monitoring activities is beneficial to the implementing agency.

- *LC Supervisor*: The LC Supervisor oversees and provides direct supervision to the LC, including case staffing meetings. Ideally, this person should have strong clinical skills, experience with case management and supervising case managers, and be familiar with program management principles.

- *Linkage Coordinator*: The LC is responsible for the actual implementation of the intervention – meeting with clients, attending the first medical appointment. The LC is typically responsible for marketing the intervention to community partners and performing data collection and entry activities. The LC should have experience providing case management services. Due to the intensive nature of ARTAS, the LC's caseload should be between 25–30 clients at any given time.

If ARTAS is being implemented by a health department, additional positions may be required. For example, if the health department is the grantee, but the intervention will be conducted by a CBO or ASO, then the health department will likely require a Contract Manager. The Contract Manager may or may not be the Program Director/Manager depending on the design of the implementation plan.

Next, the agency should assess its readiness to implement ARTAS. The following checklist contains information on recommended agency capacities to possess before implementing ARTAS. In the blank space provided, indicate whether or not the agency has the indicated capability by placing a "yes" or "no" in the column provided. For any "no" answer regarding capacity, the agency should list the necessary next steps to increase capacity in the Comments/Next Steps column. For example, if the agency does not have experience providing case management services, it should make a note of potential agencies or clinics to subcontract with to complete this component of the intervention.

Agency Readiness Checklist

Case Management Readiness	Yes	No	Comments	Next Steps
1. Does your agency provide case management services?			
2. Do you have staff with experience providing case management?			
3. Do you have staff with experience in strengths-based service delivery?			
4. Do you have the resources to obtain additional case management and strengths-based service delivery training and education for staff?			
HIV/AIDS Readiness	**Yes**	**No**	**Comments	Next Steps**
1. Does your agency provide services to people living with HIV/AIDS (PLWHA)?			
2. Does your staff have knowledge of and experience providing services to PLWHA?			
3. Have you identified additional training and educational resources to increase staff capacity and knowledge of providing services to PLWHA?			
4. Do you have the resources to obtain additional HIV/AIDS training and education for staff?			
Agency Readiness	**Yes**	**No**	**Comments	Next Steps**
1. Do you have funding for ARTAS?			
2. Do you have support from your Board of Directors and key agency staff for the intervention?			
3. Do all agency staff have an understanding of the importance, content, and mission of ARTAS?			
4. Do you have staff who can implement ARTAS? *Program Director/Manager* *LC Supervisor* *Evaluator* *LC(s)* *Contracts Manager (if necessary)*			
5. Have your staff (specifically LC Supervisor and LCs) participated in the ARTAS training?			
6. Have you identified additional training needs (communication skills, cultural competency)?			
7. Have you identified agency policies/procedures that may need to be revised to support ARTAS?			
8. Do you have office space for the staff of ARTAS?			
8(a) Is there office space for LCs at the referral sites, if desired?			
9. Do you have the supplies and equipment to implement ARTAS? Examples include computers and cell phones/pagers for LCs.			
10. If necessary, do you have the capacity to develop a monitoring and evaluation plan?			

	Yes	No	Comments | Next Steps
11. If necessary, do you have the technological capacity to collect and analyze data?			
12. If necessary, are staff proficient in the software necessary for these activities?			
13. Will you be required to clear an Institutional Review Board (IRB)? If so:			
13(a) Do you have an IRB?			
13(b) Do you have the capacity or history of working with an IRB?			
Community Readiness	**Yes**	**No**	**Comments | Next Steps**
1. Do you have relationships with potential community partners such as HIV testing sites, medical providers, case management services, and other support services?			
2. Do you have clear, specific ARTAS-related roles for community partners within the community's system of care?			
3. Do you have formal contracts and/or established referral protocols with existing community partners? *These can be a starting point to launch ARTAS.*			
4. If necessary, have you identified resources in the community to secure transportation subsidies or incentives for clients?			
5. If necessary, do you have staff or a consultant who can create marketing materials to promote ARTAS to community partners?			

B. Getting Started Activity #2: Identify Potential Barriers and Solutions

It is also important to review potential barriers to the successful implementation of ARTAS. While the agency may not be able to eliminate all potential barriers, being aware of them will allow the agency to plan accordingly. Below is a form with common barriers identified by the researchers and demonstration sites. The form lists possible solutions, in italics, for the agency to consider. Since agencies' structures and implementation plans may vary, the solutions listed are suggestions to consider. Space is provided for the agency to add additional barriers, solutions, and the person(s) responsible for monitoring and/or alleviating the barrier.

Identifying Barriers and Solutions Form

Potential Barrier: *Linkage Coordinator assigned to non-ARTAS tasks*	
Problem(s): *Non-ARTAS tasks assigned to the LC does not allow him/her adequate time to effectively complete ARTAS-related activities.*	
Solution(s): *Dedicate the LC's time solely to ARTAS. Small caseloads allow the LC to provide individualized, intensive services to each client. This includes but is not limited to: following up with clients, completing paperwork, attending sessions and appointments outside of the agency, and cultivating and maintaining effective relationships with clients and community partners.*	**Person responsible:** *Program Director/Manager (with input from the Supervisor)*
Solution(s):	**Person responsible:**

Potential Barrier: *Too little time for clinical supervision*	
Problem(s): *Fidelity to the intervention was lost because the LC did not adhere to the Core Elements of ARTAS.*	
Solution(s): *Schedule regular staff meetings with all ARTAS staff, and case staffing meetings between the Supervisor and the LC(s) to review client progress and to discuss any challenges. Routine supervision was identified as very important to ensure fidelity to the ARTAS intervention; without this, it may be easy for the LC to inadvertently stray from the Core Elements.*	**Person responsible:** *Supervisor (with cooperation from the LC)*
Solution(s): *Send the LC and Supervisor to an ARTAS training.*	**Person responsible:** *Program Director/Manager or Supervisor*
Solution(s):	**Person responsible:**

Potential Barrier: *Poor internal buy-in from other case managers*	
Problem(s): *The difference in caseloads between long-term/Ryan White case managers and the LC may be striking, and it may cause tension between the two.*	
Solution(s): *Early on, explain the short-term, intensive nature of ARTAS. Make it clear how ARTAS complements other case management and counseling services provided within the agency.*	**Person responsible:** *Program Director/Manager*
Solution(s): *Arrange for the LC to complete all required documents and enrollment forms for each client before transferring them to the long-term/Ryan White case managers.*	**Person responsible:** *Program Director/Manager or Supervisor*
Solution(s):	**Person responsible:**

Potential Barrier: Buy-in from external case managers and other partners	
Problem(s): *Community partners may feel threatened when they first learn about ARTAS. They may see the intervention as competition, and think it will take clients away from their services.*	
Solution(s): *Early on, explain the short-term, intensive nature of ARTAS. Make it clear how ARTAS complements other case management and counseling services provided within the community. Explain that ARTAS has the sole goal of linking clients to care; clients can come to Ryan White/long-term case management already linked to care so these case managers can focus on clients' other needs such as housing, nutrition assistance, and employment.*	**Person responsible:** *Program Director/Manager*
Solution(s): *Arrange for the LC to complete all required documents and enrollment forms for all clients before transferring them to the long-term/Ryan White case managers.*	**Person responsible:** *Program Director/Manager or LC*
Solution(s): *Use the job title Linkage Coordinator (as opposed to Linkage Case Manager) to avoid confusion with long-term/Ryan White case managers.*	**Person responsible:** *Program Director/Manager*
Solution(s):	**Person responsible:**

Potential Barrier: Lack of clarity among community partners	
Problem(s): *Confusion among community partners about their roles and the roles of others in the intervention may lead to low referral rates and ineffective partnerships.*	
Solution(s): *Provide ongoing education to community partners. Possible formats include one-on-one meetings and formal or informal presentations. Emphasize the goal of ARTAS, how it can enhance their existing services, and other benefits to their agency and clients.*	**Person responsible:** *LC*
Solution(s): *Develop clear, easy to understand marketing materials and a marketing plan to educate community partners about ARTAS.*	**Person responsible:** *LC*
Solution(s): *Develop and sign an MOA with each community partner that: (1) clearly states each agency's roles and responsibilities; and (2) spells out the agreed-upon referral process.*	**Person responsible:** *LC*
Solution(s):	**Person responsible:**

Potential Barrier: *Logistical challenges*	
Problem(s): *Logistical barriers, such as inadequate office space for LC to meet with clients and/or hold office hours at the testing site(s) will likely arise.*	
Solution(s): *Provide the LC with a cell phone and institute an on-call system with the referral sites. This will allow the LC to go to the testing site when a client tests positive or to speak with the client on the phone soon after the test results.*	**Person responsible:** *Program Director/Manger*
Solution(s): *Develop and sign an MOA with each community partner that spells out any logistical processes that are involved in the agreed-upon referral process.*	**Person responsible:** *LC*
Solution(s):	**Person responsible:**

Potential Barrier: *Low referral rates*	
Problem(s): *It may take some time for the testing sites to adjust to the new referral system. Passive referrals may continue because staff members are not accustomed to the ARTAS referral protocol.*	
Solution(s): *Develop and sign an MOA with each community partner that spells out any logistical processes that are involved in the agreed-upon referral process.*	**Person responsible:** *LC*
Solution(s): *Keep in regular contact with referral sites to maintain effective working relationships with the community partners, update them on progress being made, and remind them about the referral process.*	**Person responsible:** *LC*
Solution(s):	**Person responsible:**

Potential Barrier:	
Problem(s):	
Solution(s):	**Person responsible:**
Solution(s):	**Person responsible:**

Potential Barrier:	
Problem(s):	
Solution(s):	**Person responsible:**
Solution(s):	**Person responsible:**

Potential Barrier:	
Problem(s):	
Solution(s):	**Person responsible:**
Solution(s):	**Person responsible:**

C. Getting Started Activity #3: Obtain Internal/External Buy-in from Stakeholders

Gaining support or buy-in from both internal stakeholders (agency staff) and external stakeholders (community partners) is a critical Getting Started activity. This activity guides the agency through the recommended steps for:

► Identifying stakeholders within the agency and the community
► Involving these stakeholders in ARTAS
► Gaining their buy-in for ARTAS

The implementing agency should use this activity as a guide to consider which organizations to reach out to within the community and how to engage them in the implementation of ARTAS. Since implementation of ARTAS varies slightly by setting – health department vs. CBO/other – two different worksheets are provided. Whichever works best for the implementing agency should be used. The worksheets contain a list of suggested activities and a column for the staff to record pertinent information, such as key stakeholders. Examples are provided in *italics*. The activities are in bold text, and the steps to complete the activity are listed in the rows shaded in gray.

Stakeholders' Buy-in Worksheet:
Community-Based Organizations/
Non-Health Department Settings

1. Identify your stakeholders.	
Potential stakeholders include:	**List your agency's stakeholders:**
Your agency's Board of Directors/Executive Board	
Staff members from your agency who will have a role in the operation of the intervention (examples below) ● *Program Director/Manager* ● *Supervisor* ● *Linkage Coordinators* ● *Evaluator*	
Local agencies from which you could receive referrals (examples below) ● *Public health clinics* ● *STD clinics* ● *Counseling and testing sites* ● *Hospitals (inpatient)* ● *Community-based organizations providing HIV prevention services, including counseling and testing* ● *AIDS service organizations* ● *Walk-in clinics/Urgent care centers* ● *Private doctors and Private practices* ● *Correctional system (jails/prisons)* ● *Emergency rooms* ● *Drug treatment centers* ● *Mental health centers* ● *Other sites with which staff have relationships*	
Medical care providers to whom you could link clients (examples below) ● *Public health clinics* ● *Private doctors* ● *Other health care providers serving people living with HIV/AIDS*	
Long-term case management providers to whom you could transition clients (examples below) ● *Ryan White case management providers* ● *Other case management agencies serving people living with HIV/AIDS*	
Organizations that could provide other assistance or resources (examples below) ● *Other agencies providing support services, such as substance abuse treatment, mental health services, housing assistance* ● *Agencies that can provide transportation or transportation subsidies* ● *Merchants to provide incentives for clients* ● *Printers and publishers who can produce marketing materials for the intervention*	

Other agencies with which your agency needs to maintain good community or professional relations (examples below)
   ● *Local and state health departments*
   ● *Your funding source(s)*
   ● *Local medical and mental health association*	

2. Obtain buy-in from your stakeholders.

Inform them about the intervention:

What specific roles do you want each stakeholder to play (examples below)?	List which stakeholder you will ask to fill each role:
● *Refer recently diagnosed individuals to the intervention.*	
● *Be a resource to which you can refer clients for medical care.*	
● *Be a resource to which you can refer clients for long-term case management and/or other services.*	
● *Donate small incentives or provide transportation subsidies for clients.*	
● *Produce marketing materials.*	
● *Speak in favor of ARTAS in conversations with their associates.*	

Send a letter to introduce ARTAS to them.
● Use plain language in the letter so it is easily understood. ● Provide information about the intervention, its importance, how it can contribute to the existing system of care and the stakeholders' work, and what role the stakeholder might have in the intervention. ● Inform them of any upcoming meetings/presentations about ARTAS.
Hold a stakeholder meeting to explain ARTAS, answer questions, and introduce LCs and other key staff.
Follow up with stakeholders who could not attend the initial meeting. Schedule a time to give a presentation or hold a luncheon or one-on-one meeting at their agency to introduce ARTAS.

Obtain their support.
Describe specific roles they could play.
Emphasize the benefits of their involvement and how it will make their work easier. Also emphasize the benefits to the community the agency serves.

Involve them.
Establish Memoranda of Agreement with community partners. Create an MOA with the referral agency that includes an ARTAS-specific referral protocol.
Keep in regular contact with community partners to maintain good relationships with them.
Stay in regular contact with medical providers and long-term case management agencies to which they refer clients.
Continue to educate others about ARTAS during any regularly scheduled meetings of HIV service providers, medical providers, counseling and testing providers.

Stakeholders' Buy-in Worksheet:
Health Department

1. Identify your stakeholders.

Potential stakeholders include:	List your agency's stakeholders:
State health department staff including administrators and other key state and local government staff	
Staff members from your agency who will have a role in the overall implementation and operation of the intervention ● *Program Director/Manager or Contracts Manager* ● *Evaluator*	
Local agencies with which you will subcontract to implement the intervention ● *Case management providers serving people living with HIV/AIDS* ● *Community-based organizations serving people living with HIV/AIDS* ● *AIDS service organizations* ● *Other case management providers*	
Staff members from the subcontracting agency who will have a role in the operation of the intervention ● *Program Director/Manager* ● *Supervisors* ● *Linkage Coordinator*	
Local agencies from which you could receive referrals ● *Public health clinics* ● *STD clinics* ● *Counseling and testing sites* ● *Hospitals (inpatient)* ● *Community-based organizations providing HIV prevention services, including counseling and testing* ● *AIDS service organizations* ● *Walk-in clinics/urgent care centers* ● *Private doctors and private practices* ● *Correctional system (jails/prisons)* ● *Emergency rooms* ● *Drug treatment centers* ● *Mental health centers* ● *Other sites with which staff have relationships*	
Medical care providers to whom you could link clients ● *Public health clinics* ● *Private doctors* ● *Other health care providers serving people living with HIV/AIDS*	

Long-term case management providers to whom you could transition clients
   ● *Ryan White case management providers*
   ● *Other case management agencies serving people living with HIV/AIDS*	

Organizations that could provide other assistance or resources
   ● *Other agencies providing support services, such as substance abuse treatment, mental health services, housing assistance, food banks*
   ● *Agencies that can provide transportation or transportation subsidies*
   ● *Merchants to provide incentives for clients*
   ● *Printers and publishers who can produce marketing materials for the intervention*	

Other agencies with which your agency needs to maintain good community or professional relations
   ● *Your funding source(s)*
   ● *Local medical and mental health associations*	

2. Obtain buy-in from your stakeholders.

Inform them about the intervention:

What specific roles you want each stakeholder to play (examples below)?	List which stakeholder you will ask to fill each role:
● *Refer recently diagnosed individuals to the intervention.*	
● *Be a resource to which you can refer clients for medical care.*	
● *Be a resource to which you can refer clients for long-term case management and/or other services.*	
● *Donate small incentives or provide transportation subsidies for clients.*	
● *Produce marketing materials.*	
● *Speak in favor of ARTAS in conversations with their associates.*	

Send a letter to introduce ARTAS to them.

- *Use plain language in the letter so it is easily understood.*
- *Provide information about the intervention, its importance, how it can contribute to the existing system of care and the stakeholders' work, and what role the stakeholder might have in the intervention.*
- *Inform them of any upcoming meetings/presentations about ARTAS.*

Hold a stakeholder meeting to explain ARTAS, answer questions, and introduce LCs and other key staff.

Follow up with stakeholders who could not attend the initial meeting. Schedule a time to give a presentation or hold a luncheon or one-on-one meeting at their agency to introduce ARTAS.

Obtain their support.

Describe specific roles they could play.

Emphasize the benefits of their involvement and how it will make their work easier. Also emphasize the benefits to the community the agency serves.

Involve them.
Establish Memoranda of Agreement with community partners. Create an MOA with the referral agency that includes an ARTAS-specific referral protocol.
Keep in regular contact with community partners to maintain good relationships with them.
Stay in regular contact with medical providers and long-term case management agencies to which they refer clients.
Continue to educate others about ARTAS during any regularly scheduled meetings of HIV service providers, medical providers, counseling and testing providers.

D. Getting Started Activity #4: Develop a Budget

The final getting started activity is developing a budget. **Note: These figures will vary by agency and are meant only as guidance. These budget figures should be adjusted to the agency's implementation plan and to meet the needs of the target population.**

Personnel

Staff levels of effort to consider are as follows:

- ► One 25% Full-Time Equivalent (FTE), paid Program Director/Manager to oversee implementation activities. If the Program Director/Manager will serve as the Evaluator, then increase the FTE to 40%;
- ► One 25% FTE, paid Contracts Manager (if the agency is a health department contracting out the implementation of ARTAS). The Program Director/Manager may also serve as the Contracts Manager, in which case the FTE should be increased to 40%;
- ► One 15% FTE, paid Evaluator to design and conduct monitoring activities;
- ► One 7% FTE, paid Supervisor to provide clinical supervision to the LC; and
- ► As many 100% FTE, paid Linkage Coordinators as needed to serve the population. Remember, each LC will maintain a small caseload (25 to 30 clients at any given time).

Due to the low level of effort for the Supervisor, the agency will likely want to utilize current staffing capacity for this position. That is, this work could be absorbed into an existing supervisor's role.

Travel and Transportation

For training on ARTAS, the agency should plan to send each LC to a two and a half-day training. The travel costs related to the training will primarily occur during the Pre-Implementation phase. However, due to staff turnover, it is recommended that implementing agencies budget for travel for one staff person per year to attend the training during the Implementation phase. The agency should plan to reimburse the LC for work-related travel – attending the client sessions, going to medical appointments, and meeting with community partners. Since transportation is frequently a barrier to accessing medical care, it may also be useful to provide transportation subsidies to clients.

Equipment

Each LC will likely need access to a laptop or desktop computer to use for entering data and writing reports. When implementing ARTAS, the agency may want to provide each LC with a cell phone and/or beeper, so s/he can be reached immediately when a person receives an HIV-positive diagnosis. In addition, the LC would be more available to clients.

Marketing and Recruitment

It is important to conduct initial outreach to community partners to introduce them to ARTAS and gain their support. Expenses related to outreach include the production and printing of brochures and other marketing materials as well as room rental and other

costs associated with informational meetings. These costs will vary by agency based on the amount of resources the implementing agency deems necessary to devote to marketing. Some agencies will not need to market the intervention extensively because the services are co-located or because referral processes are already in place with testing and medical sites. The implementing agency may also choose to provide small incentives to clients for attending client sessions or completing the intervention.

Cost Sheet
As noted above, an agency may need a 25-40% FTE Program Director/Manager, 25% Contracts Manager, 15% FTE Evaluator, 7% FTE Supervisor, and 100% FTE Linkage Coordinator(s). The following cost sheet may be used as a guide to prepare a budget.

Regarding the marketing and recruitment line, the assumption is that marketing materials will be created in-house and not by a consultant. If a consultant is hired to create marketing materials, or if the implementing agency does not need marketing materials, the budget should be adjusted accordingly.

In using this cost sheet to develop a budget, agency staff should assume there will be no donations, volunteers, or in-kind contributions: all costs/values should be included in order to obtain an accurate idea of how much the intervention will cost the implementing agency. However, it is a good idea to list separately the potential in-kind contributions in the implementation plan.

Cost Categories for the Implementation of ARTAS

Categories	Pre-Implementation (start-up)		Implementation (intervention delivery)	
Personnel	# Staff	% time or # hrs/wk (%FTE spent on intervention)	Staff	% time or # hrs/wk (% FTE spent on intervention)
Salaried:				
Program Director/Manager	1	25-40%	1	25-40%
Contracts Manager	1	25%	1	25%
Evaluator	1	15%	1	15%
Supervisor	1	7%	1	7%
Linkage Coordinator (caseload: 25-30 clients)	#	100%	#	100%
Fringe Benefits		X%		X%
Facility(ies)	(% time used for intervention)		(% time used for intervention)	
Rent: Office	$ x % =		$ x % =	
Utilities	$ x % =		$ x % =	
Telephone/Fax	$ x % =		$ x % =	
Maintenance	$ x % =		$ x % =	
Insurance	$ x % =		$ x % =	
Equipment	(% time used for intervention)		(% time used for intervention)	
Computers	$ x % =		$ x % =	
Pager/Cell Phone	N/A		12 mo. x $ /mo. =	
Equipment Maintenance	$ x % =		$ x % =	
Internet Service Provider	$ x % =		$ x % =	
Supplies				
Copying & Printing	$		$	
Office Supplies:				
Paper	# reams x $ /ream =		# ream x $ /ream =	
Pens	# doz. x $ /doz. =		# doz. x $ /doz. =	
Client Incentives	N/A		# clients x $ /ea. =	
Marketing & Recruitment				
Printed Materials:				
Brochures	# brochures x $ /ea. =		# brochures x $ /ea. =	
Posters	# posters x $ /ea. =		# posters x $ /ea. =	
Meeting Space	$ x # meetings =		N/A	
Incentives	#pers. x $ /pers. =		# pers. x $ /pers. =	
Travel/Transportation				
LC Travel to/from client sessions	# miles x ¢/ mile =		# miles x ¢/ mile =	
Client Transportation				
Travel to Training	N/A		# clients x $ ea. =	
	# staff x $ /trip =		1 staff x $ /trip =	
Other	(% time used for intervention)		(% time used for intervention)	
Indirect Costs	$ x % =		$ x % =	
Insurance	$ x % =		$ x % =	

VI. Intervention Logic Model

Many agencies rely on logic models for program and intervention planning. Logic models are particularly useful for focusing evaluation activities and identifying program indicators to be measured. Logic models are important because they present a systematic, graphic representation of intervention resources, activities, and outcomes, and articulate the intended links among these intervention components. Logic models help implementing agencies by providing a big picture of the intervention. Implementing agencies can use the logic model as a tool to make sure they are following the Core Elements and achieving the desired outcomes.

While the visual scheme of a logic model may vary, it will contain the following core components: inputs, activities, outputs, outcomes, and impact. The **ARTAS Behavior Change Logic Model** on page 30 summarizes *what* change is intended when an agency implements the intervention. The **ARTAS Implementation Summary** on pages 31-32 summarizes *how* the behavior change logic model is intended to be implemented or the central requirements to be put into practice.

The **ARTAS Work Plan** on page 33 depicts the phase in which each activity listed on the ARTAS Implementation Summary should be conducted. Note: Several activities are conducted during one or more phase (getting starting, pre-implementation, implementation, maintenance, and adaptation).

ARTAS Behavior Change Logic Model

Problem Statement: The target populations for ARTAS are HIV-positive men and women over the age of 18, who have been recently diagnosed with HIV (i.e., within the past 6 months). The primary goal of this intervention is to facilitate linkage (or re-linkage) with medical care for the treatment of HIV/AIDS. Poor linkage to care results in high-risk behaviors that promote the likelihood of HIV transmission by HIV-infected persons, and the re-infection among those already testing positive. There is evidence to suggest that people who are linked to care are less likely to engage in high-risk behaviors. The benefits of ARTAS come from facilitating linkage with medical care which, in turn, results in better health outcomes. The contextual factors associated with recently diagnosed persons not linking to care include their inability to navigate the system to link to medical care, lack of knowledge about HIV/AIDS, and lack of information and/or resources about how to access care.

Behavioral Determinants *Corresponds to risk or contextual factors*	Activities *To address behavioral determinants*	Outcomes *Expected changes as a result of activities targeting behavioral determinants.*	
		Immediate Outcomes	**Intermediate Outcomes**
Lack of Self-efficacy (i.e., self-confidence, motivation) Lack of knowledge about the benefits of linking to medical care early on Lack of knowledge about the system of care and how to access it Low outcome expectations (e.g., clients don't believe that going to the doctor is useful)	Perform client goal setting by creating a Session Plan Encourage client to use his/her strengths and assets to link to medical care through the development of a Strengths Assessment Use a Strengths-based approach to motivate clients Relationship-building between LC and client Relationship building between LC and community partners One-on-one sessions between LC and client where the benefits of linking to care early are discussed.	Increased self-efficacy Increased knowledge about benefits of linking to care Increased knowledge about system of care and available resources Higher outcome expectations (client believes visiting a doctor will be beneficial)	Linkage to medical care

ARTAS Implementation Summary

INPUTS	ACTIVITIES	OUTPUTS
Inputs are the resources needed to implement and conduct intervention activities. Resources include funds, staff, volunteers, facilities, supplies, equipment, training and capacity-building assistance, and polices, plans, and procedures.	*Activities are the actions required to prepare for and conduct the intervention. There are two sets of activities: those needed to get the intervention started and those needed to implement and conduct intervention activities.*	*Outputs are the deliverables or products that result from implementation activities. Outputs provide evidence of service delivery.*
Experienced and culturally competent staff	Closely review the ARTAS implementation manual	Number of staff hired in [time frame]
Agency buy-in	Conduct an agency strengths assessment and review policies/procedures to ensure the support of the ARTAS Core Elements	Number of staff trained in [time frame]
Community support of the intervention	Identify potential barriers to implementation and possible solutions	Number or community partners reached to participate in ARTAS through an MOA
External training and technical assistance	Conduct an agency readiness assessment and identify technical assistance needs	Percentage of planned number of partners secured in [time frame]
Baseline information about target population's risk behaviors and influencing factors.	Request technical assistance from Project Officer and/or capacity-building assistance (CBA) provider	Percent increase in community partners providing referrals in [time frame]
	Hire, train, and build skills of ARTAS staff	Number of clients enrolled in ARTAS
	Gather baseline data and/or information about target population rates of linking to care	Percentage of planned number of clients recruited/approached for ARTAS in [time frame]
	Amend existing agency policies/procedures as needed or create new ones	Number of clients referred in from other agencies
	Create a marketing plan and materials	Number of clients linked to care
	Determine client eligibility and recruitment processes	Percentage of planned # of clients linked to care in [time frame]
	Determine client referral strategies	Average number of sessions completed by clients prior to linkage to care
	Educate agency staff about ARTAS	

	Recruit and educate community partner staff about ARTAS	Number of clients not linked to care (i.e., attrition rate)
	Inform local public health officials about ARTAS and ask for support	Percentage of planned number of clients completing the ARTAS sessions in [time frame]
	Become familiar with community partners	Number of clients referred out to social services
	Assess need for tailoring or adaptation of intervention	
	If necessary, tailor and adapt Key Characteristics of ARTAS and other intervention materials to the target population	Percentage of planned number of clients referred to other social services in [time frame]
	Obtain and use consumer, community stakeholder input	Percentage of ARTAS clients who were very satisfied/satisfied with ARTAS in [time frame]
	Develop a monitoring and evaluation plan including tools, data collection, data analyses, interpretation, and reporting	Percentage of increase in clients linked to medical care in [time frame]
		Number and types of non-medical care services clients were referred to (e.g., housing, food, transportation)

ARTAS Work Plan

Activity	Getting Started	Pre-Implementation	Implementation	Maintenance	Adaptation
Closely review the ARTAS Implementation Manual	▓				
Conduct an Agency Strengths Assessment, and review policies/procedures to ensure the support of the Core Elements	▓				
Identify potential barriers to implementation and possible solutions	▓				
Conduct an Agency Readiness Assessment, and identify TA needs	▓				
Request TA from Project Officer and/or CBA Provider	▓	▓	▓	▓	▓
Hire, train, and build skills of ARTAS staff	▓	▓			
Gather baseline data and/or information about target population rates of linking to care	▓	▓			
Amend existing policies/procedures as needed, or create new policies/procedures	▓	▓			
Create a marketing plan and materials		▓			
Determine client eligibility and recruitment process	▓	▓			
Determine client referral strategies	▓	▓			
Educate agency staff about ARTAS	▓	▓	▓	▓	
Recruit and educate community partners	▓	▓			
Inform local public health official about ARTAS, and ask for support	▓	▓			
Become familiar with community partners	▓	▓			
Assess needs for tailoring and adapting				▓	▓
If necessary, tailor and adapt the key characteristics of ARTAS and other intervention materials to the target population				▓	▓
Obtain and use consumer, community stakeholder input	▓	▓			
Develop a program monitoring and evaluation (M&E) plan	▓	▓			

PRE-IMPLEMENTATION
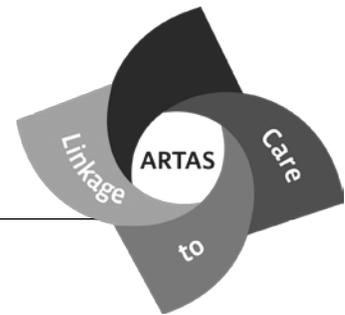
The Pre-Implementation section helps the agency prepare to conduct the intervention. Once the agency decides to implement ARTAS, it is now ready to make any necessary organizational changes, obtain the necessary human and monetary resources, build relationships with community partners, create a marketing plan, and develop a monitoring and evaluation plan. This section also contains various tools, checklists, and helpful reminders for the agency to use in the Pre-Implementation stage. The Pre-Implementation activities included in this section are:

    I.   Planning for Implementation
    II.   Staffing Guidelines
    III.   Preparation Work with Community Partners
    IV.   Client Enrollment
    V.   Safety Guidelines and Protocols
    VI.   Cultural Competency
    VII.   Boundaries
    VIII. Confidentiality
    IX.   Linkage Coordinator Preparation
    X.   Developing a Monitoring and Evaluation Plan

I. Planning for Implementation

After the agency decides to implement ARTAS, the next step is to prepare for its implementation. Key staff, including the Executive Director, ARTAS Program Director/ Manager, and LC Supervisor, should plan the Pre-Implementation and Implementation activities.

During this stage, the agency should look at internal and external factors that may support or hinder the success of the intervention. These include client-, agency-, and system-level factors. While the agency may be able to do little more than plan around the client- or system-level issues, it should be able to address agency-level issues. Agency-level issues can be addressed by adapting agency polices, practices, and staffing, and/or by adapting the intervention.

When examining the following Pre-Implementation activities, agency staff will need to assess whether changes will be required within the agency to implement ARTAS. Adapting ARTAS will be discussed later in the Adaptation section.

The following activities will help prepare the agency to implement the intervention:

► **Assess the agency using a strengths-based approach:** It is important to review the agency capacity and readiness assessments completed in the Getting Started phase, and articulate the strengths and abilities that have served the agency well in the past. Staff should consider using a modified version of the strengths-based assessment and goal-setting exercise used during the client sessions. This will allow the implementing agency to practice working within a strengths perspective. The agency should use the strengths and abilities identified to resolve any potential barriers to implementation.

► **Create a supportive environment for strengths-based practices within the agency:** Institutionalizing a new, strengths-based perspective or mindset will not occur overnight. ARTAS staff members and other key agency personnel may wish to change the culture of the agency slowly throughout the implementation of ARTAS. The agency can achieve this by introducing strengths-based practices at many levels within the agency. Examples of strengths-based practices include: training the receptionist to focus on clients' positive attributes (e.g., showing up for an appointment), using a strengths-focused approach to supervision, and revising agency paperwork to highlight a client's strengths and abilities rather than inabilities. Incorporating a strengths approach within the implementing agency can provide a greater understanding of and demonstrate support for the ARTAS Core Elements.

For example, with strengths-based supervision, the LC Supervisor conducts the case staffing meetings with an emphasis on *strengths and abilities*, not deficiencies and inabilities. Using this approach allows the Supervisor to: (1) assess the LC's understanding of the strengths approach; (2) model strengths-based behaviors for him/her on a regular basis; and (3) reinforce what the LC should be doing with his/her clients. For further information on the LC Supervisor's role in the implementation of ARTAS, **refer to Appendix A, the LC Supervisor Guide**.

Another example relates to revising agency paperwork to incorporate a strengths approach. ARTAS requires a strengths-based assessment and client-driven goal setting. However, the agency may have existing intake forms or case management forms that focus on the person's *inabilities* or *previous failed* attempts to link to medical care. Because two of the Core Elements are involved, the implementing agency must revise the paperwork used for ARTAS. To avoid confusion among the clients, the agency may want to consider revising the existing paperwork used for other services within the agency as well. The agency should seek capacity-building assistance (CBA) services if needed in this area.

► **Compare current linkage processes to the proposed ARTAS linkage processes**: The agency should detail the processes it currently uses to link clients to support services or treatment, compare them to the proposed ARTAS linkage processes, and then answer these questions:

- Are the processes consistent with one another? If not, how do they differ?
- Do the existing processes contradict the Core Elements of ARTAS?

If they are consistent, it may be possible to integrate the ARTAS linkage process into pre-existing protocols without major alterations.

If existing processes are inconsistent with the ARTAS Core Elements and/or ARTAS processes, consider revising them to ensure standardization throughout the agency and adherence to the Core Elements. Staff will need to be trained on any revisions made to the existing processes, as well as protocols established for ARTAS. It is important that staff understand any and all changes to linkage processes. The results of this activity should be used to start outlining the implementing agency's preferred referral processes. Note: The agency may need to alter the processes slightly to accommodate a key community partner. However, the agency should have a clear idea of how it would like the process to flow before reaching out to potential community partners.

► **Integrate ARTAS in the agency:** Intra-agency support for ARTAS is key to the success of the intervention. All agency staff must understand and support ARTAS at its most basic level – increasing linkage to medical care. Intra-agency communications, if done correctly, can minimize the perception that ARTAS staff are getting "special treatment" or "stealing" clients. Moreover, staff members who understand the value of ARTAS will be more inclined to work collaboratively with intervention staff and market ARTAS within their networks.

One method to communicate the goal, benefits, and approach of ARTAS is to hold information sessions for non-ARTAS staff. Along with ARTAS-specific information, providing local data about linkage rates and agency-specific data helps staff understand the importance of devoting agency resources to the intervention.

► **Assess policies and/or procedures:** During Pre-Implementation, the implementing agency should review its current non-ARTAS policies and procedures for any discrepancies with the Core Elements of the intervention. If there are inconsistencies, the agency should consider revising agency policies, if possible, to facilitate successful implementation. While the policies do not need to be completely rewritten to accommodate ARTAS, the value added to the intervention and the agency overall for making some of these changes should be considered.

Below are two examples in which the Core Elements or Key Characteristics of ARTAS may be inconsistent with the agency's existing policies or procedures and potential solutions.
- Meeting location. ARTAS is a client-driven intervention, and one of the Core Elements requires that the LC conduct case management as an active, community-based activity. This Core Element is important because

it gets the LC out into the client's community and gives him/her a better understanding of the environment in which the client is living and barriers s/he is facing. By engaging with the client at this level, the LC will have a better understanding of possible solutions to recommend.

Meeting each client in his/her environment and outside the office, whenever possible, brings up many issues that the agency will have to address in the Pre-Implementation stage. For example, the client may want to meet in a location other than the agency's office. Therefore, the agency should adjust any policies stating that client meetings are required to take place at the agency. Moreover, the agency should have guidelines for safety and acceptable meeting locations to help guide clients and the LC.

However, it is important to note that as long as the client agrees, client sessions may take place at the agency, at a mutually-agreed upon location, and/or with a second LC present. The main point here is that the Core Element requires the agency staff to *conduct case management as an active, community-based activity by meeting each client in his/her environment and outside the office.*

- Transportation. Since providing transportation is a Key Characteristic, the agency is not required to provide this service, but it may want to come up with alternatives for clients. If the implementing agency decides not allow the LC to transport a client in his/her personal vehicle, then other arrangements should be made to assist the client with transportation (e.g., reimbursement or providing transportation via an agency-owned vehicle, bus tokens, taxi fare). If policies cannot be changed, the agency can think about other strategies such as providing subsidies for taxi cabs and public transportation.

Once the agency completes these initial Pre-Implementation activities, it is time to hire the ARTAS staff.

II. Staffing Guidelines
Below are staffing guidelines for different types of agencies that may wish to implement ARTAS. Any differences based on the type of agency are noted in the text below (e.g., the health department is the grantee, but the intervention will be conducted by a CBO or ASO). Many of the recommended qualifications for each staff position discussed below were identified by some of the demonstration sites in the research study.

The implementing agency may wish to assess existing personnel, especially case managers, to determine if they possess the necessary skills and personality traits. The agency may wish to assign current case managers to ARTAS or hire new staff, as needed.

A. Staffing Plan

The staff positions to consider when implementing ARTAS are a Program Director/Manager, LC Supervisor, an Evaluator, as many Linkage Coordinators as needed to serve the population (based on a small caseload of 25 to 30 clients at any given time), and a Contracts Manager (if the implementing agency is a health department contracting out the implementation of ARTAS).

The **Program Director/Manager** is responsible for the overall implementation of the intervention including:

- Providing leadership both internally and externally
- Assessing and building the agency's capacity to implement ARTAS
- Providing fiscal management, which includes identifying and securing the necessary resources
- Hiring and managing intervention staff
- Managing and monitoring the intervention, including ensuring fidelity
- Writing (or reviewing) reports required by the funding agency
- Approving the marketing plan and materials and the monitoring and evaluation plan and materials
- Obtaining internal support for the intervention
- Obtaining external support and participation from community partners and HIV care providers, as needed

If the Program Director/Manager also serves as the **Contracts Manager** at a health department, s/he would be responsible for the overall grant management and procurement process. S/he would be responsible for collecting and reviewing any required deliverables from the subcontractors (CBOs or ASOs) and maintaining regular communication with them.

The **LC Supervisor** plays a crucial role in supporting the LC in the day-to-day implementation of ARTAS as well as activities to support the Core Elements. The LC Supervisor is responsible for:

- Supervising the LC (and other case managers)
- Coordinating activities with the Program Director/Manager and Evaluator to monitor quality assurance and fidelity to implementation
- Reaching out to community partners and HIV medical care providers, as needed
- Facilitating the communication between the ARTAS staff and other agency staff – especially with non-ARTAS case managers (CMs) – to minimize conflict
- Using a strengths-based approach to supervision to model and reinforce behaviors for the LC
- Conducting regular staff meetings and case staffing meetings
- Monitoring the activities, accomplishments, barriers. faced by each LC
- Making the initial contact with community partners and providers, especially if the LC does not have an existing relationship with the potential partner

The **LC Supervisor** should have a strong background in Social Work and case management, strong clinical skills, an excellent understanding of boundaries,

knowledge of community, regional, and state resources available (e.g., Ryan White services, ADAP), and have knowledge of HIV prevention, care, treatment, and counseling. Experience with Motivational Interviewing techniques, specifically responsive listening, is useful but not required. The Supervisor should be knowledgeable about strengths-based case management, which may include previous experience or training, and must be supportive of a strengths approach to linking people to medical care and supervision.

The **Evaluator** is responsible for designing a monitoring and evaluation plan and overseeing monitoring-related activities, including but not limited to, creating data collection forms and processes, data entry and verification, and conducting data analysis. Data entry may be included in the Evaluator's role or performed by the LC. The Evaluator position may be filled by an agency staff person or consultant with experience designing and executing monitoring and evaluation plans. The Evaluator will work in collaboration with the Program Director/Manager to ensure fidelity to the intervention and develop monitoring-related reports for the intervention and the funding agency, as requested. Note: This position may or may not be required by the funding agency.

The **Linkage Coordinator** is responsible for:
- Screening recently diagnosed patients for eligibility to participate in ARTAS
- Conducting client sessions with a caseload of 25–30 clients at any given time
- Conducting active, community-based, strengths-based case management
- Developing and implementing a marketing plan for ARTAS
- Creating marketing materials to educate potential community partners
- Building and maintaining effective working relationships with community partners
- Working closely with case managers and social workers in both a medical and community setting to coordinate medical care
- Conducting data collection and entry
- Maintaining careful and accurate documentation for all contact with ARTAS clients
- Carrying out other ARTAS duties as required

Regardless of the type of agency implementing ARTAS, the LC Supervisor and LC should be located at the same agency.

Additional, part-time positions may be required depending on the agency's implementation plan. Potential positions include a communications person or graphic designer for the marketing materials or a receptionist who will greet clients as they come into the agency.

B. Guidelines for Selecting a Linkage Coordinator
To a significant degree, successful implementation of ARTAS depends on careful selection of the LC who will deliver the intervention. While certain qualifications such as

previous experience and specific skill-sets are important, other characteristics and personality traits are also important for the LC to possess or learn to better facilitate the implementation of ARTAS. Below is a discussion of both.

First and foremost, the most important qualification of an LC candidate is the *ability to emphasize strengths rather than problems*.

The following should be seen as recommendations and guidelines for the implementing agency. The following are not strict requirements. An LC should have at least a Bachelor's degree in Social Work or similar field, with three to five years' experience, or a Master's degree with one year of experience working with the health care delivery system and assisting marginalized populations. While it is important for the LC to have experience providing case management to clients, it is also important that the LC be willing to learn and use a *new and modified approach* to case management – the strengths-based approach. A familiarity with Motivational Interviewing techniques and other effective communication skills is beneficial. The LC can seek training to gain these skills and/or strengthen existing skills. Another recommended qualification is experience with commonly used computer software systems, such as Microsoft Excel™, Microsoft Access™, SPSS, any software required by the funding agency, and other computer systems used to track clients.

Several required qualifications are based on the Core Elements. They include knowledge of and experience with:
- Existing community resources such as Medicare, Medicaid, Ryan White, ADAP
- Regional/state care delivery systems
- Services, skills, and reputations of HIV care providers and clinics
- Existing relationships within the HIV testing and care networks

Since knowledge of the above relate to the Core Elements, if they are not included in the job description or hiring criteria, the LC hired must become familiar with these entities prior to seeing clients.

Important characteristics and personality traits for the LC to possess are:
- Creative problem solving ability
- Flexibility – especially to adjust to the client's needs, conduct sessions outside the agency, and attend the first medical appointment with the client
- Appreciation of the role that case managers have in helping clients
- Genuine interest in the client's well-being
- Persistence – particularly to follow up with clients multiple times, which includes calling, visiting, and attending appointments with clients
- Patience – especially to provide education, support, and encouragement
- Compassion
- Organizational skills (e.g., detail-oriented) – particularly to maintain session notes, follow up with clients, know where and when to meet a client.
- Friendly disposition
- Ability to be comfortable with diverse populations and life styles

- Openness to learning new approaches to working with clients.

C. Caseload Guidelines

Implementing agencies should closely monitor the LC's caseloads. Due to the intensive nature of ARTAS, the recommended caseload per LC is 25–30 clients at a given time. Because the LC's caseload is much lower than the typical long-term/Ryan White case manager's (CM) caseload, it is important that the LC Supervisor – who also supervises the agency's other CMs – educate non-ARTAS CMs on: (1) the importance of ARTAS; (2) how it differs from long-term/Ryan White case management; and (3) how it benefits the client <u>and</u> the long-term/Ryan White CMs. These benefits include the client coming to long-term/Ryan White case management with an understanding of what they can expect from the case management relationship and, ideally, already linked to medical care. The LC may also complete required paperwork for the long-term/Ryan White CM to assist him/her in the transition.

III. Preparation Work with Community Partners

The development of strong referral relationships with community partners is an important part of ARTAS. Community partners include medical care providers, social service agencies, homeless shelters, criminal justice programs, substance abuse treatment agencies, courts, faith-based organizations, and other agencies with which the LC and clients interact while reducing barriers to linkage to medical care. Also included are the clinics, hospitals, health departments, and other treatment resources where clients may be linked. While ARTAS clients cannot be linked to medical care without strong referral networks, several factors should be considered *before approaching community partners* to form a referral relationship with the implementing agency. These include:

1. There must be a genuine level of trust between agencies and a willingness to participate in a referral relationship. If effective relationships are to be developed, concerns about "territory" and the perception of the LC being used to "steal clients" must be resolved early on by senior staff, not by frontline case managers. One agency implementing ARTAS said, *"We dealt with increasing the level of trust by informing agencies that ARTAS is only a short-term intervention, and we are not interested in taking their clients. We sold them on the benefits of ARTAS, such as clients coming to them more prepared, and the [LC] doing much of the intake paperwork for them ahead of time."*

   It is especially important to distinguish ARTAS from Ryan White case management or Comprehensive Risk Counseling and Services (CRCS) that agencies may already be providing. While linkage to medical care is a component of these other services, the process through which this link is made varies among agencies and can consist of simply a paper referral. Other services also have a broader focus and assist clients in addressing many issues. It should be noted that ARTAS is a short-term, intensive intervention with the specific goal of linking clients to medical care and creating a mindset that they will continue with care. ARTAS serves as a complement to Ryan White case management and CRCS by getting clients into medical care and allowing other case managers

to focus their limited time and resources on helping clients obtain other needed services.

2. It is imperative to clearly explain the goals of ARTAS and explicitly discuss how the LC relies on collaboration with other agencies. A useful tool to promote collaboration and decrease misunderstandings is a simple flow chart that outlines the basic steps of the ARTAS linkage to the medical care process and indicates where partner agencies fit into that process. Incoming referrals can come from a variety of sources, including STD clinics, counseling and testing sites, community-based organizations, another program within the implementing agency, and others. Outgoing referrals are ARTAS clients who are referred out of the program to a number of community resources, including medical providers, substance abuse/mental health treatment, long-term/Ryan White case management, and other social services that address basic client needs. Many of these agencies may also have referred clients into the program. See **Figure 2: Referral Flow Chart** on page 44.

3. People at all levels of the partner and implementing agencies should be made aware of ARTAS and the implications it has on their particular roles and responsibilities. The implementing agency should provide print materials that describe ARTAS with an emphasis on *how the intervention can benefit the staff at the implementing and partner agencies*.

4. It is important to develop a Memorandum of Agreement (MOA) between the implementing and partner agencies in order to guide the agencies' interactions at all levels. Developing an MOA allows the implementing agency to address potential problem areas, save time, and avoid misunderstandings. For an MOA **template**, see **Appendix B**.

Figure 2: Referral Flow Chart

Incoming Referrals

Hospitals	Counseling & Testing Sites
Emergency Rooms	Health Department/ Public Clinics
Urgent Care	STD Clinics
Private Physicians	
Correctional System	Substance Abuse/ Mental Health Treatment Centers
Other Intra-Agency Programs	Community-based Organizations
Self/Other Referral	AIDS Service Organizations

ARTAS

Outgoing Referrals

Private Physicians	Health Department/ Public Clinics
Substance Abuse/Mental Health Treatment Centers	Criminal Justice Programs
	Support Groups
	Employment Agencies
Community-based Organizations	Homeless Shelters
AIDS Service Organizations	Long-Term/Ryan White Case Management
Faith-Based Organizations	Other Intra-Agency Programs

A. Marketing Strategies

During the Pre-Implementation stage, it may be necessary for the LC or Program Director/Manager to develop specific marketing strategies (or consult with an agency staff person with marketing experience) that encourage community agencies in a partnership to either refer clients to ARTAS, or receive ARTAS clients being linked to medical care and other services. Such a partnership depends on several factors including, but not limited to, whether or not the agency has testing, medical, and case management services co-located and whether or not the agency has existing, formal relationships with partner agencies that are conducive to the implementation of ARTAS. The following steps will help in developing a marketing strategy:

Step 1: Identify the agencies and providers the implementing agency wishes to target. Keep in mind that every community is different. In some communities, primary care providers and clinics may be the best sources of referrals. In others, social service agencies or HIV testing sites may be the best referral source. Be sure to make a list of community agencies, contact persons, and phone numbers for outreach purposes.

Step 2: Identify the resources that are available to the implementing agency to develop print and electronic materials describing the intervention. Some agencies have a Communications department or access to consultants who can create an ARTAS brochure and/or information package. A key principle to remember is to keep the messages clear and simple. For main points to include in these brochures, see the brief summary of ARTAS, under "Prior to Working with Community Partners," on page 57 of this section.

Step 3: Schedule meetings with potential community partners to provide information about ARTAS. Community agencies to target may include HIV testing centers, HIV mobile testing units, health departments, STD clinics, substance abuse treatment programs, adolescent clinics, women's health clinics, shelters, and other social service agencies. The aim of these meetings is to educate them about ARTAS and encourage agencies and providers to enter into a Memorandum of Agreement (MOA) that clearly and formally spells out the relationship between the two agencies.

Step 4: Develop low-cost, creative strategies to inform other key stakeholders within the community about ARTAS. The aim is to help increase referrals to the intervention. A few marketing strategies to consider include:
- Inform clergy, physicians, college counselors, and community outreach workers about the intervention. Provide them with printed materials and encourage them to refer recently diagnosed individuals to the intervention.
- Attend regularly scheduled meetings of groups such as HIV consortia, referral networks, and Community Planning Groups (CPGs), and use these venues to market the ARTAS intervention to a wide range of health providers.

B. Referral Strategies

The implementing agency will want to develop two types of referral processes: Incoming Referrals, for recently diagnosed clients who are referred into the ARTAS intervention,

and Outgoing Referrals, for clients linking to medical care and other long-term services. The steps necessary to implement the two processes are outlined below:

► To obtain **Incoming Referrals** of recently diagnosed clients to ARTAS, the agency and LCs should:
  - Meet with community partners and market ARTAS to raise awareness of the program and gain buy-in among referral sources. Agencies must ensure that all partners understand their roles and responsibilities as part of the program.
  - Establish and maintain formal referral relationships through MOAs with community partners that agree to refer clients (e.g., health department clinics, HIV testing sites, STD clinics, social services agencies.
  - Establish informal relationships with people in the community who may have direct contact and influence with recently diagnosed clients (e.g., outreach workers, drug counselors, clergy, high school and college counselors).
  - Agencies should establish, and make partners aware of, specific procedures such as the method of receiving referrals (e.g.., referral source calls agency directly, agency information is given to client) and the agency's process for engaging the client in ARTAS upon receipt of referral.
  - ARTAS staff should create a system to update incoming referral sources on the status of clients they have referred to the intervention. Staff may choose to inform the referral site of the client's progress in linking to medical care by phone, e-mail, or letter. This contact is important as it shows that the referral sites are an integral part of the intervention, and also demonstrates that ARTAS is providing the services it has advertised. If the referral is coming from another program within the implementing agency, it is still important to follow this process.

► To make Outgoing Referrals linking recently diagnosed clients to medical care within 90 days, the agency and LC should:
  - Establish formal relationships, through MOAs, with medical care providers to receive clients.
  - Establish formal relationships, through MOAs, with agencies that will receive ARTAS clients into their long-term case management and/or other immediate service delivery systems such as food banks, shelters, housing agencies, and employment training programs.
  - Ensure all partners for outgoing referrals understand their roles and responsibilities as part of the program.
  - Make sure that the identification of outgoing referrals is consistent with the client-driven nature of ARTAS: the LC should work with the client to identify potential referrals instead of choosing them for the client. Since the client may have many possible referrals, the LC should help the client define his/her priorities. It is important that referrals reflect the client's priorities. After clients have identified possible referrals, the LC can discuss them with the client and offer any additional suggestions that s/he has not listed.

- When giving the referral to the client, the LC should acknowledge that there may be stigma attached to seeking certain services and should normalize the referral by talking about it in the third person, explaining that clients are routinely recommended to these services. The LC should make an effort to refer to services with which s/he is familiar and offer the client any first-hand knowledge of the services and providers.

- If the client does not agree with the referral, it is less likely that s/he will show up for the appointment. The LC should assess the client's reaction to all referrals, as client buy-in is essential in making successful outgoing referrals. If the client is not agreeable to the initial referral, offer other options.
- The LC must facilitate active referrals, and should make this expectation clear to partners to which clients will be referred after ARTAS. The LC should assist the client in handling the logistics such as arranging the first appointment, obtaining transportation, and finding someone to attend the meeting with the client, if the client so desires. It can be helpful for the LC to participate in the client's first meeting with the referral, especially if it is a long-term/Ryan White case manager, in order to facilitate consistency during the transition and ensure that all follow-up issues are addressed. The LC should develop a follow-up plan for the client to follow after accessing the referral; this may include having the client report back about the appointment.[15]

If the implementing agency provides long-term/Ryan White case management services, it is equally important to meet with case managers *within the agency* to ensure that they understand the benefits of ARTAS to their work, as well as the differences between ARTAS and long-term case management. Gaining the support and trust of case managers within the implementing agency is equally as important as establishing formal outgoing referral relationships. This discussion can be similar to the discussion with partner agencies about how ARTAS can supplement and enhance Ryan White case management, Comprehensive Risk Counseling and Services (CRCS), and other services the implementing agency may offer. LCs have smaller caseloads and are *completely focused on linking clients to medical care*, whereas other case managers have larger caseloads and must address a number of client issues. ARTAS's success in this area allows the other case managers to focus limited energy and resources (monetary and otherwise) on addressing the clients' multiple other needs.

Finalizing Referral Processes
Before the agency begins to implement ARTAS, it should ensure that the Memoranda of Agreement and other necessary documents have been signed by all relevant agencies. It is important to document the ARTAS referral protocol in writing, listing the specific actions to be taken, and, where applicable, make sure the protocol lists the specific person responsible for each task and when/how often it is to be completed. It may be useful to visually depict the referral process by using a flow chart or other graphic.

As discussed earlier, when developing the referral protocol for ARTAS, the agency should try to model it after the existing system of referrals being used within the community. Structuring the protocol after a system with which referral sites are familiar can decrease confusion about the process, as well as make it easier for the sites to make referrals to the new program. However, it is also important to clearly explain how the ARTAS referral protocol differs from the other processes within the community's existing system of care. The agency should ensure that there is a parallel referral process and services available in the community for clients who are not eligible for ARTAS.

Referral processes will vary by state and community, but some general differences between ARTAS and standard referral processes are listed below. **Note:** These are based on general processes that may not be in place in all communities implementing ARTAS or other services.

ARTAS Referral Processes	Standard Referral Processes
● Immediate follow-up on incoming referrals; LC may be available when diagnosis is given.	● Client is referred to agency post-diagnosis; referral follow-up time will vary by agency.
● The same LC conducts intake and works with client through the duration of the program.	● Initial intake may be performed by intake counselor or non-case management staff at agency.
● LC facilitates active referrals to medical care and other services. LC may attend the first medical appointment with the client. LC works with client to determine client's needs for outgoing referrals and to set up appointments.	● Referral to medical care and other services may be passive (client is given agency information but must follow up on his/her own).

If necessary, the agency should hold a final meeting with ARTAS staff and the community partners to ensure that everyone understands the goal of ARTAS, comprehends the referral protocol for the program, and has copies of this protocol to refer to and distribute at their agency, before the intervention begins. Answer any remaining questions and explain that LCs will remain in contact with the agencies throughout the ARTAS intervention. At this point, it is also important to solve any remaining logistical issues, such as finding space at the referral site for the LC to meet privately with the client and ensuring that the referral sites have the names and cell phone numbers for each LC.

IV. Client Enrollment
All incoming referrals should be directed to one of the LCs in the implementing agency or someone else who is trained to conduct the ARTAS intake. Upon receiving an incoming referral, the LC should determine whether or not the client is eligible to participate in the intervention based on the eligibility criteria determined by the

implementing agency. The agency may want to consider using the criteria used in the research studies. These criteria state that the client:

- ► Be 18 years of age or older
- ► Be recently diagnosed with HIV within the last 6 to 12 months
- ► Not be on antiretroviral treatment
- ► Not be receiving case management or social work services for HIV-related needs
- ► Be interested in participating in the intervention
- ► Not have visited an HIV care provider more than once

However, it is important to note that the implementing agencies should *choose eligibility criteria that best suit the needs of their target population and agency* <u>unless the eligibility criteria are determined by the funding agency</u>. While the LC screens the client for ARTAS, s/he should obtain the initial intake information from the referral source. If the client meets the eligibility criteria and agrees to participate in the intervention, the LC should enroll the client into ARTAS.

If the initial conversation between the LC and client occurs face-to-face, they may choose to conduct the first client session immediately. If the conversation takes place over the telephone or the client wishes to come back at a later date, the LC and client should schedule the first client session during their initial conversation. During the first client session, the LC will explain ARTAS again, and complete any agency-required and ARTAS-specific paperwork.

If the client **is not eligible** or does not wish to participate in ARTAS, s/he should be referred to long-term/Ryan White case management or other support services. For a diagram of the **ARTAS Client Enrollment Flow Process**, see Figure 3.

Figure 3: ARTAS Client Enrollment Flow Process (*Adapted from the Virginia Department of Health's POWER Program*)

ARTAS Client Enrollment Flow Process

Point of Entry (POE)
Counseling and testing sites
Community based organizations
Public health/ STD clinics

Client receives negative test result and post-test counseling.

Client receives positive confirmatory test result from counselor and is told about ARTAS.

Client is ineligible for or refuses ARTAS.

Client is referred into the current system.

Client is referred to ARTAS. Site contacts LC.

GOAL: Client is engaged in medical care within three months of entering ARTAS.

Client is ineligible for or refuses ARTAS.

Counselor introduces client and LC.
Client accepts ARTAS.
LC and client schedule first session or conduct session at that time.

LC conducts up to five client sessions, utilizing the strengths-based approach.

Client is linked to medical care and/or ARTAS ends.
Client is referred to long-term/ Ryan White case management, another primary care provider, and other services.

V. Safety Guidelines and Protocols

Aspects of ARTAS that serve as valuable tools for building effective, working relationships with clients can also raise concerns regarding safety. It is important to be aware of safety issues that may need to be considered as part of the intervention, and plan accordingly to minimize them and address the issues as they occur.

If the implementing agency provides case management services, it may already have safety guidelines in place. The agency should assess existing guidelines to ensure that they are relevant to ARTAS and supportive of the intervention's Core Elements. The agency may wish to change certain policies to implement ARTAS, or to adapt the intervention to maintain its current policies. Whichever option the implementing agency chooses, the guidelines must sufficiently protect staff and clients, and adhere to the Core Elements.

The two main safety concerns related to ARTAS and guidance for how to handle them are:

► **Transporting Clients in the LC's Personal Vehicle:**
   - If this is an allowable activity under the agency's existing policy, follow the established protocol.
   - If this is not an allowable activity under the agency's existing policy but an exception will be made for ARTAS, create guidelines for the LC to follow. Consider any restrictions or recommendations that are necessary regarding location of pick-up/drop-off, number of passengers, and insurance and liability.
   - If it is not allowed and no exceptions will be made, allocate resources in the budget for client transportation and/or seek donated services.

► **Conducting Client Sessions in the Community:** (**Note:** While meeting the client outside the office whenever possible is a Core Element of the intervention, the implementing agency may want to create general safety guidelines for the LC).
   - Train the LC on the agency's safety guidelines and stress the importance of being cautious when conducting sessions in the community.
   - If the LC is uncomfortable with a meeting place or meeting with a client at night, s/he may bring a colleague (if approved by the client) or change the meeting time or location while still ensuring the client is comfortable.

Recommendations for safety guidelines and procedures for the LC to follow during client sessions occurring outside the agency include, but are not limited to:
   - Meet in a public place that also maintains the client's privacy.
   - Keep a calendar of the LC's whereabouts at the agency that includes the meeting location and time, when s/he is expected back in the office, and the client with whom the LC is meeting.
   - Check-in with the Supervisor or designated agency employee before and after each client session.
   - Do not divulge personal information, such as home address, to clients.

- Immediately leave any location or situation that feels uncomfortable, unsafe, or threatening, and go to a secure site.
- Always travel with a fully-charged cell phone.
- Pre-program local emergency numbers into the LC's cell phone.
- Determine – in advance – the safest driving route to the destination and safest place to park.
- If meeting in a client's home or a private location, be the last person to enter a room and ensure the door remains unlocked.

Additional training on safety may be necessary for staff. The agency should explore the training opportunities provided in the state and/or community for outreach workers, case managers, and similar staff. These training opportunities can be used to train staff and/or assist senior staff in the creation of policies to increase and maintain safety.

VI. Cultural Competency

Cultural competency is both a complex challenge and an opportunity to meet the health needs of people living with HIV/AIDS. Cultural competency is an ongoing process of developing the awareness, behavior, structures, and practices that allow an organization, its programs, and its staff to serve diverse groups and communities. When the LC is "culturally competent," s/he has awareness of and sensitivity to clients' attitudes, behaviors, and cultural mores. Key behaviors that demonstrate cultural competence include, but are not limited to:

- ► Ability to listen for meaning when communicating with clients
- ► Compassion and empathy for others
- ► Respect for differences (e.g. cultural, language, sexual orientation, gender)
- ► Ability to meet clients where they are
- ► Acceptance of clients for who they are
- ► A nonjudgmental perspective
- ► Ability to ask questions in such a way as to minimize miscommunication

In working with clients from diverse cultures and backgrounds, it is important for the LC to understand:

- ► Attitudes, behaviors, belief systems, and family structures specific to the populations served
- ► Gender differences and roles relevant to HIV/AIDS service provision
- ► Potentially destructive psychosocial effects of cultural beliefs — stigma, guilt, and shame of HIV-positive status — that present in many populations
- ► Impact that cultural mores, environment, values, and beliefs have on a client's ability to seek and access health care services
- ► Different communication styles (e.g., both verbal and nonverbal)
- ► Nonjudgmental attitudes regarding client choices, behaviors, and lifestyles

While not a requirement to implement ARTAS, there is great value in the LC taking a cultural competency course or engaging in diversity awareness activities to enhance his/her ability to relate well to clients from diverse backgrounds.

The U.S. Department of Health and Human Services developed a set of 14 standards to help health care providers engage in culturally competent practices. These are referred to as the **CLAS (National Standards on Culturally and Linguistically Appropriate Services)**, which can be found in **Appendix C**. Some of the standards are Federal requirements for organizations receiving U.S. Government funds, while others are only guidelines or recommendations. Each LC should review the set of standards for relevance to implementing ARTAS in a culturally competent way.

VII. Boundaries

As noted earlier, agencies already providing case management services will have existing policies, such as policies around confidentiality, boundaries, and safety. If the implementing agency has existing policies and protocols around boundaries, review them to ensure they are consistent with ARTAS. **If the agency does not have an existing protocol in place to inform staff and clients about the policy, then it will need to create one. Staff should be informed of and trained on the policy**. Any materials related to the policy must be written in plain language. The general rule is to write at a fifth grade reading level; however, this will depend on the community's needs. The agency may choose to include in the protocol that someone at the agency – either the LC or intake specialist – review the boundaries policy orally with each client at the first visit. In addition, it is important to for the LC to have excellent understanding of boundaries.

In any client/LC relationship, there are always boundaries that need to be respected and observed. One approach to viewing boundaries is to consider four categories:
  ► Category 1: Absolute boundaries
  ► Category 2: Agency-derived boundaries
  ► Category 3: Linkage Coordinator-derived boundaries
  ► Category 4: Client-derived boundaries

The crucial questions about agency-, LC-, and client-derived boundaries are whether or not they protect clients and staff, facilitate the goal of ARTAS, and adhere to the Core Elements.

Absolute boundaries are the most obvious. Several examples include:
  • **Do not** have sex or engage in intimate relationships of any kind with clients.
  • **Do not** loan money to or borrow money from clients.
  • **Do not** hire clients to do work for the individual LC.

Agency-derived boundaries include absolute boundaries plus others that are specific to the functioning of the agency. Examples of significant agency-derived boundary issues that may affect linkage to medical care are policies regarding transporting and meeting with a client. Some agency policies do not allow the use of personal vehicles for transporting a client or meeting with a client at his/her place of residence. Agency-derived boundaries may be dictated by governmental laws or certifying and funding agencies.

Linkage Coordinator-derived boundaries include personal boundaries set by the LC regarding his/her relationships with clients. For example, the LC must make decisions about whether to give out home or personal cell phone numbers and the extent to which s/he will be available outside of the agency's normal business hours. If the implementing agency purchases a cell phone or pager for the expressed purpose of giving the number to ARTAS clients, the LC must decide at what time of day s/he will turn it on and off. Due to the short-term, intensive nature of the LC/client relationship, the LC will need to be very careful to maintain boundaries with his/her ARTAS clients. On the one hand, the short-term, intensive design of the intervention may provide useful perimeters to the client/LC relationship, i.e., knowing there will only be a few client sessions may serve as encouragement for the client to act promptly. On the other hand, it may blur the usual client/LC boundaries.

Because the client sessions are held at a client-identified location and the LC accompanies the client to medical appointments, the LC gets a firsthand view of his/her clients' struggles, obstacles, and the environment in which they live. This may lead to a stronger bond between the client and LC. However, that strong bond may lead to the LC doing more for the client than s/he would normally do for other clients.

Boundary issues are frequently a topic of conversation between the LC and agency staff. The impetus for the discussion is usually when someone is concerned about an LC becoming too enmeshed with a client, frequently marked by a client's view of an LC as a "friend."

In addition, the LC and/or the agency may wish to establish boundaries around an LC serving family members, friends, neighbors or others with whom s/he has existing personal relationships. Moreover, the LC and client may run into each other in public places, such as in the neighborhood or at a store. The LC and client should establish rules early on in their relationship about how they wish to handle such situations.

Client-derived boundaries include personal boundaries set by the client in relationship with the LC. Given concerns related to disclosing one's HIV status, the client may impose certain boundaries related to his/her preferred communication method with the LC outside of the client sessions. For example, the client may insist the LC or agency never call him/her at home or at work. Or the client may set boundaries around where the client sessions take place.

The crucial questions about agency-, LC-, and client- boundaries are whether or not they protect clients and staff, facilitate the goal of ARTAS, and adhere to the Core Elements.

Regardless of the boundary "category," the implementing agency must have a system in place to create client/professional boundaries and resolve any related issues that may occur. Every professional certifying and licensing body for social workers and case managers – as well as most employers – have rules on the acceptable and unacceptable relationships between professionals and clients. Every intervention staff

person must be familiar with the boundary-related policies and the procedures to report a violation. The LC should receive a written copy, training, and an annual reminder of the agency's policies and procedures. Clients should receive a copy of the policies and procedures as well.

Tips for the LC:
- Clearly state any personal boundaries.
- Avoid justifying, rationalizing, or apologizing for these boundaries.
- Set boundaries without feeling guilty.
- Enforce boundaries and be consistent with all clients.
- Be prepared for clients to get angry about personal boundaries.
- If a client violates personal boundaries:
  - Let the person know what s/he is doing.
  - Request that s/he stop doing this, and tell him/her what is expected.
  - Tell him/her that the behavior is not appreciated and/or is disrespectful.
  - Step out of the situation briefly, if needed.
  - Discontinue the relationship and tell the client that s/he is no longer part of the intervention or will be transferred to another LC, if necessary.

VIII. Confidentiality
All case managers, including the LC, are bound by codes of ethics to respect a client's confidentiality and right to privacy. In the course of conducting the five client sessions, the LC should only solicit private information that is essential to linking clients to medical care or completing the paperwork. The following are critical points about confidentiality which are to be observed in a client/LC relationship:
- The LC should adhere to an appropriate code of ethics which governs his/her interactions with clients. National bodies like the National Association of Social Workers or state certifying agencies normally have a code of ethics for social work professionals. Following such a code of ethics not only protects the client but also the LC and agency.
- Once private information is shared by the client, the code of ethics immediately applies. The information obtained from clients in the five sessions is deemed confidential, and the LC is expected to protect its confidentiality. However, the LC may disclose confidential information with written consent from the client, when appropriate. For example, if a client is linked to medical care and would like to have his/her records transferred to another agency, the client must give written consent.
- The LC should never discuss confidential information *about* clients in public or semi-public areas such as hallways, waiting rooms, elevators, and restaurants. Because client sessions may be held outside the agency and in public (or semi-public) places such as libraries or restaurants, the LC must take precautions to protect the client's confidentiality.
- The general expectations regarding confidentiality do not apply when disclosure is necessary to prevent serious or imminent harm to a client or another person.
- The client's right to privacy should also be respected and the LC should ensure that the space used to conduct the five client sessions allows for privacy.

- When phone calls are made or letters are mailed to the client, they must be done in a manner to maintain privacy and confidentiality. It is likely that some clients may not have disclosed their HIV status to anyone, or to very few people, and may not want letters with the name of the agency mailed to their home address.
- The LC should protect the confidentiality of clients' written and electronic records and other sensitive information. Reasonable steps must be taken to ensure that client records are stored in a secure location and are not available to unauthorized persons. Client records should be transferred or disposed of in a manner that protects confidentiality and is consistent with state or local laws governing patient records. This includes, but is not limited to: transferring records and information through computers, electronic mail, or facsimile machines; using telephones and answering machines (leaving voicemail messages); maintaining double locked file cabinets; maintaining password protected files; having fax machines for ARTAS purposes; using plain envelopes without the agency name or address; and following all client-derived boundaries regarding contact and communication.

IX. Linkage Coordinator Preparation

To prepare for agency implementation of ARTAS, the Linkage Coordinator needs to conduct certain specific activities *prior to seeing the first client*. Thorough planning and preparation will greatly improve the LC's ability to assist clients during their sessions. It will also help the agency achieve its goal of increasing linkage to medical care. Some Pre-Implementation activities focus on enhancing the LC's ability to work directly with the client while other activities focus on the LC's effective use of community resources.

A. Prior to Working with Clients

In addition to the LC qualifications listed above under "Guidelines for Selecting a Linkage Coordinator" on page 41, before meeting with the first client the LC should become proficient in:

1. The Core Elements and real world application of ARTAS
2. The _latest_ information about HIV/AIDS, prevention, care, and treatment and how to explain these concepts in easy-to-understand language. Suggested sources of information and training include the CDC web site, www.cdc.gov, or the state or local health department; obtaining capacity-building assistance (CBA) services; and taking an HIV/AIDS course through the state or local health department, if available
3. The community resources available and other service delivery systems such as HIV care providers, clinics, and treatment centers
4. Other common co-existing conditions, such as depression, post-traumatic stress disorder (PTSD), and anxiety disorders, and community resources for these common conditions

The Core Elements of ARTAS emphasize the components of a strengths attitude and working from a strengths perspective, which are discussed below:

► Since ARTAS is client-driven, the LC should learn to focus on helping clients identify goals and barriers.

- ► An LC does not simply link a client to medical care where the LC thinks the client should go. Therefore, the LC should learn to help clients assess the advantages and disadvantages of connecting with a particular health care provider and/or any resource or system for assistance.
- ► The LC should learn to not automatically assume *anything* about a client. This includes assuming that every client benefits from long-term case management services. Rather, the LC should be able to actively solicit a wide range of formal and informal resources to help clients overcome personal barriers. Resources may include other individuals who are successfully linked to medical care and individuals or groups of people who are infected with and affected by HIV.
- ► The LC should be culturally competent and not judge or challenge clients on any aspect of their lifestyles or motivations to change or even their decision to not change a particular behavior or to not link to medical care.
- ► The LC does not simply provide solutions to problems. The LC must help clients *learn and practice* specific skills by helping the client create the ARTAS Session Plan.
- ► The LC should strive for engagement with their clients rather than control over them.

Training for new LCs may include shadowing and coaching activities. During the shadowing exercise, the new LC will observe mock or real client sessions and use a tool to track and identify the key components they see modeled by an experienced LC and the client. For quality assurance, all LCs should expect to be assessed by their Supervisor using these same activities. These activities are fully described in the **LC Supervisor Guide** (**Appendix A**).

As a Pre-Implementation activity, LCs can use the tool from the shadowing activity to conduct informal formative research activities, such as holding discussions with experienced LCs or other strengths-based case managers. During these discussions, a new LC can present a scenario to obtain feedback or listen to the experienced LC discuss how s/he addressed specific situations. These discussions will help new LCs learn how someone else handled a particular case. During these discussions, the new LC can use the Shadowing Tool to track and identify the key components they heard modeled by the experienced LC. The LC should use the recorded results to develop ways to effectively build trusting relationships with their clients.

B. Prior to Working with Community Partners
Because the LC is the primary marketer of the intervention to community partners, it is important to learn how to "sell" the intervention to others. Moreover, the LC must simultaneously learn about community resources in great detail *prior to seeing the first client*. If the LC is unprepared, it may impact his/her relationship with client, ability to build trust with the client, and ability to link the client to available services.

Challenges faced by people who are recently diagnosed with HIV will require referrals to a host of service providers including, but not limited to, health clinics, food banks, employment agencies, social services providers, physicians, mental health services,

faith-based organizations, and others. Understanding the goals of these agencies and how they accomplish those goals are important facets of preparation for each LC.

When preparing to work with potential community partners, HIV care providers, and other service delivery systems, the LC should focus on two major areas/skills. The first is to be able to briefly and clearly explain the intervention. The second is to gain thorough knowledge about the partner agencies (whether referral agencies, HIV care providers, or other services), their staff, and processes. The following is a detailed description of these two areas:

1. **Summarizing ARTAS**: Learning to briefly and succinctly summarize the intervention to potential community partners in an easy-to-understand way is the first partner-related Pre-Implementation activity for the LC. In addition to knowing how to briefly and easily explain ARTAS, the LC must be able to "sell" the intervention. Therefore, it is important to know and articulate each agency's role and the benefits of ARTAS to clients, each agency, and the overall health care system.

   Below are the basic summary points to make about the intervention. Other key points should be added to tailor the discussion to each potential partner. If the LC has to reach out to a large number of potential partners, then the points below (along with the tailored messages) can be turned into marketing materials for mass distribution. Developing a marketing plan was discussed on page 45 of this section.

   The main points, applicable to all agencies, when making a brief summary of ARTAS are as follows:

   - ARTAS links people who are recently diagnosed with HIV to medical care.
   - ARTAS is a short-term, individual-level intervention that is evidence-based. ARTAS participants linked to medical care at a rate of 78% (compared to 60% in the control group).
   - A specially-trained Linkage Coordinator conducts up to five structured client sessions over a 90-day period or until the client attends his/her first clinical appointment with an HIV care provider, whichever comes first.
   - Once any one of the above events occurs, ARTAS ends and the client is systematically transferred to a long-term/Ryan White Case Manager (CM) and/or other needed services identified by the client.
   - The benefits to partnering agencies/clinics are: (1) having clients who are more likely to follow through on a referral; (2) having an additional staff person to work with clients at no cost; and (3) having clients entering the system with more knowledge about the purpose of case management.
   - If the client is transferred to a long-term/Ryan White CM, an additional incentive can be for the LC to complete required documentations before transferring the client. This eases the burden on the long-term/Ryan White CM.
   - The intervention improves clients' willingness and ability to successfully link to care.

Tailoring the ARTAS Summary: The LC may want to identify specific issues that are important to the service providers in the area and include this information in the presentation given to potential community partners. This would include the agency/clinic's role in the intervention. These key points should be discussed with the appropriate intervention staff before sharing the information with potential partners.

2. **Becoming Familiar with Community Partners:** The second partner-related, Pre-Implementation activity for the LC involves developing a thorough knowledge of existing services, partner agencies (whether referral agencies, HIV care providers, or other services), their staff, and processes. It is crucial that each LC become familiar with both the *formal and informal* practices and characteristics of partner agencies and their services.

   An example of a formal practice is the agency's eligibility criteria. Examples of informal characteristics include becoming familiar with the staff delivering services, the staff and agency's strengths working with clients who have certain needs, and knowing which agencies or clinics work most effectively with specific target groups. Other key information includes hours of operation, key contact personnel, and estimated wait times. Such information should be put in a convenient format with useful information tailored to the client's needs. Not just a referral guide, this should be a "living document" that is updated continually.

Summary of Activities for Building a Strong Knowledge Base of Community Resources
Following is a summary of activities the LC may conduct during the ARTAS Pre-Implementation phase to develop a solid knowledge base of resources and services available in the community.

1: Complete the **"Agency/Clinic 'Need to Know Information' Form"** on page 61 (one per agency/clinic). This information will be used to create or update Step 2.

2: Create or refer to an existing directory of resources (i.e., AIDS services organizations, health department clinics, faith-based organizations) based on Step 1. Organize the agencies by categories that will be most useful to the LC and clients. Ideas for potential categories include general health care, mental health treatment, substance abuse treatment, HIV-related medical care, housing, dental services, transportation, and interpreter services.
Tip: Create an electronic database to store this information. With an electronic database, the LC can easily update information and quickly sort by important fields relevant to the client's needs, such "Language," "Housing Services."

3: Personally contact individuals at the agency/clinic and schedule a meeting with the key staff who are likely to serve as advocates for ARTAS. These may include health care providers, case managers, counseling and testing staff, and others.

4: Ask the staff member(s) to walk the LC through the typical application and screening processes. This may include a step-by-step explanation of the processes or a "mock" client intake, where the staff member simulates the process with the LC acting as the client.

5: Ask the staff member(s) for permission to shadow them as they conduct intake processes with a client.

6: Make a notation of any differences in the processes/procedures between the Step 4 and Step 5. Also, make a notation of any differences in the processes/procedures in these steps and *formal* requirements listed by the agency/clinic. Make note of any *informal* requirements or characteristics of the agency/clinic or of key staff who will facilitate the referral process.

7: Cultivate personal and professional relationships with the staff members who will facilitate the ARTAS referral process.

8: Create an inviting and easy-to-use referral directory for clients. The directory should include both the *formal* requirements (photo identification required) <u>and</u> the *informal* hints that are helpful for the client.

Agency/Clinic "Need to Know Information" Form

Agency Name: _____ **Contact Person:** _____

1. What services does the agency/clinic offer? **Check all that apply**:
    ___General health care　　　　　　　　　　___Housing
    ___Mental health treatment　　　　　　　　___Housing referrals
    ___Substance abuse treatment　　　　　　___Dental services
    ___HIV-related medical care　　　　　　　　___Domestic violence counseling
    ___HIV prevention　　　　　　　　　　　　　___Transportation
    ___HIV testing and counseling　　　　　　___Others, please specify

2. Does your agency (or you personally) have an existing relationship with this agency/clinic and/or its staff? (Yes or No) _____
    a. If yes,
        i.   What is the nature of the relationship?
        ii. Is the relationship a strong and effective one?
        iii. What are the areas for improvement?
        iv. Who is responsible (or able) to create opportunities to improve the relationship?

3. What are the clinic/agency's eligibility criteria?

4. If the clinic/agency is known for working most effectively with a specific target group(s), please list which group(s) (e.g., substance users, Hispanics, women).

5. What partner agency activities/ policies may conflict with ARTAS's Core Elements?

6. What activities or polices may conflict with the strength-based nature of ARTAS, and impede its successful implementation?

7. Does the agency/clinic have policies or procedures that are not supportive of ARTAS implementation? Do any policies and procedures interfere with the establishment of a collaborative, trusting relationship, compatible with a strengths-based, client centered approach?
    a. If yes, list those policies and procedures here:

8. What are the clinic/agency's hours? Do they have "nontraditional" hours, i.e., evenings and weekends?

9. Are there specific days of the week or times of the day that are typically less busy than others?

10. What personal documents (e.g., identification needed – government-issued ID, driver's license – insurance eligibility and/or documentation) are required from clients to successfully apply for services?

LC's Preparation with Health Care Provider: As discussed in previous sections of this manual, to be prepared the LC must build relationships with health care providers and clinic staff for client appointments to be successful. Therefore, the client's medical appointment should not be the first interaction between the LC and the doctor, nurse, or other clinic staff. The LC should be familiar with the clinic staff's roles, specialties, and personalities. This includes the doctors, nurses, social workers, long-term/Ryan White case managers, and intake specialists. The clinic staff should also be familiar with ARTAS and in agreement with the LC's role, e.g., that s/he may accompany the client through all aspects of the medical appointment, including administrative, psychosocial, and medical.

To prepare, the LC should discuss and get answers (preferably in a written agreement) in advance to the following questions:
1. If a wait list exists to receive treatment at the clinic, will the client's name be added to it, or will s/he be given preferential treatment for participating in ARTAS and seen before others on the wait list?
2. Will the clinic staff allow the LC to accompany the client to all aspects of the appointment given client approval: administrative, psychosocial, and medical?
3. When transferring the client from ARTAS to long-term/Ryan White case management services:
    a. Can the LC attend the first Ryan White long-term case management session or a pre-session to introduce the two parties?
    b. Will the LC complete some or all of the intake and enrollment paperwork prior to the client's first session?
    c. What information does the clinic/agency expect to receive from the LC?
    d. What follow-up information will the clinic/agency provide the LC post-linkage (e.g., how can the LC verify the client attended the appointment, if s/he did not accompany the client? Will there be a formal or informal process to keep the LC updated on the client)?

C. Effective Communication Skills
Effective communication skills are beneficial to build relationships with clients. Techniques can be drawn from other client-centered approaches to counseling such as Motivational Interviewing. This approach recognizes that the client is ultimately responsible for his/her own behavior change. As such, it can be useful for the LC to be familiar with Motivational Interviewing techniques such as Responsive Listening prior to seeing the first client. **Responsive Listening** is the term used to describe a counseling method that focuses on building an understanding between the LC and client.[16] Techniques to achieve Responsive Listening include:
- **Affirming** is the practice of verbally supporting or validating the client's thoughts, emotions, or actions. Affirmation can be statements or questions.
- **Reflecting** is the act of making a statement that clarifies, amplifies, or guesses at the meaning of the client's statement. All verbal communication involves encoding and vocalizing by the speaker, and hearing and decoding by the listener. Reflecting is a way of giving voice to decoded interpretation of the client's message.

- **Summarizing** is the practice of restating or reframing what the client said, usually in a condensed form.
- **Asking Open-Ended Questions** prompts the client to provide an answer beyond a simple "yes," "no," or "maybe," and does not lead the client to a specific or desired answer.
- **Nonverbal Communication** is expressed through body language and facial expressions and is a good way to "read" the client regardless if the client is speaking or not.
- **Managing Silence** is an important communication tool. Silence can be used as a powerful stimulus for conversation that leads the client to an important expression of a thought or emotion. However, it important to know *when* and *how* to use silence. Managing silence also means knowing *how to end silence*. Using the first four techniques listed above are effective ways to end silence.

While these techniques are not required to implement ARTAS, they may help improve the LC's ability to build a rapport and encourage communication with a client, and to strengthen clients' investment in the medical linkage process.

For full descriptions and sample dialogues of each technique, see "LC skills to facilitate effective implementation of ARTAS" in the Implementation Section of this manual.

XII. Developing a Monitoring and Evaluation Plan

During the Pre-Implementation phase, the implementing agency is encouraged to develop a monitoring and evaluation plan. This plan should be implemented throughout the delivery of ARTAS. **It is important to review any monitoring and evaluation requirements (activities and/or indicators) with the funding agency before designing a plan.** The implementing agency should review the sample monitoring forms referenced in the Maintenance Section of this manual; the agency may adapt the forms to fit its implementation plan and monitoring activities. For qualifying agencies, Capacity Building Assistance (CBA) services for monitoring and evaluation are available through CDC.

Note: This section discusses developing a monitoring and evaluation plan; however, implementing and/or funding agencies may choose to include any or all of the following types of monitoring and evaluation activities: **formative evaluation, process monitoring, process evaluation, and outcome monitoring**. Prior demonstration of effectiveness shows that the ARTAS intervention was effective in a closely monitored random controlled trial. This suggests that it can be effective under less controlled conditions. Although the implementing agency does not need to prove that the ARTAS intervention is effective, it should ensure that its activities match those developed as a result of the original research.

A. Reasons to Monitor and Evaluate

Key reasons to monitor an intervention include documentation of the implementation process, program improvement, and accountability.

Documenting the implementation process – includes documenting what activities take place during implementation, the challenges encountered, and approaches used to resolve challenges.

Program improvement – As the intervention is implemented, it is important to identify the strengths and weaknesses of the program and use that information to improve the program.

Monitoring also helps agencies to compare actual outcomes to target outcomes. Examples may include:
- Number of people enrolled
- Number of sessions conducted
- Number of clients referred to medical care

Accountability – refers to being accountable at the agency and staff level, to funders, clients, board of directors. Staff need to show evidence of program progress to supervisors and clients, supervisors to agency administrators, and administrators to funders and board of directors.

The information gathered through monitoring and evaluation activities should be used to help the implementing agency fine-tune the intervention delivery by addressing areas where problems in the implementation plan were encountered. Below is a basic description of different types of monitoring and evaluation: formative evaluation, process monitoring, process evaluation, and outcome monitoring.

B. The Logic Model and Types of Monitoring and Evaluation
The Behavior Change Logic Model, discussed on page 30, is the basic structure of the intervention and is related to monitoring and evaluation. The components include a problem statement, the behavioral determinants or barriers that the clients face that prevent them from linking to care, the intervention activities to address those barriers, and the client outcomes.

In addition to the Logic Model, the CDC evaluation pyramid, shown in **Figure 4** below, is helpful for framing monitoring and evaluation.

Figure 4: CDC Evaluation Pyramid
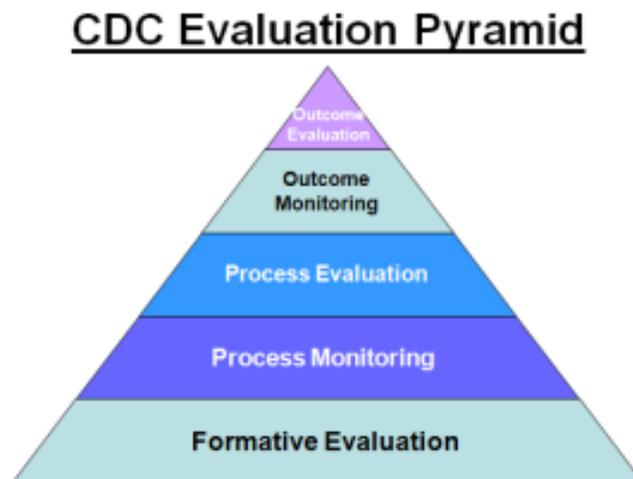
The different types of monitoring and evaluation activities, and their relation to the Logic Model are described below:

Formative evaluation, the first type of evaluation an agency may wish to conduct, is defined as a process of gathering information that is used to develop an evaluation plan. In the case of ARTAS, formative evaluation refers to the process of collecting data that describes the types of HIV care services that clients can be linked to in a given community. Through the formative evaluation process, agencies should gather data on such factors as the location of HIV services, hours of operation, eligibility requirements, and fees. In addition, agencies can use a community mapping tool to identify medical care providers that clients can be linked to for care. See **Appendix D** for a sample **Community Mapping Tool.**

In relation to the Logic Model formative evaluation serves to gather information that can be used when working with the behavioral determinants, or contextual factors, which are the client barriers to linking to care.

Process monitoring is defined as the routine documentation and review of program activities, populations served, and resources used in order to improve the program. The items that are counted or measured are also known as "indicators". Performance indicators can be established to determine specific number the program expects to reach. For example, a linkage coordinator may be planning on recruiting 15 clients per month, and enrolling 5 new clients per month. These performance indicators provide benchmarks or targets. If the benchmarks aren't being met, the agency may need to make modifications to improve performance.

On the Logic Model, this relates to the second column, "Activities to address behavioral determinants." Process monitoring takes place here – for example, documenting client goal-setting and strengths assessment information.

Questions to ask include:
- How many people were recruited for the ARTAS intervention?
- For how many clients were strengths based assessments conducted?
- How many sessions did we conduct with each client?
- How many collaborative agreements have been developed to help clients link to care.
- What and how many referrals were made?

Process evaluation assesses planned versus actual program performance over a period of time for the purpose of program improvement and future planning. It also involves collecting more detailed data about *how* the intervention was delivered, differences between the intended population and the actual population served, and access to the intervention. Process evaluation looks at whether the agency maintained fidelity to the intervention's Core Elements and what Key Characteristics were used. It is a quality assurance activity that ensures that the agency is delivering ARTAS and not an unproven variation of the intervention.

Process evaluation involves comparing the process monitoring data to what was planned. The results of this comparison can inform future program planning as well as demonstrate areas of success. Questions include:
- Was each core element addressed?
- Were any of the ARTAS key characteristics changed?
- Which key characteristics were changed?
- Was the intended target population recruited/enrolled?
- What recruitment sites were most productive?
- Were the intended numbers of clients enrolled?
- Were sessions held in a convenient place for the client?
- What challenges were faced in recruiting clients?
- What challenges were faced during the sessions?
- What was the feedback from the participating clients?

On the Logic Model, process evaluation also takes place in the middle "Activities" column. Once the activities progress over the course of ARTAS sessions, more information can be captured on how activities were implemented and if they were performed as planned.

Outcome monitoring is defined as the routine documentation and review of program-associated outcomes (e.g., linkage to care) in order to determine the extent to which the intervention goals and objectives are being met. All anticipated outcomes related to ARTAS should be stated in measurable terms. Outcome monitoring cannot be done effectively unless data are collected either during Pre-Implementation or early in the Implementation phase (i.e., during Session One) so that baseline measures can be gathered. These baseline measures are used for comparison later once post- or follow-up measures are collected later in the Implementation phase or at the end of the client's ARTAS participation.

Outcome monitoring tells us about how clients have changed from before they started the intervention to after the intervention. It may measure the changes in clients' behaviors, intentions, attitudes and actions *before* the intervention compared to *after* the intervention.

For ARTAS, the main program-related outcome is linkage to care, so outcomes monitoring answers the question: *What proportion of clients who attended ARTAS linked to care?*

There are also immediate outcomes:
- Increased client awareness of and ability to express their own strengths
- Increased self-efficacy (self-confidence, motivation)
- Increased knowledge about benefits of linking to care
- Increased knowledge about system of care and available resources
- Higher outcome expectations (client believes that he/she can obtain medical care for HIV, and that visiting a doctor will be beneficial)

On the Logic Model, outcome monitoring relates to the third column, "Outcomes," including immediate and intermediate outcomes.

Agencies may have staff persons that are knowledgeable about monitoring and evaluation, or they may wish to hire a consultant to perform the monitoring activities. For further monitoring guidance and assistance, agencies should access CBA services through your CDC project officer and/or local/state health department.

This section provided an overview of Pre-Implementation activities such as how to build relationships with community partners, develop a marketing plan, and develop a monitoring and evaluation plan. The next section provides an overview of Implementation-related activities.

Outcome evaluation is defined as the process of determining whether the intervention resulted in the expected outcomes or predetermined set of goals. Outcome evaluation requires very rigorous measurement including control groups and comparison groups. This is the level of evaluation that was done in the original research, but is not something that is required for grantees at an agency level.

IMPLEMENTATION
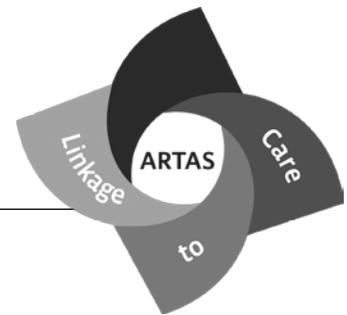
This section provides guidance on specific skills needed to
implement ARTAS effectively and on how to conduct each of the five client sessions.
Below is a full list of topics covered:
- I. Linkage Coordinator Skills to Facilitate Effective Implementation of ARTAS
- II. Maintaining Working Relationships with Community Partners

I. Linkage Coordinator Skills to Facilitate Effective Implementation of ARTAS
The skills to be reviewed are:
- A. Building Effective Relationships
- B. Conducting a Strengths Assessment
- C. Goal-setting
- D. Communication Skills
- E. Facilitation Skills

The following skills (relationship-building, the strengths assessment, and goal-setting)
are essential to the implementation of ARTAS because they are Core Elements.

A. Building Effective Relationships
The first essential skill for the LC is the ability to build effective relationships. This skill
relates to both the LC/client relationship and the ARTAS staff/community partner
relationships. To implement ARTAS with fidelity to the Core Elements, the LC must
build effective working relationships with his/her clients. In focus groups with clients who
participated in other applications of SBCM, the clients identified key ways in which their
relationships with a strengths-based case manager became a trusting relationship.
These included the strengths-based case manager:[17]
- ► Making time for the client
- ► Being persistent in following up with the client
- ► Treating the client as a person
- ► Being a good listener
- ► Being nonjudgmental
- ► Being there for the client
- ► Going at the client's pace
- ► Focusing on strengths
- ► Being understanding

Moreover, the LC will have to build positive relationships with health care providers, HIV
testing centers, and other community partners who will be the primary sources for
referring and receiving clients. Without a strong referral network and a positive working
relationship between the implementing and partner agencies, it will be difficult to

implement ARTAS. This is why an emphasis is placed on Pre-Implementation activities with partners; regular communication with them throughout the Implementation phase is strongly encouraged.

Building mutually respectful relationships with community partners and keeping them abreast and involved in the intervention's progress are ways to build and maintain these relationships. Other ways include highlighting the benefits to the community partners for their participation, maintaining open communication, and establishing clear protocols. To build effective relationships, the LC will need to be a good communicator.

B. Conducting a Strengths-Based Assessment
The second essential skill for the LC is the ability to conduct a strengths assessment. The purpose of the ARTAS Strengths Assessment is to help the client identify personal strengths, abilities, and skills that s/he can use to access medical care and accomplish other short-term goals.

Focusing on strengths during the assessment helps the LC and client:
1. Avoid engaging in a conversation based in skepticism and hopelessness as may be common in persons confronting numerous life challenges
2. Encourage a positive, trusting relationship between them
3. Promote confidence in the client to follow-through with accessing medical care

The strengths assessment was originally created to be a comprehensive summary of a client's life across multiple life domains, such as general life skills, relationships, and personal attributes.[18] However, the ARTAS Strengths Assessment has a narrower focus and covers experiences identified by the client. The Strengths Assessment gives the client an opportunity to identify specific situation(s) in his/her life where the client achieved success based on his/her actions and abilities. The client and LC will use these successful situation(s) to identify resources for accomplishing future goals, such as linking to medical care.

A strengths assessment is the opposite of most clinical assessments. Discussions during the strengths assessment focus on a client's ability to accomplish a task, use a skill, or fulfill a goal in a significant life domain. The strengths assessment draws on past successes. Discussions related to the client's arrest record, drug use, and past failures are avoided. See the next page for a sample Strengths Assessment.

The **Life Domains List** (see page 187 in the Client Session Guide Forms section) can be a helpful tool to use *only as a reference* for the Linkage Coordinator. It lists questions that can be used as a refresher about various life domains and ways that clients show strengths in those domains. Please note: Using while the client is present, and writing down the "answers" to the life domain list is not appropriate. The exercise should not become a catalog of deficits and past failures.

STRENGTHS ASSESSMENT FORM

Date: _April 13, 2009_
Session Number: _Four_
New Assessment or Updated Assessment (Circle one)

1. **My strengths, abilities, or skills identified:**
   a. Strengths: _I keep my family organized._
   b. Skills: _I make the kids' lunches, get them to school on time, and pick them up every day._
   c. Abilities: _I can plan ahead if I think something will interfere with my kids' school schedule. If I can't pick them up one day, I make sure my mom or sister can._
   d. Items from the Life Domains List: _Ms. Angie, my LC, helped me see that everyday things like getting the kids to school is a strength._

2. **Examples I gave about a time(s) that I successfully faced barrier(s) in my life:** _I had a job at the corner market and I paid most of my own bills._
   a. Examples of barrier(s): _I never had a job before, so I didn't think anyone would hire me._
   b. Things I did to overcome the barrier(s): _I talked to the manager, and explained why I did not have a job before. I told him I could work every morning at 8 because my kids go to school at 7:30. I worked hard to make him believe he could rely on me._

3. **Things I am good at:** _Cooking, cleaning, counting money, organizing my family._

4. **Example(s) of when I felt like most things in my life were going well:** _When I got my job._
   a. Things I did to make them go well: _I knew I needed a job to take care of my kids when my boyfriend went to jail. I got a job. I asked my mom to watch the kids. I got up early every morning, so the kids didn't miss school and I didn't miss work._

C. Goal-setting

The third essential skill for the LC is goal-setting. The LC helps the client plan and set goals to overcome barriers to linking with medical care. This section defines key terms and discusses how to develop SMART objectives.

The following terms, which are used on the ARTAS Session Plan form, are defined as follows:

► **Goal**: A goal is an end point that the client intends to reach, which in ARTAS is linking with medical care. A client may identify other goals that s/he wishes to pursue.

► **Objective**: An objective is a measurable milestone or significant step that must be accomplished on the way to meeting a goal. It is typical to have multiple objectives to meet one single goal.

► **Activities:** Activities are the smaller actions that lead to achieving an objective.

Using the SMART objective principles allows the LC and client to make clear objectives. **SMART stands for: Specific, Measurable, Achievable, Relevant, and Time-bound.**

Specific: Making objectives specific means including the "who," "what," and "where" of the objective. "Who" refers to the person completing the action (e.g., the LC, client). "What" refers to the action (e.g., link to services). "Where" refers to the location of the action (e.g., homeless shelter).

When describing the action, use only one action verb per activity (e.g., "find a doctor" rather than "find and go to a doctor"). More than one verb means that more than one action must be measured, which causes problems when it comes to measuring success. For example, suppose the client is able to find a doctor but did not go to him/her. Did the client meet the objective? Because the objective had two actions, success is difficult to measure.

Also, avoid verbs with vague meanings (e.g., "understand," "do") when describing expected results. Instead, use verbs that reflect measurable action, such as "identify" or "list." *Remember:* The greater the specificity, the greater the possibility for measurement.

Measurable: Objectives need to be measurable. Here the focus is on "how much" change is expected. Objectives should quantify the amount of change the LC or client hopes to achieve (e.g., the client will identify three barriers to seeking medical care by the next session.). "Three" represents the "how much" of the objective.

Achievable: Objectives should be achievable given the client's resources and needs. For example, if the LC reads the following: "The client will follow 100% of the doctor's recommendations," s/he realizes that this is not achievable. Without knowing the doctor's recommendations, the client cannot say with certainty that

s/he will follow 100% of them. The recommendations may be against the client's cultural beliefs or impractical due to financial concerns.

Relevant: Objectives are relevant when they relate directly to the client's goals and together represent reasonable steps that can be achieved within a specific time frame. For instance, if an LC's goal is "To get MOAs signed before seeing my first client" a relevant objective may be "Execute two signed MOAs from community partners by November 6th."

Time-bound: Objectives should be defined within a time frame. Here the focus is on "when" the objective will be met.

Goal-setting and the ARTAS Session Plan

The ARTAS Session Plan provides the LC and the client with a tool to guide their work together. It reminds the LC of the intended goal of ARTAS – to link clients to medical care – and lists objectives and action steps to achieve this goal and others. To improve the chances that this happens, LC will help his/her client: (1) identify and resolve barriers that interfere with the goal of linkage to medical care; and (2) identify and accomplish personal objectives that will put the client in a better position to follow through with linking to medical care. A completed ARTAS Session Plan is available on the next page to serve as an example.

ARTAS SESSION PLAN

Goal 1: Link with Medical Services

Objective 1: _Find a doctor I like by the end of ARTAS._

	Activity	Related Strengths	Potential Barriers	Target Date	Person(s) Responsible
1	_Write a list of three things I'm looking for in a doctor._	_I treat others with respect._	_Little experience with doctors._	_Before our 2nd session._	_Jane_
2	_Write a list of at least four doctors or clinics in the city._	_I know how to get around the city._	_Don't know many doctors._	_Before our 2nd session._	_Ms. Angie_
3	_Compare my list with Ms. Angie's list._	_Good at thinking about pros and cons._	_N/A_	_At our 2nd session._	_Jane and Ms. Angie_

Objective 2: _Complete all Medicaid enrollment forms before scheduling an appointment with a doctor I like._

	Activity	Related Strengths	Potential Barriers	Target Date	Person(s) Responsible
1	_Write down all forms needed for the doctor/clinic I choose._	_Participating in ARTAS._	_Don't know what forms to use._	_Before our 2nd session._	_Ms. Angie_
2	_Get a copy of my Social Security card so I can fill out the forms._	_Had a Social Security card before._	_Getting time off to go for my card._	_Before our 4th session._	_Jane_
3	_Fill out all forms needed for the doctor/clinic I choose._	_Participating in ARTAS._	_N/A_	_At our 4th session._	_Jane, with Ms. Angie's help_

The following skills (communication skills and facilitation skills) are <u>not required</u> for ARTAS based on the Core Elements; however, effective communication and facilitation skills support the implementing agency's implementation efforts.

D. Communication Skills

Effective communication skills support successful implementation of ARTAS. The LC should be able to engage in a meaningful dialogue and exchange with the client throughout the five client sessions leading to the outcome of linkage to medical care. Following are a few specific communication skills that may be helpful to effectively and efficiently implement ARTAS: self-awareness, setting the tone, responsive listening, affirming, reflecting, summarizing, open-ended questions, and verbal/nonverbal communication.

► **Self-Awareness:** Good communication requires a high level of self-awareness and knowledge of his/her personal communication style. Being self-aware means considering the tone and body language the LC typically communicates to others when speaking. An LC should have an awareness of his/her own communication style and be able to make the necessary adjustments to have a successful conversation with the client and/or community partners. It is also important that the LC know his/her personal attitudes and/or triggers that may preclude working effectively with particular clients. For example, if s/he is a recovering drug user, s/he may not be the best LC for someone who is actively using. If this is the case (where possible), the Supervisor or intake coordinator should be asked to assign clients accordingly.

► **Setting the tone:** It is important to set the tone in the first client encounter – whether on the phone or in person – by being welcoming, making an immediate connection, and building trust. A key factor in building a trusted relationship with the client is to be nonjudgmental. Also, the LC should ensure there are no distractions such as noise, ringing phones, or interruptions by co-workers, when meeting with a client. To minimize the possibility of distractions, turn off all phones and put a "Do not disturb" sign on the door.

► **Responsive Listening:** Communication is a two-way process: speaking and listening. Responsive listening says to a client, *"you are being heard and understood."* Nearly half of the time spent communicating involves listening. How well the LC listens will impact his/her relationship with the client. In responsive listening, the LC does not simply hear client's *words*; s/he hears the client's *thoughts, beliefs, and feelings*. Listening is a communication skill that improves with practice.

A responsive listener:
- Concentrates on the client
- Observes the client's voice and inflection, and pays attention to facial expressions and other nonverbal clues for more insight into what is being communicated
- Listens without interrupting the client

- Paraphrases or asks clarifying questions to confirm s/he understands the client's intended message (e.g., *"What I heard you say was…is that correct?"* or *"am I correct by saying that you meant…"*)
- Provides feedback to the client

The LC should find ways to overcome certain internal and external barriers to effective listening. Internal barriers include:
- Hearing what is <u>expected</u>, <u>not</u> what is said
- Defensiveness on part of LC or client
- Stereotyping
- Not seeking clarification about what the client said

External barriers include noise, uncomfortable temperature, an inappropriate location, or ringing telephones (including cell phones).

> To assess personal listening skills, the LC may want to take the **Responsive Listening Self-Assessment** (**Appendix E)**. The LC can also practice with a trusted colleague or friend and ask him/her to provide honest feedback. In each client session, it is important for the LC to pay attention to and work on the listening skills s/he needs to improve.

> ► **Affirming**: Affirmation is the practice of verbally supporting or validating a client's thoughts, emotions, or actions. Affirmation can be made with statements or questions. Affirming is one of the main ways to build positive relationships with clients and encourage them to focus on strengths. This is particularly helpful when the LC is trying to get clients to see a strength they may not be aware they had.

> Affirming responses let the client know the LC is listening (and observing), and provide an opportunity for the LC to support the client's actions towards linkage to medical care. Some examples of affirmations are:
> - *"I appreciate you taking the time to make it here today."*
> - *"You've been through a lot, and the fact that you're taking action shows a great deal of inner strength."*
> - *"This is great! Where did you find all this information?"*

> Affirming also provides a chance to elaborate on a strength, resource, or asset. The elaboration can operate in two directions, both of which are effective. When a client shows a <u>specific</u> strength, the LC can elaborate by <u>generalizing</u>:
> - *"You got here early again. You're a punctual person."*

> When the client shows or mentions a more <u>general</u> strength, the LC's elaboration can help the client see how that strength can be put to a <u>specific use</u>:
> - *"You're very persistent. I bet that will come in handy when you go to the clinic next week."*

As with all responsive listening methods, affirming helps the LC become attuned to the needs of the client and deliver a message in a way the client can accept. A client may find affirmations difficult because s/he may be used to talking about or hearing about his/her deficits. The LC may have to be assertive in his/her response if the client minimizes an affirmation. A sample conversation may sound like this:

> LC: *"It took a lot of planning and effort to make it to your first clinic appointment. You did well."* [Affirmation of effort]
>
> Client: *"Anyone could do that."* [Minimizing effort]
>
> LC: *"Well, I don't know. I know people who wouldn't have had the energy or foresight to get the bus schedules, plan for someone to watch their kids, find a friend with a car when the bus didn't show up, and remind the receptionist about their appointment time when she didn't call their name…You're really persistent."* [Affirmation of both effort and the personal quality of persistence]
>
> Client: *"My parents taught me that."* [Accepting affirmation of effort, but minimizing responsibility for the persistence asset]
>
> LC: *"Well, they were good teachers and you turned out to be a very persistent person."* [Notice the LC's use of the present tense, reaffirming the personal asset]

► **Reflecting**: Reflecting is the practice of making a statement that clarifies, amplifies, or guesses at the meaning of a client's statement. For example:

> Client: "*My boyfriend is going to be really upset.*"
> LC: "*Your boyfriend is going to be upset when you tell him about your test results.*"

There is nothing wrong with the simple reflection illustrated here. But *amplified reflection* – reflection that makes a guess about meaning or emotional content – is more effective, and clients tend to respond better to this style of reflection, such as:

> Client: *"My boyfriend is going to be really upset."*
> LC: *"You're worried about what he might do."*

In this example, the client may not be worried, but by using this *amplified reflection*, the LC is assessing the reasonable implications of the client's statement. Why would the LC not simply *ask* the client, rather than making a reflective statement? Consider the direct question approach:

> Client: *"My boyfriend is going to be really upset."*
> LC: "*Are you worried about that?*"

Now the client is likely to defend being worried or not worried, rather than continuing to speak freely about the relationship or the anticipated problem. In general, reflective statements are less likely to generate a defensive response. The LC can provide the impetus for the client's further exploration by slightly understating what the client has said. For example:

Client: "*I can't believe this is happening to me. I'm absolutely devastated.*"
LC: "*This is pretty rough.*"

This response will usually prompt the client to continue to speak to make sure the LC understands that the situation is more than "pretty rough." Reflecting can help build a trusting relationship between the LC and client.

► **Summarizing:** Summarizing is the practice of restating or reframing what the client says – usually in a condensed form. Summarizing is used to:
  - Reinforce motivational statements or talk about making a change to current behavior
  - Call attention to elements of resistance, ambivalence, or reluctance to seeking treatment
  - Check for accuracy
  - Move toward a plan to change, if appropriate

Below is a sample dialogue using the summarizing technique:

Client: "*I want to stay healthy. My kids depend on me. And even though it's kind of scary, I'm probably better off going to a clinic to find out if I need medicine or anything like that. I'm just not comfortable going to the clinic in my neighborhood. If I go to the one on Grand, it's going to be hard getting there on the bus. But, I guess it's best to get a check-up.*"

LC: "*Let me make sure I understand what you've said because it sounds like you've reached a really important decision. You've given this some thought. Staying healthy is important to you, especially because your kids really need you. So you've decided to go to the clinic for a check-up. Is that right?*"

Summarizing also helps the LC to call attention to resistance, ambivalence, or reluctance to seeking medical care, as well as to check in with the client for accuracy. The dialogue could continue as follows:

LC: "*So to summarize, you think getting a check-up might be scary, but at the same time, you feel like you really need to find out how your health is. And you've given some thought to the barriers of going to the Grand Avenue clinic.*"

► **Open-Ended Questions**: These are questions that cannot be answered with a brief statement or one-word answers such as "yes" or "no." Some examples of open-ended questions include:
  - What brought you here today?

- What do you hope to achieve by entering treatment?
- What helped you to figure that out?
- What do you see as the next step?

Polite imperatives can be substituted for open-ended questions:
- Tell me about your biggest concern.
- Tell me how you got through that.
- Tell me about your thoughts about linking with medical care.

As with responsive listening, asking open-ended questions takes practice. One good way for the LC to increase his/her ability to ask open-ended questions is to begin with "What" or "How" when asking questions of a client. Beware: not all "What" or "How" questions are open-ended. An example of a closed-ended question disguised as open-ended one is:
- What do you want to do now, make an appointment or wait until tomorrow?

Furthermore, just because a question is open-ended does not mean it is a good question. Be careful not to use "why" questions when possible. "Why" questions can be interpreted as judgmental and/or accusatory. Examples of the types of questions to avoid include:
- What makes you so sure that you'll stay healthy without medical care?
- Why did you think it would be okay to cancel your appointment?
- What are some reasons why a person might ignore his/her doctor's advice?

Finally, it is sometimes appropriate to ask close-ended questions, such as when closing out the session. Some other opportunities for closed-ended questions include when confirming the next client session appointment and ask if s/he would like the LC to call him/her with as a reminder.

For the LC to improve his/her effectiveness as a responsive listener, s/he will have to make a conscientious effort to use more reflections, affirmations, and summaries. When the LC asks too many questions, even when the questions are open-ended, s/he creates an interrogative atmosphere that diminishes the personal connection with the client. Such an interaction will likely remind the client of previous situations where answering questions was a routine activity without a meaningful relationship. When an LC must gather information, it is better to do so by making a reflective statement, which will usually prompt more information than by simply asking questions.

► **Verbal and Nonverbal Communication**: Effective communication includes understanding both verbal and nonverbal communication. Examples of effective verbal communication include good volume and a friendly tone. Nonverbal communication includes:
- Nodding in agreement
- Fidgeting

- Eye contact (or no eye contact)
- Body posture
- Hand gestures
- Facial expressions

In conducting the ARTAS client sessions, the LC should pay attention to the client's verbal and nonverbal clues.

Tips for Effective Communication using ARTAS
Following are helpful tips for the LC to engage with his/her clients for a short period of time:
► Be aware of personal judgments, beliefs, and assumptions, which can distort what the client hears in the conversation.
► Make a connection with client in the first session and work to build trust.
► Be a responsive listener.
► Treat the client in a respectful, nonjudgmental manner.
► Ask open-ended questions, reflect, and summarize to be sure the LC understands what the client is saying.
► Be culturally competent in interactions with each client.
► Value the client's views and perceptions.
► Be sensitive to the emotional issues a client is experiencing upon just learning their HIV status.

Other helpful tips for the LC to remember include when and how to use the techniques discussed in this section. It is important to keep in mind the primary goal of ARTAS: linking clients to medical care.

Affirm *any* commitment to linking to medical care or taking other steps in that direction. Examples are: (1) looking at medical care in a new light; (2) being willing to talk to others about visiting a clinic; or (3) being able to discuss fears, concerns, and barriers to linkage. At some point in every session, the LC should ask the client to describe his/her ideas, thoughts, feelings, or concerns about linking with medical care.

Affirm self-motivating statements. This provides the client with an opportunity to hear someone else's observation about a self-motivating statement that highlights a critical strength. Respond to any situations that are consistent with or relevant to seeking medical care.

Normalize ambivalence the client is feeling about linking to medical care with affirmations. When the LC normalizes clients' feelings of reluctance, fear, or opposition, s/he reduces their necessity to defend their reluctance to seek medical care. The normal response is to defend one's reason for being afraid when someone says: "*There's nothing to be afraid of.*" A less defensive response is elicited when someone says: "*I don't blame you for being scared.*" The same applies to the LC's role in addressing client reluctance or fear. Affirm the reasons for the client's reluctance and help them understand those feelings as a normal response. This will help the LC avoid

the role of trying to convince a client to do something s/he does not want to do, and help the LC and client move the discussion toward the advantages and disadvantages of seeking medical care.

Do not be afraid to push the envelope when reflecting or summarizing. If the LC misstates or misinterpret a client's response or the emotional impact of a statement, the client will correct the LC as long as the LC created a trusting relationship with the client. The LC should give the client permission to correct him/her when wrong. One way create this safe space is by saying directly, "*Please feel free to correct me if I'm wrong.*"

Try summarizing if you feel stuck. This method allows the LC to assess his/her understanding of the client's problem/statement, and tells the client s/he is paying attention.

Politely interrupt the client with a summary if you lose track of what the client is saying. *"Excuse me. You're touching on some really important issues and I want to make sure I don't miss anything. First, you said that… And then… Next, you talked a little about… Is that right so far?"*

Put down the pen! During the ARTAS-II study, one of the most consistent themes in the client feedback was that the LC was different – and more effective – because s/he looked at the client while listening. If the LC looks at the client while s/he speaks, the LC cannot write at the same time. It is okay to jot down a quick note or write out responses on the "ARTAS Session Plan" as the client will receive a copy. However, in general, the LC should keep the writing to a minimum.

Do not jump too quickly to problem-solving. ARTAS involves giving advice when asked, suggesting alternatives, and providing direction. While the LC is able to assume an expert role, s/he does not want to become yet another person in the client's life telling the client what to do. It is also important to maintain professional boundaries and remain client-focused.

Remember that ARTAS is not about ordering or coercing a client into medical care. It is about helping a client come to the decision that obtaining medical care is right for him/her. When the client is in charge, s/he gains the ability to overcome the many obstacles presented. It is the LC's job to take advantage of the opportunity to build the important asset of self-reliance within the client.

Use silence as a part of the LC's communication repertoire. Case managers, including LCs, are usually active communicators. This is an important, useful quality. However, silence is also a powerful stimulus that can lead clients to important expressions of thought or emotion. If the client is getting too uncomfortable with the silence, use a simple reflection: *"This is really hard for you to talk about…"* and try more silence. Silence can be an indicator that a statement the LC made had an impact on the client, and the client is trying to process this information.

Use confirmations to let the client know the LC is listening, when a client is speaking freely and the LC is confident that s/he does not need to provide verbal feedback. Common confirmation responses include: head nods, maintaining eye contact, or brief verbal confirmations such as *"Okay," "Yeah," "Uhm" and "I see."*

E. Facilitation Skills

In addition to client-centered skills and techniques listed above, ARTAS staff – particularly the LC – it may be helpful to have good facilitation skills. These skills can be useful during meetings with community partners and colleagues and in training new staff. Facilitation refers to the process of designing and running a successful meeting or training.

Role of the Facilitator

As a facilitator in meetings with agency colleagues and community partners, or in trainings with staff, the LC will, first and foremost, want to structure a productive meeting.

The facilitator's role is as follows:
- ► Be clear about the purpose and objectives of the meeting/training.
- ► Create an agenda to achieve meeting/training objectives, whether the meeting is 15 minutes or 50 minutes.
- ► Run the meeting effectively and keep it moving.
- ► Pay attention to the space and the meeting room's temperature to ensure the participants' comfort.
- ► Ensure every participant has an opportunity to speak.
- ► Manage group dynamics which may arise from different communication styles.
- ► Be well prepared with background information on ARTAS (e.g., brochure or fact sheet).
- ► Set a positive tone about ARTAS and express a willingness to work together with other providers and existing referral networks.

Process versus Content

In ARTAS, the LC will need to have sufficient facilitation skills to manage both process and content of a meeting/training. By definition, "process" refers the facilitator's action to manage the flow of the meeting and move the process along using techniques to manage the group. On the other hand, "content" refers to the meeting objectives, agenda, discussion topics, and expected outcomes.

Tips on Preparing for the Meeting/Training

The following are helpful tips for the LC to <u>prepare</u> for meetings to inform community partners about ARTAS and/or training sessions for new ARTAS staff:
- ► Ensure that meeting/training attendees have a clear understanding of the meeting purpose in advance.
- ► Know the audience and keep their potential concerns in mind.
- ► Develop an agenda ahead of time and consider whether it should be sent in advance of the meeting.

- ► Decide how to record the information from the meeting.
- ► Take care of all of the meeting logistics (e.g., location, room setup, equipment, supplies, refreshments). In considering the meeting location, one implementing agency incorporated the discussion of ARTAS into an existing monthly HIV provider network meeting. This eliminated the need for providers to come out to an extra meeting and provided a venue to share information with others.

Tips on Facilitating the Meeting/Training

The following are helpful tips for the LC to facilitate meetings to inform community partners about ARTAS and/or training sessions for new ARTAS staff:
- ► Set ground rules – such as turning off cell phones, respecting other people's opinions – before the meeting starts and ask participants to agree to uphold them.
- ► Assess the group to determine the mood or atmosphere (e.g., low energy/high energy, frustration, antsy, impatient, uninterested, in a hurry to get done).
- ► Clearly state the meeting's purpose and keep the meeting on track.
- ► Be aware of group dynamics and manage them effectively to achieve the goals of the meeting.
- ► Share information about ARTAS clearly and encourage open discussion.
- ► Keep a positive tone to the meeting.
- ► Pay close attention to time and even try to end the meeting early, if possible.
- ► Try to get a commitment from providers to refer clients who test positive to ARTAS, and to receive ARTAS clients for long-term case management and medical care.
- ► Be sure to pass around a sign-up sheet so that the LC can follow up with participants afterwards about referring and receiving clients.

Some of these tips may be helpful for the LC as s/he is preparing for and conducting client sessions as well.

II. Maintaining Working Relationships with Community Partners

While relationships with community partners must be in place prior to the implementation phase of ARTAS, it is essential that the LC maintain contact with them for the duration of the intervention. The LC's work with community partners is not finished once a community partner is identified and that relationship is established. Keeping in contact with these sites serves as a reminder of the intervention, encourages referrals, and contributes to the successful implementation of ARTAS.

The Project Director/Manager may want to monitor the referral processes, at least in the beginning of the Implementation phase, to ensure all agencies are complying with the protocol, assist with any challenges faced, and identify solutions where needed.

To maintain effective working relationships with community partners, the LC should engage in regular face-to-face, telephone, or e-mail contact with them. The LC should also plan to participate in regular meetings with other HIV providers in groups such as community-wide referral networks, Community Planning Groups, Regional Advisory

Groups, and case manager meetings; and use these opportunities to continually market ARTAS to new community partners and medical care providers.

Staff turnover at partner agencies may affect the intervention's impact. The LC should plan to educate and build an effective, working relationship with newly hired staff. To minimize the disruption that can result from staff turnover, the LC and implementing agency should maintain ongoing and frequent nurturing of relationships with key staff at all levels of the partner agencies. The LC may find it helpful to make monthly calls or visits to community partners, especially the referral sites, to refresh their memories about the agreed-upon referral process and to keep the intervention in the forefront of their minds as they encounter clients recently diagnosed with HIV. Some of the ARTAS-II demonstration sites found it helpful to require the LC to contact referral sites at specific intervals, such as once a month. Regular contact between the LC and community partners can result in:

- Trusting relationships among community partners and the LC
- Increased visibility of the intervention
- Regular reminders about ARTAS
- Opportunities to answer questions that arise about the intervention or referral process
- Opportunities to provide or obtain updates on linked clients and show ARTAS is providing the services as advertised
- Finding clients who miss an appointment with the LC (if the client allows the locator information to be shared with the ARTAS implementing agency)
- Close monitoring of ARTAS marketing materials

Monitoring the marketing materials at each site and determining when more are needed provides an opportunity to gain feedback on how the materials are being used and if they need to be adjusted to meet clients' needs. It may be necessary to rewrite them (for example, to simplify the writing or add more pictures) to make them more effective. The general rule is to write at a fifth grade reading level; however, implementing agencies will need to assess their community's needs.

Throughout implementation, each LC should continue to identify and establish relationships with additional organizations providing HIV-related services in the community. The LC should follow the process used when initially enlisting community partners to gain "buy-in" from these organizations.

The next section of the manual provides a comprehensive overview of how to conduct each of the five client sessions and helpful tips for the LC.

CLIENT SESSION GUIDE
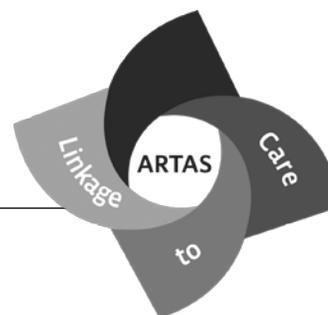
The Client Session Guide contains a step-by-step guide to facilitate each of the five client sessions, helpful tips, and the forms and documents needed to conduct and track each client session. This guide is written for the Linkage Coordinator implementing ARTAS.

The goal of ARTAS is to link people who are recently diagnosed with HIV to medical care. To advocate for linkage to medical care with the client, you will help the client identify benefits and resolve barriers to linkage. Undoubtedly, the client will have other goals s/he would like to address; these goals should be achievable in a short time frame and should not conflict with the Core Elements of ARTAS. Accomplishing the client's other goals may strengthen the relationship between you and the client and/or eliminate a source of stress for the client.

In addition, many clients identify system-level barriers, such as restrictive service application hours, biases against people with living with HIV/AIDS, and a lack of childcare. Addressing these barriers will help facilitate linkage to medical care. Therefore, you should be skilled in resolving common system-level barriers.

Instructions on How to Use the Client Session Guide

Note: As noted previously, ARTAS is an individual-level intervention. As such, the content, timing, and structure of each client session will differ greatly depending on the client and his/her needs, barriers, and strengths. You should be prepared to adjust the session content, timing, and structure to the client.

The following Client Session Guide provides a basic structure for each client session. The five client sessions are:
Session One: Building the Relationship
Session Two: Emphasizing Personal Strengths
Session Three: Learning to Make Contact
Session Four: Reviewing Progress
Session Five: Completing the Work

Format of this Guide: A cover page with the overall activities for the session, an agenda, forms and documents needed, and an estimated length of time is provided for each client session.

While you should attempt to complete every activity listed for each session, since ARTAS is client-centered and the sessions are client-driven, you must be flexible in addressing the client's needs. Therefore, it is more important to be consistent with the client's needs, strengths-focused, and client-driven than it is to complete all session activities. As such, the agenda, time, content, and forms must be adjusted to the client's needs.

After the cover page, each session is organized by agenda items, which correspond to one or two activities for the session. For each agenda item, you will find the following subheadings:

Purpose: The purpose is the activity or activities you should accomplish by the end of this discussion.

Forms and Documents: The forms and documents are those that you should have on hand to review and/or complete with the client. Some forms will be completed after the session ends, and they are listed within the step-by-step procedure. Please remember, you may not use every form or document with each client. It depends on where the client is in his/her decision to link to medical care.

Advanced Preparation: The advanced preparation is a list of activities you should do before starting a client session and that typically relate to the key considerations.

Key Considerations: The key considerations are reminders for you. These items may include information on what to expect from the client (e.g., a client may be ambivalent about the first session).

Procedure: The procedure is a step-by-step description of how to conduct each activity/activities of the session. Because this is an individual-level intervention, the structure of this section will differ greatly depending on the client. Within this section you will find guidelines on what to cover and what to skip based on where the client is at that point in the session.

Finally, it is important to note that the content within each of the five sessions is intentionally redundant in places. Because a client may be under a great deal of stress and/or at different stages of decision-making from one session to the next, repeating information and key points are important to ensure s/he understands and retains the information. As you progress from one session to the next with the client, you will also note subtle differences in the step-by-step procedures

and key considerations. These differences are reminders for you to check in with the client on unresolved barriers and further explore why s/he is not ready to link to medical care. The differences are noted throughout the Client Session Guide.

As a supplement to individual client sessions, a section called Client Session Guide Forms includes instructions and the forms needed during and after each client session. Some forms will be completed with the client, and others will be completed after the client session. This information will be provided in the instructions and in the step-by-step procedure. Finally, the guide provides an overview of helpful tips to consider when implementing ARTAS.

See **Figure 1: ARTAS Client Session Flow Process** on the next page for a visual representation of the client sessions. The figure depicts how a client flows into ARTAS, through the client sessions, linkage to medical care, and referral to other programs upon completion of ARTAS. It also shows how ARTAS complements long-term/Ryan White case management and CRCS. A client can be referred from long-term/Ryan White case management or CRCS into ARTAS to provide more intensive, individualized work to link him/her to medical care. Or, a client can also be referred to these programs if s/he is not interested in or eligible for ARTAS, or upon completion of ARTAS.

ARTAS Client Session Flow Process

Testing Site
Client receives positive
confirmatory test result

Client is referred to Ryan White long-term case management

Client is referred to ARTAS

If client is not eligible for or interested in ARTAS, refer client to Ryan White or long-term case management.

Introduce ARTAS to client. Determine if client is eligible and interested in participating in ARTAS.

If client is eligible and interested, proceed to client sessions.

Session One

Medical Care

The client can link to medical care at any point during ARTAS, beginning from the first session. If the client links to care, he/she can return for the final session for transition to other services.

Phone reminder as needed

If a client falls out of ARTAS within 90 days, attempt to locate him/her for the duration of the 90 day period.

Sessions Two, Three and Four

If the client drops out of or does not want to continue ARTAS, refer him/her to other services, including long-term/ Ryan White Case management.

Other Services

Long-term/Ryan White Case Management

Transition/ Referrals

Closeout Session

Other Primary Care Providers

CS249136 **Figure 1: ARTAS Client Session Flow Process**

Session One: Building the Relationship
Approximately: 1 ½-2 Hours

Session One: Activities
- A: Introduce the goals of case management and ARTAS
- B: Discuss concerns about recent HIV diagnosis
- C: Begin to identify personal strengths, abilities, and skills, and assess others' role in impeding or promoting access to services
- D: Encourage linkage to medical care
- E: Summarize the session, the client's strengths, and agreed-upon next steps
- F: Plan for the next session(s), with the medical care provider and/or you

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Session One Guide Agenda
1A. Introduction
1B. Guided Discussion
1C. Client Assessment
1D. Linkage to Medical Care
1E. Review and Summarize the Session
1F. Schedule Medical Appointment and/or Next Session

Forms and Documents Needed for Session One:
- *Overview of ARTAS document*
- *Strengths Assessment*
- *ARTAS Session Plan*
- *Resource Directory*
  - *A Listing of Medical and Psychiatric Service Providers and Local Social Service Providers (e.g., housing, food, insurance)*
- *Fact Sheet on Current Treatment Options and their Side Effects*
- *Appointment Cards*
- *Incentives, if provided*
- *Session Notes*
- *Session Notes Summary Sheet*
- *Case Staffing Form*
- *Life Domains List*

Remember: The sessions are client-driven. As such, <u>the agenda, time, content, and forms must be adjusted to the client's needs.</u>

1A: Introduction

Purpose: Introduce yourself and ensure the client understands the goals of case management, ARTAS, and the strengths model used to guide the process.

Forms and Documents: - *Overview of ARTAS Document*

Advanced Preparation:
- Review the Overview of ARTAS Document.

Key Considerations: Remember that:
- A client may be ambivalent about the first session.
- Each client begins at a different place. Some may have just learned of their HIV status; others may have been living with HIV for some time.
- The client may have already overcome some barriers by attending this session.
- The client may have experienced a wide range of emotions leading up to this session, including fear, anger, distrust, helplessness, and fatalism.
- The client might have had negative personal experiences with medical providers in the past.

Caution should be exercised to not self-disclose at this point. At this early stage, it is not possible to know what shared life experiences will enhance or impede your relationship with the client. This applies to issues such as personal faith, HIV status, relationships with others living with HIV or who have died from AIDS, or past substance use.

Procedure:
For all clients:
1. Introduce yourself to the client. Describe your professional background, especially as it applies to working with people living with HIV/AIDS (PLWHA). Emphasize your training, interest in assisting PLWHA, and/or knowledge of HIV/AIDS-specific health care services.

2. Give the client the Overview of ARTAS document. (Note: During the Pre-Implementation phase, you should have created a brief ARTAS summary to reach out to community partners. Give the client that document or a modified version). Either read the overview verbatim or paraphrase its key points. It is important that you confidently convey the key points to the client. The key points for the **ARTAS Overview Document** can be found on page 165 in the Session Forms section.

3. **Next step, continue to 1B: Guided Discussion.**

1B: Guided Discussion

Purpose: To give the client an opportunity to talk about his/her feelings and thoughts related to his/her recent HIV diagnosis.

Forms and Documents: - *Fact Sheet on Current Treatment Options and their Side Effects*

Advanced Preparation:
- Review the Fact Sheet on Current Treatment Options and their Side Effects.

Key Considerations: You should:
- Possess a comprehensive and in-depth knowledge base about HIV/AIDS (the medical, psychological, and social aspects), and be able to answer the client's detailed questions.
- Refer to current resources to answer the client's questions.
- Promote the personal and partner benefits of risk reduction and the value of seeking medical care early.
- Diminish fears or concerns the client might have about treatment and/or visiting a doctor.
- Be realistic about the limitations of treatment – that there is no cure for HIV; however, instill hope related to healthy outcomes in the client.
- Help the client explore personal resources to help him/her to be successful.
- Be careful to neither directly confront nor reinforce the client's statements at this time.

Procedure:
For all clients:
1. Start the discussion with a statement that lets the client know you understand and are aware that it is natural to have many feelings and unanswered questions after receiving an HIV-positive diagnosis. Start the discussion like this:
    - *"When a person finds out they're HIV-positive, a lot of things go through their mind. How have you been feeling since you found out?"*

Possible open-ended follow-up questions include:
    - *"What resources did the health department tell you about when you received your test results?"* and
    - *"What were your biggest worries when you received your positive test results?"*

2. Ask the client what materials about HIV/AIDS the testing site gave him/her, if any. Possible open-ended follow-up questions include:
    - *"What did you think about the material you received?"* or
    - *"What additional questions do you have about HIV/AIDS?"*

3. Clarify any questions the client has about HIV (specifically about symptoms, care and treatment options, support services, and counseling).

4. Review the **Fact Sheet on Current Treatment Options and Side Effects** (see sample on page 165 of the Session Forms section), and offer to give him/her a copy of the document. Possible open-ended follow-up questions include:
   - *"What other questions do you have?"*
   - *"Have you discussed your HIV status with a doctor or nurse since you received your test results? If so, what did you talk about? Do you have additional questions?"* and
   - *"What are your concerns about seeking treatment or medical care?"*

5. **Next step, continue to 1C: Client Assessment.**

1C: Client Assessment

Purpose: Begin to identify personal strengths, abilities, and skills and assess others' role in impeding or promoting access to medical and/or social services.

Forms and Documents: - *Strengths Assessment*

Advanced Preparation:
- Review the state/local legal requirements regarding HIV disclosure.

Key Considerations: You should:
- Use effective communication skills.
- Know the state/local legal requirements regarding disclosing one's HIV status.
- Have natural conversations with the client to identify additional strengths.
- Ask open-ended questions that encourage the client to identify strengths.
- Show the client genuine respect and concern, as this is the starting point of a helping relationship.

Procedure:
For all clients:
1. Explain how identifying the client's strengths, abilities, and skills relates to his/her ability to stay healthy and link to medical care. For example,:

    "Often times, when you see ways that you've been successful in the past, it helps you to be successful again. Knowing how you've been successful helps you plan how to deal with barriers or problems you may have getting the medical care you need or achieving other goals."

2. Ask the client to talk about his/her personal experiences. Guide the client to speak from a strengths perspective and about his/her abilities, rather than putting himself/herself down. While the Strengths Assessment is formally introduced in **Session Two**, it is important to start talking about strengths from the very beginning.

3. Cite examples of the client's strengths and abilities that have already become apparent in your conversation or during this session. This will help the client think about personal strengths, resources, and skills. Some common examples include:
    - The courage to get tested for HIV
    - The wisdom to come to Session One of ARTAS
    - The ability or desire to live independently
    - Being punctual, if s/he arrived on time

4. Help the client assess the role others have in supporting or impeding his/her access to medical care. Ask the client:
    - *"Who do you think could support or help you get to the doctor? Think about friends, family, neighbors, significant others, anyone. These are*

people you feel can take you to appointments, let you borrow their car, provide financial assistance, watch your kids, give emotional support, and other things you might need."

5. Discuss the advantages or disadvantages of telling a significant other or sexual partner(s) about testing positive.

    If the client is currently involved in a sexual relationship(s), ask him/her:
    - *"Does your significant other/sexual partner(s) know you're HIV-positive or not?"*

    If yes, follow up with:
    - *"How do you think you could get [insert name of significant other/partner] to help you get into medical care?"*

    If no, follow up with:
    - *"What do you think are some of the advantages to telling [insert name of significant other/partner]?"and*
    - *"What are some of the disadvantages?"*

Discuss any important advantages or disadvantages that the client did not mention, including any state laws or legal requirements to disclose one's HIV status to sexual partners (regardless of condom use or other protective measures taken) and/or to health care providers. It is important that you be familiar with these requirements and be able to clearly articulate them to the client.

6. **Next step, continue to 1D: Linkage to Medical Care.**

1D: Linkage to Medical Care

Purpose: Encourage the client to seek medical care, and, if interested, assist him/her in the process to make that linkage.

Forms and Documents: *- ARTAS Session Plan*
- Resource Directory
- Session Notes
- Session Notes Summary Sheet
- Case Staffing Form

Advanced Preparation:
- Review any specific requirements, characteristics/traits, agency policies, and required paperwork of the health care providers.
- Review any local, state, or federal policies such as eligibility requirements for services, Medicaid, ADAP, Ryan White services, wait lists, mandatory disclosure laws.

Key Considerations: Inform the client about the following:
- Care and treatment services provided at your agency and/or your community partners.
- Specific requirements, such as timeliness, rescheduling policies, or paperwork required for health care providers in the area.
- Characteristics or traits of a particular clinic(s) or community partner(s) that match the client's needs. For example, a clinic with bilingual staff or interpreters for a non-English-speaking/limited-English-proficient client.
- Relevant policies (at the agency, local, state, and/or federal levels), issues, or potential barriers, such as eligibility requirements for services, Medicaid, ADAP, Ryan White services, wait lists, mandatory disclosure laws. Focus on policies with the most immediate impact on the client.

Procedure:
For all clients:
1. Ask the client about his/her expectations and concerns about seeking medical care and treatment for HIV. Be sensitive to the client's <u>stated and unstated reasons</u> for not wanting to seek medical treatment. Begin the discussion with these questions:
   - *"What are your thoughts about linking to medical care?"*and
   - *"What barriers or problems might get in the way of your going to a doctor or medical clinic?"*

2. Assess the client's tangible and perceived barriers. The client may have a multitude of personal barriers that impede his/her ability to seek services, such as:
   - Homelessness
   - No transportation

- No financial resources
- Active drug or alcohol addiction

Some of the perceived barriers could be fears about family, friends, and community members discovering his/her HIV status or health care needs.

3. Engage the client in a discussion about medical options, provide information, and help him/her clarify concerns, issues, and barriers. <u>Remember, it is not your role to make the decision to link to medical care for the client.</u>

4. Demonstrate your thorough knowledge of the medical care environment and requirements and provide information based on available resources. This includes:
    - Providers and their specialties and personalities
    - How to navigate the system to apply for and access Ryan White, Medicaid, or other services
    - In other words, all the background research you did in the Pre-Implementation Section to become familiar with community partners

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At this point, one of four things is likely to happen. Based on where the client is in his/her decision, follow these instructions:

If the client decides to link to medical care at this point, continue with Step 5.

If the client is not ready to make this decision, skip to 1E: Review and Summarize the Session.

If the client a) wants to drop out of ARTAS, or b) does not want to link to medical care, skip to Step 8.

For clients who wish to link to medical care at this point:
5. Introduce the ARTAS Session Plan:
    > *"Our goal is to help you get connected to a doctor. As you may recall, we will have up to five sessions in 90 days to help you achieve this and other goals by identifying your strengths and overcoming barriers.*
    >
    > *The ARTAS Session Plan is one of the activities that can guide us to accomplish your goal(s). This plan will help us organize our work together and make sure that we identify everything we need to work on. We'll write down the goals to remind us of what we're doing and you will always have a copy of your most recent ARTAS Session Plan, if you want it."*

6. Follow the **ARTAS Session Plan Instructions** on page 157 of the Session Forms section. The ARTAS Session Plan helps the client identify objectives and possible barriers, activities to accomplish the objective(s), the person responsible, target dates to complete each activity, and the related strength. It is

recommended that the plan be committed to in writing to allow you and the client to easily track progress and pinpoint activities that may need to be adjusted over time.

7. **Next step, continue to 1E: Review and Summarize the Session.**

For clients who want to drop out of ARTAS <u>or</u> do not want to link to medical care now or in the near future (<u>if at any point the client decides to link to medical care and/or not drop out of ARTAS, continue to 1E: Review and Summarize the Session</u>):

8. Keep the conversation positive! Cover the following topics:
    a. Engage the client in a discussion about: (1) his/her reasons for attending the first ARTAS session; and (2) his/her reasons for deciding not to continue with ARTAS/seeking medical care.
    b. Let the client know that ambiguity about linking to medical care is normal.
    c. Review the client's strengths discussed during the session.
    d. Discuss his/her accomplishments made during the session and ask how, if at all, the session has been helpful.
    e. Keep the door open. Remind the client that your sessions together can continue as long as s/he thinks it can help clarify and remove barriers to seeking treatment before the end of the 90 days.
    f. Offer the client your business card and end the session.

9. **Next step, end the session and complete paperwork**:
    - Depending on your agency's procedures and/or schedule for the day, you may want to take a few minutes to complete all the required paperwork before moving on to the next client and/or task. Recommended paperwork to complete includes:
        ○ Session Notes
        ○ Session Notes Summary Sheet (if the client dropped out)
        ○ Case Staffing Form

1E: Review and Summarize the Session

Purpose: To review what was discussed with the client during the session and summarize the agreed-upon next steps.

Forms and Documents: - *ARTAS Session Plan*

Advanced Preparation: None.

Key Considerations: You should:
- Review the ARTAS Session Plan activities and discuss/revise anything that was documented incorrectly, if a plan was developed.

Procedure:
For clients who wish to link to medical care at this point, or clients who are not ready to make this decision:
1. Provide a summary of the session or ask the client to summarize the session and the client's strengths. During the first session, the client may be very emotional and upset, particularly if s/he has been recently diagnosed. Therefore, summarizing the session is extremely important to help the client remember the key points.

2. Review the ARTAS Session Plan activities, person responsible, and target date to complete the items with the client, if a plan was developed. Remember, some of these are activities you are committing to complete prior to the session.

3. **Next step, continue to 1F: Schedule Medical Appointment and/or Next Session.**

1F: Schedule Medical Appointment and/or Next Session

Purpose: To schedule appointments with you, medical providers, and other support services as needed.

Forms and Documents: - *ARTAS Session Plan*
- *Resource Directory*
- *Appointment Cards*
- *Incentive, if provided*
- *Session Notes*
- *Session Notes Summary Sheet*
- *Case Staffing Form*

Advanced Preparation:
- Review your availability for the next session and/or medical appointment.
- Review the Resource Directory for medical providers, clinics, and other services as needed.
- Bring the transportation vouchers/tokens/schedules.

Key Considerations: You should:
- Refer the client to services as needed. The client may present with other needs that are related to his/her recent seroconversion or existing HIV status.
- If the client wishes to schedule a medical appointment, provide him/her with detailed information about the clinic hours and services they provide.
- Make sure all paperwork is completed and discuss how client information will be used. Stress privacy and confidentiality.
- Arrange and confirm all appointments with or for the client, medical as well as other services as needed.
- Offer to take the client or provide transportation to all scheduled appointments.
- Work on all identified barriers to following through with scheduled appointments.

Procedure:

For clients who wish to link to medical care at this point:
1. Clarify whether or not the client would like you to accompany him/her to the medical appointment.

2. Discuss the best time and date to schedule the appointment.
   - If the ARTAS Session Plan has activities that must be completed before the medical appointment that may take some time, schedule the appointment further out or wait until the next session to schedule the medical appointment. Examples of activities that might take more time to complete are arranging for transportation and processing Medicaid enrollment forms.

3. Call the clinic or community partner (or have the client call) to schedule an appointment.

- **If the next time you see the client will be at the medical visit**:
  - Give him/her information about the staff and doctor, required documents.
  - Discuss in detail what the client should expect at each stage of the appointment.
  - Help the client write down questions s/he would like to ask the health care provider and/or other clinic staff. Depending on the client, practice asking and answering questions with him/her so s/he feels comfortable with the list of prepared questions.
  - Ask the client if s/he would like for you to call him/her before the medical appointment, as a reminder.

For all clients:

4. Schedule and/or make arrangements for the client to access needed social services, such as temporary housing and food banks.

5. Schedule a day, time, and meeting location for the next ARTAS session. Make sure accommodations are compatible with agency safety guidelines.
   - If the next session is before the medical appointment or the client is not linking to medical care at this point, offer to write down these details and to call the client before your next session as a reminder. The topics covered will follow the format for **Session Two**.
   - If it is scheduled for after the medical appointment, the next session will be **Session Five** (completing the work with the client).

6. Offer the client an **appointment card** (see samples on page 171 of the Session Forms section) to document the time, location, and agency name.

7. Give the client transportation tokens or vouchers to get home and/or to the next session or appointment. Or offer to pick the client up, if that is an allowable activity at your agency.

8. Gather any contact and/or locator information from the client before s/he leaves. Locator information will allow you to locate the client through family, friends, or other individuals that know how to reach him/her if the client's address changes, phone is disconnected, or the client is not reachable through the means provided in the initial intake (conducted within the agreed-upon rules for communicating with the client). Remind the client that you will attempt to contact him/her through these means only after a missed appointment.

   - To gather this information, discuss how the locator information will be used and be sure to inform the client that none of his/her personal information will be shared with the contacts provided. Information collected from the contact persons includes the following: usual place of residence; telephone number or address of someone who usually knows where the client can be found; places where s/he picks up mail or messages.

- Ask the client if the contacts are aware of his/her HIV status and assure the client that his/her contacts will not be told the reason for the call. You can say you are a friend trying to reach the client.

9. End the session by thanking the client for coming and congratulate him/her for a productive session. Remind the client that linking to medical care is important to his/her overall health, and that you are there to help him/her attain services needed so that s/he is ready to access medical care and treatment.

10. **Next step, complete paperwork**:
    - Depending on your agency's procedures and/or schedule for the day, you may want to take a few minutes to complete all the required paperwork before moving on to the next client and/or task. Recommended paperwork to complete includes:
        - Session Notes
        - Session Notes Summary Sheet (if the client dropped out)
        - Case Staffing Form

Sessions Two, Three, and Four
Approximately: 1 ½ - 2 hours

Sessions Two, Three, and Four Activities:
- A: Solicit client issues and questions from the initial session
- B: Continue identifying personal strengths, abilities, and skills
- C: Encourage linkage to medical care
- D: Identify and address personal needs and barriers to linkage
- E: Summarize the session, the client's strengths, and agreed-upon next steps
- F: Plan for the next session(s), with the medical care provider and/or you

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Sessions Two, Three, and Four Guide Agenda

2A. Review of Session One

2B. Client Assessment

2C-D. Linkage to Medical Care

2E. Review and Summarize the Session

2F. Schedule Medical Appointment and/or Next Session

Forms and Documents Needed for Sessions Two, Three, and Four:
- *ARTAS Session Plan*
- *Strengths Assessment*
- *Resource Directory*
  - *A Listing of Medical and Psychiatric Service Providers and Local Social Service Providers (e.g., housing, food, insurance)*
- *Appointment Cards*
- *Incentive, if provided*
- *Session Notes*
- *Session Notes Summary Sheet*
- *Case Staffing Form*
- *Life Domains List*

Remember: The sessions are client-driven. As such, <u>the agenda, time, content, and forms must be adjusted to the client's needs.</u>

2A: Review of Session One (Two and Three if appropriate)

Purpose: To clarify and address any questions or areas of confusion the client has from the initial contact or previous session.

Forms and Documents: *- ARTAS Session Plan*

Advanced Preparation:
- Review the client's ARTAS Session Plan, if one was developed in the previous session.

Key Considerations: Remember that the client:
- Needs support and resources to effectively link to medical care. Be sure to review the client's needs and refer him/her to needed services to assist in accessing medical care.
- Often needs assistance to identify personal strengths and abilities to facilitate his/her linkage to medical care.
- May need to reflect on his/her HIV status and barriers encountered in disclosing his/her status to others and in accessing social services.

Procedure: **For all clients:**
1. Welcome the client back for Session Two (Three or Four) and congratulate him/her on following up successfully with today's session. Recognize the many demands the client has and state how much you appreciate him/her taking time to meet with you.

2. Ask the client what questions, concerns, or new insights s/he has as a result of the previous session. You may also want to ask about his/her thoughts about linking to medical care since your last session and any reactions s/he has to the focus on strengths, which will help you to assess whether or not s/he is starting to adopt the new approach.

3. Summarize any additional points made during the discussion.

For clients who have not decided to link to medical care:
4. **Next step, continue to 2B: Client Assessment.**

For clients who have decided to link to medical care but have not yet attended their appointment:
5. Review the outcomes of all activities listed on the ARTAS Session Plan for both you and the client. If necessary, revise the plan.

6. Ask the client about any new barriers and/or strengths discovered as a result of completing the ARTAS Session Plan activities. If necessary, revise the plan.

7. **Next step, skip to section 2E: Review and Summarize the Session.**

2B: Client Assessment

Purpose: To help the client self-identify personal strengths, abilities, and skills.

Forms and Documents: - *Resource Directory*
                                    - *Strengths Assessment*

Advanced Preparation:
- Review the state/local legal requirements regarding HIV disclosure.
- Review the client's Strengths Assessment, if one was started in the previous session.

Key Considerations: You should:
- Use effective communication skills.
- Know the state/local legal requirements regarding disclosing one's HIV status.
- Have natural conversations with the client to identify additional strengths.
- Ask open-ended questions that encourage the client to provide more substantive information to build on the list of strengths developed in Session One.
- Show the client genuine respect and concern, as this is the starting point of a helping relationship.

Procedure:
For clients who have not yet decided to link to medical care:
1. Remind the client how identifying strengths, abilities, and skills relate to his/her ability to stay healthy and link to medical care. For example:
    "Often times, when you see ways that you've been successful in the past, it helps you to be successful again. Knowing how you've been successful helps you plan how to deal with barriers or problems you may have getting the medical care you need or achieving other goals."

2. Remind the client of examples of his/her strengths and abilities that have already become apparent in the previous session. This will help the client think about personal strengths, resources, and skills. Some common examples include:
    - The courage to get tested for HIV
    - The wisdom to come to ARTAS
    - The ability or desire to live independently
    - Being punctual, if s/he arrived on time

3. **This is a new activity started in Session Two.** Conduct the **Strengths Assessment** by following the instructions and introduction script starting on page 149 of the Session Forms section.

4. **Next step, continue to 2C-D: Linkage to Medical Care.**

2C-D: Linkage to Medical Care

Purpose: Encourage the client to seek medical care, and if interested, assist him/her in the process to make that linkage.

Forms and Documents: *- ARTAS Session Plan*
                                       - Resource Directory
                                       - Session Notes
                                       - Session Notes Summary Sheet
                                       - Case Staffing Form

Advanced Preparation:
- Review any specific requirements, characteristics/traits, agency policies, and required paperwork of the health care providers.
- Review any local, state, or federal policies such as eligibility requirements for services, Medicaid, ADAP, Ryan White services, wait lists, mandatory disclosure laws.
- Review the client's ARTAS Session Plan, if one was developed in the previous session.

Key Considerations: Inform the client about the following:
- Care and treatment services provided at your agency and/or your community partners.
- Specific requirements, such as timeliness, rescheduling policies, or paperwork required for health care providers in the area.
- Characteristics or traits of a particular clinic(s) or community partner(s) that match the client's needs. For example, a clinic with bilingual staff or interpreters for a non-English-speaking/limited-English-proficient client.
- Relevant policies (at the agency, local, state, and/or federal levels), issues, or potential barriers, such as eligibility requirements for services, Medicaid, ADAP, Ryan White services, wait lists, mandatory disclosure laws. Focus on policies with the most immediate impact on the client.

Procedure:
For clients who have not decided to link to medical care:
1. Ask the client about his/her expectations and concerns about seeking medical care and treatment for HIV. Be sensitive to the client's <u>stated and unstated reasons</u> for not wanting to seek medical treatment. Begin the discussion with these questions:
    - *"What are your thoughts about linking to medical care?"*and
    - *"What barriers or problems might get in the way of your going to a doctor or medical clinic?"*

2. Assess the client's tangible and perceived barriers. The client may have a multitude of personal barriers that impede his/her ability to seek services, such as:
    - Homelessness

- No transportation
- No financial resources
- Active drug or alcohol addiction

Some of the perceived barriers could be fears about family, friends, and community members discovering his/her HIV status or health care needs.

3. Engage the client in a discussion about medical options, provide information, and help him/her clarify concerns, issues, and barriers. <u>Remember, it is not your role to make the decision to link to medical care for the client.</u>

4. Demonstrate your thorough knowledge of the medical care environment and requirements and provide information based on available resources. This includes:
   - Providers and their specialties and personalities
   - How to navigate the system to apply for and access Ryan White, Medicaid, or other services
   - In other words, all the background research you did in the Pre-Implementation Section to become familiar with community partners

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At this point, one of four things is likely to happen. Based on where the client is in his/her decision, follow these instructions:

If the client decides to link to medical care at this point, continue to Step 5.

If the client is not ready to make this decision, skip to 2E: Review and Summarize the Session.

If the client a) wants to drop out of ARTAS, or b) does not want to link to medical care, skip to Step 8.

For clients who wish to link to medical care at this point:
5. Introduce the ARTAS Session Plan:
   "Our goal is to help you get connected to a doctor. As you may recall, we will have up to five sessions in 90 days to help you achieve this and other goals by identifying your strengths and overcoming barriers."

   "The ARTAS Session Plan is one of the activities that can guide us to accomplish your goal(s). This plan will help us organize our work together and make sure that we identify everything we need to work on. We'll write down the goals to remind us of what we're doing, and you will always have a copy of your most recent ARTAS Session Plan, if you want it."

6. Follow the **ARTAS Session Plan Instructions** on page 157 of the Session Forms section. The ARTAS Session Plan helps the client identify objectives and possible barriers, activities to accomplish the objective(s), the person responsible, target dates to complete each activity, and the related strength. It is recommended that the plan be committed to in writing to allow you and the client to easily track progress and pinpoint activities that may need to be adjusted over time.

7. **Next step, continue to 2E: Review and Summarize the Session.**

For clients who want to drop out of ARTAS or do not want to link to medical care now or in the near future (if at any point the client decides to link to medical care and/or not drop out of ARTAS, continue to 2E: Review and Summarize the Session):

8. Keep the conversation positive! Cover the following topics:
   a. Engage the client in a discussion about: (1) his/her reasons for attending the second (third or fourth) ARTAS session; and (2) his/her reasons for deciding not to continue with ARTAS/seek medical care.
   b. Let the client know that ambiguity about linking to medical care is normal.
   c. Review the client's strengths discussed during the session.
   d. Discuss his/her accomplishments made during the session and ask how, if at all, the session has been helpful.
   e. Keep the door open. Remind the client that your sessions together can continue as long as s/he thinks it can help clarify and remove barriers to seeking treatment before the end of the 90 days.
   f. Offer the client your business card and end the session.

9. **Next step, end the session and complete paperwork**:
   - Depending on your agency's procedures and/or schedule for the day, you may want to take a few minutes to complete all the required paperwork before moving on to the next client and/or task. Recommended paperwork to complete includes:
     ○ Session Notes
     ○ Session Notes Summary Sheet (if the client dropped out)
     ○ Case Staffing Form

2E: Review and Summarize the Session

Purpose: To review what was discussed with the client during the session and summarize the agreed-upon next steps.

Forms and Documents: *- ARTAS Session Plan*

Advanced Preparation: None.

Key Considerations: You should:
- Review the ARTAS Session Plan activities and discuss/revise anything that was documented incorrectly, if a plan was developed.

Procedure:
For clients who wish to link to medical care at this point, or clients who are not ready to make this decision:
1. Provide a summary of the session or ask the client to summarize the session and the client's strengths. During the session, the client may be very emotional and upset, particularly if s/he has been recently diagnosed. Therefore, summarizing the session and the client's strengths are extremely important to help the client remember the key points.

2. Review the ARTAS Session Plan activities, person responsible, and target date to complete the items with the client, if a plan was developed. Remember, some of these are activities you are committing to complete prior to the session.

3. **Next step, continue to 2F: Schedule Medical Appointment and/or Next Session.**

2F: Schedule Medical Appointment and/or Next Session

Purpose: To schedule appointments with you, medical providers, and support services as needed.

Forms and Documents: - *ARTAS Session Plan*
- *Resource Directory*
- *Appointment Cards*
- *Incentive, if provided*
- *Session Notes*
- *Session Notes Summary Sheet*
- *Case Staffing Form*

Advanced Preparation:
- Review your availability for the next session and/or medical appointment.
- Review the Resource Directory for medical providers, clinics, and other services as needed.
- Bring the transportation vouchers/tokens/schedules.

Key Considerations: You should:
- Refer the client to services as needed. The client may present with other needs that are related to his/her recent seroconversion or existing HIV status.
- If the client wishes to schedule a medical appointment, provide him/her with detailed information about the clinic hours and services they provide.
- Make sure all paperwork is completed and discuss how client information will be used. Stress privacy and confidentiality.
- Arrange and confirm all appointments with or for the client, medical as well as other services as needed.
- Offer to take the client or provide transportation to all scheduled appointments.
- Work on all identified barriers to following through with scheduled appointments.

Procedure:

For clients who wish to link to medical care at this point:
1. Clarify whether or not the client would like you to accompany him/her to the medical appointment.

2. Discuss the best time and date to schedule the appointment.
   - If the ARTAS Session Plan has activities that must be completed before the medical appointment that may take some time, schedule the appointment further out or wait until the next session to schedule the medical appointment. Examples of activities that might take more time to complete are arranging for transportation and processing Medicaid enrollment forms.

3. Call the clinic or community partner (or have the client call) to schedule an appointment.
   - **If the next time you see the client will be at the medical visit**:
     - ○ Give him/her information about the staff and doctor, required documents.
     - ○ Discuss in detail what the client should expect at each stage of the appointment.
     - ○ Help the client write down questions s/he would like to ask the health care provider and/or other clinic staff. Depending on the client, practice asking and answering questions with him/her so s/he feels comfortable with the list of prepared questions.
     - ○ Ask the client if s/he would like for you to call him/her before the medical appointment, as a reminder.

For all clients:
4. Schedule and/or make arrangements for the client to access needed social services, such as temporary housing and food banks.

5. Schedule a day, time, and meeting location for the next ARTAS session. Make sure accommodations are compatible with agency safety guidelines.
   - If the next session is <u>before the medical appointment or the client is not linking to medical care at this point</u>, offer to write down these details and to call the client before your next session as a reminder. The topics covered will follow the format for **Session Three**.
   - If it is scheduled for <u>after the medical appointment</u>, the next session will be **Session Five** (completing the work with the client).

6. Offer the client an **appointment card** (see samples on page 171 of the Session Forms section) to document the time, location, and agency name.

7. Give the client transportation tokens or vouchers to get home and/or to the next session or appointment. Or offer to pick the client up, if that is an allowable activity at your agency.

8. Gather any contact and/or locator information from the client before s/he leaves. Locator information will allow you to locate the client through family, friends, or other individuals who know how to reach him/her if the client's address changes, phone is disconnected, or the client is not reachable through the means provided in the initial intake (conducted within the agreed-upon rules for communicating with the client). Remind the client that you will attempt to contact him/her through these means only after a missed appointment.

   - To gather this information, discuss how the locator information will be used and be sure to inform the client that none of his/her personal information will be shared with the contacts provided. Information collected from the contact persons includes the following: usual place of residence;

telephone number or address of someone who usually knows where the client can be found; places where s/he picks up mail or messages.
- Ask the client if the contacts are aware of his/her HIV status and assure the client that his/her contacts will not be told the reason for the call. You can say you are a friend trying to reach the client.

9. End the session by thanking the client for coming and congratulate him/her for a productive session. Remind the client that linking to medical care is important to his/her overall health, and that you are there to help him/her attain services needed so that s/he is ready to access medical care and treatment.

10. **Next step, complete paperwork**:
- Depending on your agency's procedures and/or schedule for the day, you may want to take a few minutes to complete all the required paperwork before moving on to the next client and/or task. Recommended paperwork to complete includes:
    - Session Notes
    - Session Notes Summary Sheet (if the client dropped out)
    - Case Staffing Form

Session Five: Completing the Work
Approximately: 1 ½ - 2 hours

Session Five: Activities
- A: Review the transition process for clients linked to medical care
- B: Review the transition process for clients not yet linked to medical care
- C: Transition to long-term/Ryan White case management or other providers

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Session Five Guide Agenda
5A. Review the Transition Process: Linked Clients
OR
5B. Review the Transition Process: Non-linked Clients
AND
5C. Transition to long-term/Ryan White case manager or other providers

Forms and Documents Needed for Session Five:
- *ARTAS Session Plan*
- *Resource Directory*
- *Contact information for long-term/Ryan White case manager and agency*
- *Paperwork for long-term/Ryan White case manager*
- *Session Notes*
- *Session Notes Summary Sheet*
- *Case Staffing Form*
- *Client Satisfaction Questionnaire*

Note: For Session Five, you do not conduct all three agenda items for each client. **For clients linked to medical care, conduct agenda items 5A and 5C.**

For clients who have not linked to medical care (non-linked clients), conduct agenda items 5B and 5C.

Remember: The sessions are client-driven. As such, the agenda, time, content, and forms must be adjusted to the client's needs.

5A: Review the Transition Process – Linked Clients

Purpose: To review the client's progress made during ARTAS and discuss the client's visit with the medical provider.

Forms and Documents: *- ARTAS Session Plan*
- Resource Directory
  ○ *List of Community Service Providers (e.g., substance abuse, mental health, housing, food, and insurance)*

Advanced Preparation:
- Review the client's ARTAS Session Plan, if one was developed in the previous session.

Key Considerations: Remember that the client:
- May not be ready to transition from ARTAS and/or end your relationship.

Procedure:

For all clients:
1. Welcome the client back for the last session and congratulate him/her on following up successfully with today's session. Recognize the many demands the client has and state how much you appreciate him/her taking time to meet with you.

2. Ask the client what questions, concerns, or new insights s/he has as a result of the previous session(s).

3. Summarize any additional points made during the discussion.

For clients who have decided to link to medical care but have not yet attended their appointment:
4. Review the outcomes of all activities listed on the ARTAS Session Plan for both you and the client. If necessary, revise the plan.

5. Ask the client about any new barriers and/or strengths discovered as a result of completing the ARTAS Session Plan activities. If necessary, revise the plan.

6. **This is a new step added to Session Five.** Discuss how the client can continue to use this plan to achieve his/her goals after ARTAS.

7. **This is a new step added to Session Five.** Complete the steps listed under **4F: Schedule Medical Appointment and/or Next Session.** Then, skip to Step #9 in this section.

For clients who attended a medical appointment:

8. Discuss the client's appointment with the medical provider, including his/her reactions and any questions s/he may have. Review with the client what happened during the medical visit and ask what the client thought went well and what could be improved.

For all clients:

9. Discuss the barriers that the client identified and overcame during ARTAS. Review strategies that s/he identified as successful. Point out any additional strategies that you noticed that s/he may not have noted.

10. Discuss any remaining barriers that could interfere with the client attending his/her next medical appointment or linking to other support services. Strategize with the client to identify ways that s/he can overcome these. If there are items in the ARTAS Session Plan that the client has yet to complete, obtain a commitment from him/her that s/he will continue to work on these.

11. Ask the client what questions, concerns, or insights s/he has now that s/he completed the intervention. Address any additional issues that arise.

12. Encourage self-help through HIV support groups and linkage to long-term social services. Review the community resources discussed during earlier sessions. Also review the important role the client's family, friends, social groups, and other informal networks can play in supporting his/her continued use of medical care and other services. Provide verbal and written information regarding community services available.

13. **Next step, skip to 5C: Transition to long-term/Ryan White case manager or other providers.**

5B: Review the Transition Process – Non-linked Clients

Purpose: To review the client's progress made during ARTAS and discuss how the client will link to medical care.

Forms and Documents: *- ARTAS Session Plan*
- Resource Directory
  ○ *List of Medical Providers*
  ○ *List of Community Service Providers (e.g., substance abuse, mental health, housing, food, and insurance)*
- Paperwork for long-term/Ryan White case management

Advanced Preparation:
- Review the client's ARTAS Session Plan, if one was developed in the previous session.

Key Considerations: Remember that the client:
- May not be ready to transition from ARTAS and/or end your relationship.
- May feel discouraged or that s/he has failed by not linking to medical care during ARTAS.

Procedure:
For all non-linked clients:
1. Welcome the client back for the last session and congratulate him/her on following up successfully with today's session. Recognize the many demands the client has and state how much you appreciate him/her taking time to meet with you.

2. Ask the client what questions, concerns, or new insights s/he has as a result of the previous session(s). You may also want to ask about the client's thoughts about linking to medical care since your last session and any reactions s/he has to the focus on strengths.

3. Summarize any additional points made during the discussion.

4. Using the ARTAS Session Plan, review the client's progress over the course of the intervention. Discuss the client's strengths and how s/he used these to complete the tasks listed in his/her plan. Emphasize the client's accomplishments during ARTAS.

5. Discuss the barriers that the client identified and overcame during ARTAS. Review strategies that s/he identifies as being successful. Point out any additional strategies that you have noticed s/he may not have noted.

6. Discuss the client's hesitance to link to medical care. Review the psychological and/or physical barriers that are preventing the client from accessing medical care. Discuss with the client how s/he can overcome these barriers. If the client

desires, revise the ARTAS Session Plan to reflect concrete steps s/he can take, post-ARTAS, to link to medical care.

7. Remind the client about the benefits of early entry into medical care. Provide him/her with contact information for community medical providers and promote the client's independent contact with the clinic. Offer him/her the opportunity to call you one additional time following his/her independent clinic visit.

8. Ask the client what questions, concerns, or insights s/he has now that s/he completed the intervention. Address any additional issues that arise.

9. Encourage self-help and linkage to medical and long-term social services. Review the community resources discussed during earlier sessions. Also review the important role the client's family, friends, social groups, and other informal networks can play in supporting his/her linkage to medical care and other services. Provide verbal and written information regarding other community services available.

10. **Next step, continue to 5C: Transition to long-term/Ryan White case manager or other providers.**

5C: Transition to long-term/Ryan White case manager

Purpose: Explain to client the purpose of long-term/Ryan White case management services and how it differs from ARTAS. Facilitate the transition to the new case manager.

Forms and Documents: *- Contact information for long-term/Ryan White*
case manager
- Session Notes
- Session Notes Summary Sheet
- Case Staffing Form
- Client Satisfaction Questionnaire

Advanced Preparation:
- Ask the new long-term/Ryan White case manager to be available during the client session so s/he can meet the client.
- Bring the name and contact information of the long-term/Ryan White case manager.

Key Considerations: Remember:
- The client may be unsure about what to expect from long-term/Ryan White case management or the new case manager.
- The client may be hesitant to connect with a new case manager.
- To ask the long-term/Ryan White case manager to join the session, if the client agrees.

Procedure:
For all clients:
1. Explain what the client can and cannot expect from long-term/Ryan White case management and how it differs from ARTAS, as follows:
    - While ARTAS focused mainly on overcoming short-term barriers to linking to medical care, the long-term/Ryan White case manager can work with the client on more general issues such as housing, employment, other treatment needs.
    - The relationship with the long-term/Ryan White case manager will not be as intensive as his/her relationship with you. As a result, the case manager may not be able to accompany the client to appointments.
    - The relationship between the client and long-term/Ryan White case manager will not be restricted to 90 days or five sessions.
    - The client will still be expected to actively participate in his/her care.

2. Emphasize how the client can use the strengths identified during his/her participation in ARTAS to overcome barriers to services provided by the new case manager. Validate the client's concerns by saying: *"This kind of case management is different and you won't be working with me. But you can have a similar working relationship with your new case manager."*

3. Answer any questions and address any concerns the client has about this new form of case management.

4. Ask the client if s/he would be open to having the long-term/Ryan White case manager join the session, if s/he is available. <u>Note: Plan in advance with the new case manager and ensure s/he is available</u>.

   a. <u>If the client would like to meet the new case manager</u>, bring him/her into the session and introduce them to each other. Ask the client to tell his/her story, share the work s/he has done in ARTAS, and the strengths s/he has identified. Ask the client to discuss the barriers that s/he identified through ARTAS and what s/he has done to overcome them. Review any other barriers to accessing medical care or support services that will need to be addressed. Discuss any other issues that have arisen during ARTAS that the client will need to address during long-term/Ryan White case management.

   b. <u>If the client is not comfortable having the long-term/Ryan White case manager join the session</u>, discuss his/her reluctance. Discuss how the client will access case management on his/her own and how s/he can overcome barriers or discomfort to doing so. Review the benefits of case management and what the client can gain from participating. Provide the client with the contact information for his/her long-term/Ryan White case manager, and ask his/her permission to give his/her contact information to the new case manager.

5. Complete all paperwork necessary to transfer the client to another agency and/or case manager, if this is in the MOA between your agency and community partner. This could include discharge forms for your agency, intake/referral forms for the partner agency, and updates on client progress/status.

6. Thank the client for coming and congratulate him/her for completing the intervention and working with you. Remind the client that linking to medical care is important to his/her overall health, and that you hope s/he uses the skills you talked about to obtain services needed so s/he can access medical care and treatment.

7. End the session by asking the client to complete the **Client Satisfaction Questionnaire**, on page 187 in the Session Forms section.

8. **Next step, end the session and complete paperwork**:
   - Depending on your agency's procedures and/or schedule for the day, you may want to take a few minutes to complete all the required paperwork before moving on to the next client and/or task. Recommended paperwork to complete includes:
     ○ Session Notes
     ○ Session Notes Summary Sheet (if the client dropped out)
     ○ Case Staffing Form

Session Forms

This section contains all the forms and additional document you will use to conduct each client session. Each form or document is referenced throughout the Client Session Guide in bold and includes the page number where the form/document can be found in this section. Before each form, you will find the instructions on how to introduce and/or use it with the client.

Table of Contents

Strengths Assessment Instructions

1. Clearly introduce the intent of the Strengths Assessment. The exact introduction you choose should be tailored to your personal style and the client's reading level or cognitive ability. Below is a sample introduction to the Strengths Assessment process:

   "One of the activities that we will complete together to help you identify your needs is a Strengths Assessment. This assessment is different from past assessments that you may have completed with another case manager. The design of this assessment helps you to recognize your <u>strengths, skills, abilities, and things that you're good at doing</u>. We have found that when people can recognize what they are good at, it helps them accomplish new or difficult goals. By recognizing areas where you've been successful, you can use those examples to put you in a better position to accomplish your personal goals and to take the necessary steps to seek treatment. You may already be aware of these strengths. Or, they may be things you haven't thought about for a long time or things you've never thought about.

   Some people find it hard at first to focus on their personal strengths because most of us were taught that it is bragging to talk about what we've done right. I don't think that at all. I think focusing on our personal strengths reminds each of us how we all have talents and abilities that help us do what we need to do for ourselves."

2. Choose one of two options to complete the assessment with a client. Both options accomplish the same things: building effective relationships, gathering information, and engaging the client.

   Option 1: Simply talk to the client about his/her life. This option occurs in a natural, but guided, conversation designed to help the client think about and identify strengths and abilities. Pick up on the stories told that reflect the client's *abilities*. Summarize or use open-ended questions to encourage clients to talk about positive rather than negative experiences. For example, *"Earlier you noted something about a job at the corner market. Tell me more about what you did to find that job and to get hired."*

   OR

   Option 2: Start the conversation about strengths using very general, but direct questions, such as:
   - *What strengths do you think you have?*
   - *What are your abilities?*
   - *When have you successfully faced barriers, and what did you do to overcome them?*
   - *What are you good at?*
   - *Tell me about a time when you felt like most things were going well. What were you doing to make them go well?*

3. During the conversation (regardless of which option you choose), listen for examples where the client identifies his/her strengths. Focus on what the client says, and remember these examples by using reflection, summarizing, and affirmations to reinforce the ideas for you and the client (if necessary, jot down a <u>quick</u> note). This is important because many of the ideas and examples will apply to the client's goals.

4. Make a list of the strengths, abilities, and skills identified by the client in his/her stories during the conversation. Use the client's own words. What is most important is giving the client an opportunity to see – in writing – a list of his/her personal, positive attributes. Therefore, you can choose a format for the assessment that suits your agency. A suggested format for the **Strengths Assessment** is on page 153.

5. Copy the list for the client, if s/he would like to take it home.

While the above Strengths Assessment exercise is designed to solicit examples of previous successes from the client, you should <u>never</u> view the assessment process as static. That is to say, it is an ongoing process, rather than a one-time, discrete activity. Because the intervention is client-driven, a client may not be ready to share his/her personal stories immediately or may not be able to share strengths right away. S/he will choose to share on his/her terms. Therefore, it is important for you to continually search for strengths, skills, and abilities during each client session, brief phone call, general conversation, or other contact with the client. By doing so, you provide an opportunity for the client to choose the right time to share and to help the client see the day-to-day presence and connection of his/her strengths.

Collecting Information that is not Strengths-Based: While the emphasis of ARTAS is identifying strengths and abilities, it is always appropriate and necessary to incorporate sound clinical practice into each session. Therefore, it is also essential to collect information that is not strengths-based. Examples of non-strengths information that must be collected include:
- Suicidal ideation or attempts
- Risk to do harm to others
- Physical problems associated with substance abuse, including overdose risk, delirium tremens, or drug withdrawal
- Inherent limitations, such as not being able to read, having a learning disability, or having physical impairments that may affect the client's ability to link to medical care

By having knowledge of and sensitivity to inherent limitations, you will be able to identify valuable resources for the client.

When collecting this non-strengths information, you should remember to treat the client as an individual and never as a member of a group with problems.

Additional key points to remember when conducting the Strengths Assessment are listed below.

- Believe in the power of strengths and abilities, and believe that every client possesses strengths and abilities. Many clients, because of their previous contact with services providers, are adept at spotting someone who is being phony, condescending, or patronizing.
- From time to time, it may be necessary to gently refocus a client on his/her strengths and away from a discussion of problems and deficiencies. A Strengths Assessment stands out as a *significantly different approach to addressing a client's needs*, as many ARTAS clients have confronted numerous negative events in their lives.
- Remind yourself and your clients that important problems are not being ignored by completing a Strengths Assessment. More accurately, the focus on strengths and abilities prepares the client to deal with barriers to accessing medical care and other challenges s/he might face.
- Be careful about reaching too far to find strengths. For example, suggesting to a client: "*You've been a successful sex worker. Let's talk about your strengths in that area.*" While this situation includes some strengths, such as negotiating skills around price, the emphasis should on the specific characteristic – being resourceful – and not on the larger role – being a sex worker. Encourage clients to identify how these characteristics can be readily adapted to a healthier lifestyle.
- Emphasize *the client's role* in making things go right and help him/her explore how s/he personally influenced the positive outcome. A client may attempt to give someone else the credit for his/her strengths and/or for times when things were going well.
- Often you will hear a client discuss certain actions but then not directly describe them as strengths. If you think those actions, thoughts, or feelings are strengths, use responsive listening techniques to encourage the client to consider them as such. Ultimately it is your client's perceptions of something as a positive in his/her life that will enable him/her to mobilize to solve current problems/barriers.
- Periodically summarize strengths that have been identified by the client. This will help him/her identify patterns that exist.
- Avoid acting as an investigator. It is better to assume a facilitator role in the search for abilities.
- Keep the goal of linkage to care as an honest part of the Strengths Assessment and all discussions. Do not try to covertly or overtly steer the client in a desired direction.

STRENGTHS ASSESSMENT FORM

Client ID: _____

LC's Name: _____

Date: _____ **Session Number:** _____

Is this the 1st assessment completed for the client or is it an amendment? _____

1. **What strengths, abilities, or skills did the client identify (either directly or indirectly)?**
   a. Strengths:
   b. Skills:
   c. Abilities:
   d. Which items from the Life Domains List, if needed, prompted the client?

2. **What examples did the client give about a time when s/he successfully faced barriers?**
   a. What did s/he do to overcome the barrier(s)?

3. **What did the client explicitly say s/he was good at?**

4. **What did the client implicitly say s/he was good at, i.e., what did you hear him/her say?**
   a. Did the client agree with what you heard as something s/he is good at once you repeated it back?

5. **What example(s) did the client give about a time/experience when s/he felt like most things were going well in his/her life? What was s/he doing to make them go well?**

STRENGTHS ASSESSMENT FORM

Date: _____

Session Number: _____

New Assessment or Updated Assessment? (Circle one)

1. **My strengths, abilities, or skills identified:**
   a. Strengths:
   b. Skills:
   c. Abilities:
   d. Items from the Life Domains List:

2. **Examples I gave about a time(s) that I successfully faced barrier(s) in my life:**
   a. Examples of barrier(s):
   b. Things I did to overcome the barrier(s):

3. **Things I am good at:**

4. **Example(s) of when I felt like most things in my life were going well:**
   a. Things I did to make them go well:

ARTAS Session Plan Instructions

Introduce the ARTAS Session Plan in a way that demonstrates how easy it is to use and provides a way for the client to maintain ownership of the plan.

While the format is less important than the content captured, a sample form to use as a guide for the **ARTAS Session Plan** is on page 161. It is useful for the plan to be organized by: objectives, activities, related strengths, potential barriers, person responsible, and target dates for each objective and activity.

> ► **Identifying Goals**: In keeping with a strengths-based perspective, all goals should be a reflection of the client's wishes, not your or the agency's wishes. Take great care not to impose your own goals on a client. Even the goal of linking to medical care should not be imposed on the client. While you advocate for linking medical care, you must be careful not to force this goal or any others onto the client. Advocate for the linkage goal without interfering with the client's other goals, as long as they do not conflict with the Core Elements of ARTAS.
>
> Goals are written as broad statements, and <u>always in the client's exact words</u>. Using a client's own words decreases the distance between the client and the goal, and places the responsibility for accomplishing the goal squarely on the client. Further, it eliminates the possibility that you inadvertently alter the goal to something you believe is more important. In the end, the client must embrace his/her goals if s/he is to be successful.
>
> ► **Creating Objectives and Activities**: Objectives will be appropriate and effective if you follow the SMART technique for writing objectives. The components of a SMART objective are: Specific, Measurable, Achievable, Relevant, and Time-bound. For more details on writing SMART objectives, please see "Linkage Coordinator Skills Needed to Effectively Implement ARTAS" on page 69 in the Implementation Section.

Activities are the smaller steps to accomplish a client's objectives. Below is an example of a client goal, the objectives, and the activities s/he needs to complete to accomplish his/her goal. The establishment of target dates for each objective and activity allows for periodic review of the client's progress and the opportunity to make adjustments as necessary.

> **GOAL**: Find a job I enjoy.
> **OBJECTIVE 1**: Take the GED exam by the end of the year.
>
> **ACTIVITIES**: (1) Obtain a GED application by April 1st; (2) Study a GED work guide ten hours each week from April 1st to June 30th; and (3) Schedule an appointment to take the GED exam in July.
>
> **OBJECTIVE 2**: Complete a course on identifying job interests at Smith Vocational School by August 1st.
>
> **ACTIVITIES**: (1) Identify courses available, the dates, and the cost; (2) Save $10 a month until I've save enough money; and (3) Sign-up and attend the course.

Creating objectives and activities requires detailed attention and must be taken seriously. Goal-setting is important because it helps the client to:
1. Learn a problem-solving approach that is transferable to other areas of life; and
2. Evaluate progress in very personal and specific terms.

Even if the client does not complete every identified activity, s/he will receive support and feedback allowing the client to learn from the experience. One client from the ARTAS study described his work with the LC as follows: *"I had a [LC] who had me write every little step down, plan out every day what I was gonna do. I was so used to planning on big things and never seein' 'em get done. It was great to see some progress every day."*

The overall result of the goal-setting process and ARTAS is to position each client to take responsibility for his/her medical care.

► **Your Role in Developing the ARTAS Session Plan**: You have multiple responsibilities in developing the ARTAS Session Plan with each client, and to help his/her accomplish the plan successfully. Help the client to:
- Create SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) objectives.
- Identify activities for each objective.
- Prioritize multiple objectives.
- Identify alternatives to accomplish objectives.
- Weigh the advantages and disadvantages of different actions.
- Connect his/her strengths and assets to the objectives and activities created.
- Become knowledgeable about existing resources to help them achieve their goals.

You or the client should write down the plan. Offer the client a copy of the ARTAS Session Plan. Make a copy and give it to the client if s/he would like one. While planning could merely be a verbal agreement between you and the client, it is valuable to commit the plan in writing. Doing so provides his/her with a tangible, visual document that identifies his/her goals and the steps necessary to accomplish them. A written plan provides each client with a firm record of his/her accomplishments, and serves as a reminder once the five client sessions are finished.

It is important for you and the client to review the ARTAS Session Plan during each client session to: (1) assess progress made; and (2) make any necessary adjustments to the plan based on newly identified strengths, goals, or barriers.

General points about the ARTAS Session Plan are listed below.
- Be attentive to the client's ability to effectively think through a plan, commit to it, and then successfully carry it out. While some clients may be very competent at achieving goals, others may engage in wishful thinking, procrastination, and other thought processes that interfere with moving forward.
- Be precise in helping each client define measurable objectives and the activities necessary to accomplish each objective. The more specific a client is, the more likely s/he is to think through the alternative solutions.
- Maintain professional boundaries. Assume the facilitator role in helping your clients accomplish their objectives and goals.
- Be creative with clients and, when possible, help them to come up with a solution that gets at several barriers at once. The fact that clients frequently have multiple barriers may be overwhelming. Your ability to help them deal with several issues at once will be greatly appreciated.
- Remember to encourage clients to use their strengths as a starting point to accomplish their goals. Periodically summarize strengths you have heard. For instance, if a client has shared that s/he used to deal drugs, you may help the client to see that his/her strengths may be in the areas of talking to people, time management, handling money, and organizational skills. By doing so, the client can use these same strengths to link to care through organizing appointments, seeing the doctor, talking to the pharmacist about medication, and managing money for housing and other expenses.

Check in with clients to ask if they see particular actions, thoughts, or feelings as strengths. Do not impose your view, but assist clients to make those linkages. Ultimately, the client's perception of something as a positive in his/her life will mobilize him/her to solve current problems.

ARTAS SESSION PLAN

Date:_____

Name:_____

Client ID:_____

Linkage Coordinator:_____

Goal 1: Link to Medical Care

Objective 1: _____

Activity		Related Strengths	Potential Barriers	Target Date	Person(s) Responsible
1					
2					
3					

Objective 2: _____

Activity		Related Strengths	Potential Barriers	Target Date	Person(s) Responsible
1					
2					
3					

Goal 2: _____

Objective 1: _____

Activity		Related Strengths	Potential Barriers	Target Date	Person(s) Responsible
1					
2					
3					

Objective 2: _____

Activity		Related Strengths	Potential Barriers	Target Date	Person(s) Responsible
1					
2					
3					

Overview of ARTAS Document

Instructions: During the first client session, either read the overview verbatim (if your agency has one prepared) or paraphrase its key points. It is important that you confidently convey the key points to the client. Below are the main points that should be conveyed to the client and included in an Overview of ARTAS document.

- **ARTAS is time- and session-limited**, up to five sessions over a 90-day period.
- **The goal of ARTAS is to assist people in linking with medical care soon after receiving a positive test result for HIV**. ARTAS considers this goal important because people who promptly seek medical care have better health outcomes than those who do not. Promptly linking with medical care can also reduce transmission of HIV to other people.
- **A significant other or important person in the client's life can assist him/her with accessing medical care**. If the client chooses, s/he can bring a significant other or important person to the client sessions and/or medical appointment to assist with the linkage to medical care.
- **ARTAS can provide practical assistance to the client**, including providing transportation to a clinic, making contact with the clinic, notifying a partner, getting housing, and identifying other barriers to following through with medical care.
- **ARTAS can help the client identify and overcome barriers to achieve goals – linking to medical care and/or others – by identifying and accessing resources and personal strengths**.
- **The ARTAS Session Plan will be created to guide the process and track the client's work.** The client can have a copy of any information recorded during these sessions.
- **Sessions can take place at a location, time, and day of the client's choice.**

Sample Fact Sheet on Current Treatment Options
and their Side Effects
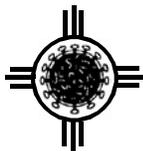
AIDS InfoNet (www.aidsinfonet.org)
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Fact Sheet Number 403
WHAT IS ANTIRETROVIRAL THERAPY (ART)

WHAT IS ART?
ART means treating retroviral infections like HIV with drugs. The drugs do not kill the virus. However, they slow down the growth of the virus. When the virus is slowed down, so is HIV disease. Antiretroviral drugs are referred to as ARV. ARV therapy is referred to as ART.

WHAT IS THE HIV LIFE CYCLE?
There are several steps in the HIV life cycle. (See Fact Sheet 400 for a diagram.)

1. Free virus circulates in the bloodstream.
2. HIV attaches to a cell.
3. HIV empties its contents into the cell.
4. The HIV genetic code (RNA) is used by the reverse transcriptase enzyme to build HIV DNA.
5. The HIV DNA is inserted into the cell's DNA by the integrase enzyme. This establishes the HIV infection in the cell.
6. When the infected cell reproduces, it activates the HIV DNA, which makes the raw material for new HIV viruses.
7. Packets of material for a new virus come together.
8. The immature virus pushes out of the infected cell in a process called "budding."
9. The immature virus breaks free of the infected cell.
10. The new virus matures: raw materials are cut by the protease enzyme and assembled into a functioning virus.

APPROVED ARV DRUGS
Each type, or "class", of ARV drugs attacks HIV in a different way. The first class of anti-HIV drugs was the **nucleoside reverse transcriptase inhibitors** (also called NRTIs or "**nukes**".) These drugs block Step 4, where the HIV genetic material is used to create DNA from RNA. The following drugs in this class are used:

- Zidovudine (Retrovir, AZT)
- Didanosine (Videx, Videx EC, ddI)
- Stavudine (Zerit, d4T)
- Lamivudine (Epivir, 3TC)
- Abacavir (Ziagen, ABC)
- Tenofovir, a nucleotide analog (Viread, TDF)
- Combivir (zidovudine/lamivudine combination)
- Trizivir (zidovudine/lamivudine/abacavir combination)
- Emtricitabine (Emtriva, FTC)
- Truvada (combination of emtricitabine and tenofovir)
- Epzicom (combination of abacavir and lamivudine)

Another class of drugs blocks the same step of the life cycle, but in a different way. These are the **non-nucleoside reverse transcriptase inhibitors**, also called **non-nukes** or **NNRTIs**. Four have been approved:

- Nevirapine (Viramune, NVP)
- Delavirdine (Rescriptor, DLV)
- Efavirenz (Sustiva or Stocrin, EFV)
- Etravirine (Intelence, ETR)

The third class of ARV drugs is the **protease inhibitors or PIs**. These drugs block Step 10, where the raw material for new HIV virus is cut into specific pieces. Ten protease inhibitors are approved:

- Saquinavir (Invirase, SQV)

- Indinavir (Crixivan, IDV)
- Ritonavir (Norvir, RTV)
- Nelfinavir (Viracept, NFV)
- Amprenavir (Agenerase, APV)
- Lopinavir/ritonavir (Kaletra or Aluvia, LPV/RTV)

- Atazanavir (Reyataz, ATZ)
- Fosamprenavir (Lexiva, Telzir, FPV)
- Tipranavir (Aptivus, TPV)
- Darunavir (Prezista, DRV)

A newer class of ARV drugs is **entry inhibitors.** They prevent HIV from entering a cell by blocking Step 2 of the life cycle. Two drugs of this type have been approved:
- Enfuvirtide (Fuzeon, T-20)
- Maraviroc (Selzentry or Celsentri, MVC)

The newest type of ARV drug is the integrase inhibitor. It prevents HIV from inserting its genetic code into the human cell's code in step 5 of the life cycle. The first drug of this type is:
- Raltegravir (Isentress, RGV)

HOW ARE THE DRUGS USED?
Antiretroviral drugs are usually used in combinations of three or more drugs from more than one class. This is called "Combination Therapy." Combination therapy works better than using just one ARV alone, It also helps prevent drug resistance.

Manufacturers of ARVs keep trying to make their drugs easier to take, and have combined some of them into a single pill. See Fact Sheet 409 for more information on combination medications.

WHAT IS DRUG RESISTANCE?
When HIV multiplies, most of the new copies are mutations: they are slightly different from the original virus. Some mutations keep multiplying even when you are taking ARV drugs. When this happens, the drug will stop working. This is called "developing resistance" to the drug.

If only one ARV drug is used, it is easy for the virus to develop resistance. For this reason, using just one ARV drug (monotherapy) is not recommended. But if two drugs are used, a successful mutant would have to "get around" both drugs at the same time. And if three drugs are used, it's very hard for the right mutations to show up that can resist all three drugs at the same time. Using a triple-drug combination means that it takes much longer for resistance to develop.

CAN THESE DRUGS CURE AIDS?
At present, there is no known cure for HIV infection or AIDS. ARVs reduce the viral load, the amount of HIV in your bloodstream. A blood test measures the viral load. People with lower viral loads stay healthier longer. They are also less likely to transmit HIV infection to others.

Some people's viral load is so low that it is "undetectable" by the viral load test. This does **not** mean that all the virus is gone, and it does not mean a person is cured of HIV infection. See Fact Sheet 125 for more information on viral load.

WHEN DO I START?
There is not a clear answer to this question. Most doctors will consider your CD4 cell count and any symptoms you've had. ARV therapy is usually started if your CD4 cell count is dropping to near 350, if you are pregnant, need treatment for hepatitis B, or have symptoms of HIV-related disease. See fact sheet 404 for more information on treatment guidelines. This is an important decision you should discuss with your health care provider.

WHICH DRUGS DO I USE?
Each ARV drug can have side effects. Some may be serious. Refer to the fact sheet for each individual drug. Some combinations of drugs are easier to tolerate than others, and some seem to work better than others. Each person is different, and you and your health care provider will have to decide which drugs to use.

The viral load test is used to see if ARV drugs are working. If the viral load does not go down, or if it goes down but comes back up, it might be time to change ARV drugs.

WHAT'S NEXT?

New drugs are being studied in all of the existing classes. Researchers are also trying to develop new types of drugs, such as drugs that will block other steps in the HIV life cycle, and drugs that will strengthen the body's immune defenses. See fact sheets 470 and 480 for more information on newer classes of drugs.

AIDS InfoNet
www.aidsinfonet.org
Fact Sheet Number 550
SIDE EFFECTS

WHAT ARE SIDE EFFECTS?

Side effects are what a drug does to you that you don't want it to do. Medications are prescribed for a specific purpose, such as to control HIV. Anything else the drug does is a side effect.

Some side effects are mild, like a slight headache. Others, like liver damage, can be severe and, in rare cases, fatal. Some go on for just a few days or weeks, but others might continue as long as you take a medication, or even after you stop. Some occur within days or weeks of starting a drug. Others may only show up after months or years of therapy.

WHO GETS SIDE EFFECTS?

Most people taking antiretroviral medications (ARVs) have some side effects. In general, higher amounts of drugs cause more side effects. If you are smaller than average, you might experience more side effects. Also, if your body processes drugs more slowly than normal, you could have higher blood levels and maybe more side effects.

Some side effects become worse if the drug is taken on an empty stomach. Others may increase if the drug is taken with fatty food or drink such as whole milk.

Each medication comes with information on its most common side effects. **Don't assume that you will get every side effect that's listed!** Most people have only minor side effects when they take their ARVs.

HOW TO DEAL WITH SIDE EFFECTS

There are several steps you can take to prepare yourself to deal with side effects.
Learn about the normal side effects for the medications you're taking. The InfoNet fact sheets list common side effects for each drug.

- Talk to your health care provider about what side effects to expect. Ask when you should get medical attention because a side effect goes on too long, or has gotten severe.
- Find out if you can treat mild side effects with home remedies or over-the-counter medications.
- In some cases, your health care provider can write you a prescription for something you can take to deal with a side effect if it gets severe.
- Stock up! If you're having stomach problems, make sure you have plenty of food that you like to eat and that's easy on your stomach. Don't run out of toilet paper!

Do not stop taking any of your medications, or skip or reduce your dose, without talking to your health care provider! Doing so can allow the virus to develop resistance (see fact sheet 126), and you might not be able to use some ARVs. *BEFORE* side effects make you skip or reduce doses, talk to your health care provider about changing drugs!

WHICH SIDE EFFECTS ARE THE MOST COMMON?

When you start antiretroviral therapy (ART), you may get headaches, hypertension, or a general sense of feeling ill. These usually improve and disappear over time.

Fatigue (Fact Sheet 551): People with HIV often feel tired at least part of the time. It's important to find the cause of fatigue and deal with it.

Anemia (Fact Sheet 552) can cause fatigue. Anemia increases your risk of getting sicker with HIV infection. Routine blood tests can detect anemia, and it can be treated.

Digestive Problems: Many drugs can make you feel sick to your stomach. They can cause nausea, vomiting, gas, or diarrhea. Home remedies include:
- Instead of three big meals, eat small amounts, more often.
- Eat mild foods and soups, not spicy.
- Ginger ale or ginger tea might settle your stomach. So can the smell of fresh lemon.

- Exercise regularly.

Don't skip meals or to lose too much weight! Marijuana (see Fact Sheet 731) can reduce nausea. Be careful with over-the-counter or prescription nausea drugs. They can interact with ARVs.
- **Gas and bloating** can be reduced by avoiding foods like beans, some raw vegetables, and vegetable skins.
- **Diarrhea (Fact Sheet 554)** can range from a small hassle to a serious condition. Tell your health care provider if diarrhea goes on too long or if it's serious. Drink lots of liquids.

Lipodystrophy (Fact Sheet 553) includes fat loss in arms, legs and face; fat gain in the stomach or behind the neck; and increases in fats (cholesterol) and sugar (glucose) in the blood. These changes may increase the risk of heart attack or stroke.

High levels of fats and sugar in the blood (Fact Sheet 123), including cholesterol, triglycerides and glucose. This can increase the risk of heart disease (Fact Sheet 652.)

Skin Problems: Some medications cause rashes. Most are temporary, but in rare cases they indicate a serious reaction. Talk to your health care provider if you have a rash. Other skin problems include dry skin or hair loss. Moisturizers help some skin problems.

Neuropathy (Fact Sheet 555) is a painful condition caused by nerve damage. It normally starts in the feet or hands.

Mitochondrial Toxicity (Fact Sheet 556) is damage to structures inside the cells. It might cause neuropathy or kidney damage, and can cause a buildup of lactic acid in the body.

Bone Problems (Fact Sheet 557) have recently been identified in people with HIV. Bones can lose their mineral content and become brittle. A loss of blood supply can cause hip problems. Get enough calcium from food and supplements. Weight-bearing exercise like walking or weight lifting can be helpful.

THE BOTTOM LINE
Most people who take ARVs have some side effects. However, don't assume you will get every side effect you hear about!

Get information on the most common side effects and how to treat them. Read the InfoNet fact sheets on individual drugs and their side effects. Stock up on home remedies and other items that can help you deal with side effects.

Be sure you know when to go back to your health care provider because a side effect may have gone on too long or gotten severe.

Don't let side effects keep you from taking your medications! Do not assume that taking ART means you have to put up with the side effects. If you can't deal with them, if they continue for more than a few months, or they affect your quality of life, talk to your health care provider about changing your drugs.

Revised November 13, 2008

Appointment Cards

Below are sample appointment cards that you can use to remind your clients of upcoming appointments with you, a medical provider, or other services. At a minimum, the card should include the date, time, and location of the appointment, as well as the agency/provider name.

Appointment	**Appointment**
Your appointment is on	*Your appointment is on*
_____ at _____ a.m./p.m.	_____ at _____ a.m./p.m.
(Date) (Time)	(Date) (Time)
with	*with*
_____	_____
(Name)	(Name)
_____	_____
(Agency address)	(Agency address)

Appointment	**Appointment**
Your appointment is on	*Your appointment is on*
_____ at _____ a.m./p.m.	_____ at _____ a.m./p.m.
(Date) (Time)	(Date) (Time)
with	*with*
_____	_____
(Name)	(Name)
_____	_____
(Agency address)	(Agency address)

Appointment	**Appointment**
Your appointment is on	*Your appointment is on*
_____ at _____ a.m./p.m.	_____ at _____ a.m./p.m.
(Date) (Time)	(Date) (Time)
with	*with*
_____	_____
(Name)	(Name)
_____	_____
(Agency address)	(Agency address)

Session Notes Instructions

The Session Notes form serves as case notes for each client session. You should record all client session information on the form below. One Session Notes form should be completed promptly after meeting with a client and placed in the client's file. You may also find it useful to complete a form following a telephone conversation or when a client cancels or misses an appointment. There are three sections to the Session Notes form: (1) general information about the session; (2) narrative about the session; and (3) the type of referrals made during the session.

Code Listings for the Session Notes form: The following are the suggested codes to use for each of the sections listed on the Session Notes form. These numerical codes will simplify the data entry and data analysis processes, and will allow your agency to input uniform numerical codes rather than words for each field.

<u>Section I</u>
Session Number: Fill in the session number, 1-5. If this is a telephone communication, use numbers starting with "6" for the first phone communication, and then increase the numbering from there. For example, the first phone communication is 6, the second is 7, and so on. If the phone communication is with someone other than the client, e.g., you are contacting a person on the client's Locator Form, do not complete a session form for this communication.

Persons Involved in the Session: Multiple codes may be used to describe who participated in each client session. Note: Not all codes will be used for each session.

(1) Client	(5) Friend
(2) Linkage Coordinator	(6) Medical Care Staff
(3) Family Member, such as a sibling	(7) Other Clinical Staff (Non-medical)
(4) Significant Other – Partner/Spouse	(8) Other Agency Personnel

Session Location(s): Multiple codes may be used if the session takes place in more than one location.

(1) Agency Office	(5) Community Partner Agency
(2) Client's Residence	(6) Telephone
(3) Medical Care Clinic or Hospital	(7) Car/Vehicle
(4) Public Location ____ (please specify)	(8) Other ____ (please specify)

Client Transportation to and from the Session: Multiple codes may be used to identify how the client was able to get to and from the session with the LC.

(1) Client Vehicle	(3) LC or Agency's Vehicle
(2) Public Transportation	(4) Friend or Family

(5) Walked
(6) Taxi Cab

(7) None (session took place at client's residence)
(8) Other _____ (please specify)

Section II
Narrative: This section should cover, at a minimum, the following areas:
- Objectives and activities for the session that were or were not accomplished, and why
- Notable client reactions to completing or not completing the objectives and activities
- Client's threats to self or others or pressing medical/psychological problems to be followed-up on immediately

Record what parts of the ARTAS Session Plan were discussed.

Section III
Referrals: This section should include information about all non-medical referrals made during the session. If a referral was made to a community partner(s) (resource, agency, or service provider), enter the code(s) below in the field labeled "Referred to." Note: Please customize the referral categories as your agency sees fit.

Mental Health Treatment – 1	HIV Testing Site – 2	Food Pantry – 3
Social Security Admin. – 4	State License Bureau – 5	Housing – 6
Employment – 7	Child/Day Care – 8	Immigration – 9
Legal Services – 10	Faith Community – 11	Self Help Groups – 12
Job Center – 13	Vital Statistics Bureau – 14	Children's Services – 15
Clothing/Hygiene – 16	Other – 17 (please specify)	

In the "Method of Referral" field, use the following code(s) to record how the referral was handled:
1: LC provided the client with the name and contact information for a referral site(s), and left it up to the client to make the connection.

2: LC called the resource and asked questions on the client's behalf. When appropriate, the LC advocated for the client's involvement with the referral site.

3: LC accompanied the client to the referral site.

Note: Referrals to medical care should not be recorded here.

The code (1, 2, or 3) should be recorded on the "Method of Referral" row under the corresponding "Referral to" column.

Session Notes need not be completed for telephone calls where no new or significant discussions take place. Examples of this might include reminding a client of an appointment or clarifying transportation needs.

Session Notes

Client ID: _____ _____ _____   **Date of Session** _____/_____/_____

LC Name:

_____

Session Start Time: _____:_____ AM/PM (circle one)   **End Time**: _____:_____AM/PM
(circle one) **Total Time**: _____ (in Minutes)

Session Number (1-5): _____

Persons Involved in Session: _____, _____, _____, _____, _____(From Code List above)

Primary Session Location(s): _____, _____, _____, _____, _____ (From Code List above)

Client Transportation to/from Session: _____, _____, _____, _____(From Code List above)

Narrative:_____
_____
_____
_____
_____
_____
_____
_____
_____

Non-Clinic Referrals

Was a referral(s) made to a community partner (whether another Agency, Resource, or Service
Provider) during this Session? <u>Yes (1) or No (2)</u> If yes, where was referral made and how
assertive was the referral?

Referred to:						
Method of Referral:						

Linkage Coordinator Signature: _____

Session Notes Summary Sheet Instructions

During the Implementation phase, your agency may find it important to summarize non-clinical client information and track a client's overall progress. This Session Notes Summary Sheet is a condensed summary of the all notes recorded on the individual Session Notes forms (Remember: one Session Notes form should be completed per client session).

The information requested in the sheet on the next page can be found in the individual session notes and recorded here. This information can be summarized for the monitoring and evaluation plan (process monitoring) and/or to help to you track clients' progress. The Summary Sheet should be completed **after** the last client session.

Please use the same codes for the Session Notes Summary Sheet as those listed in the instructions for the Session Notes form.

Did the client link to medical care? This question captures information about whether or not a client followed through with the referral to medical care. You may have this information directly because you accompanied the client to the medical appointment. If you did not attend the medical appointment with the client, all efforts should be made to follow up with the client (even if it occurs after the last session). Therefore, this question should be completed based on your personal knowledge, a later personal contact with the client, or from a telephone call from the client or clinic.

Code Listings for the Session Notes Summary form: The code listings for the referrals section of the Session Notes Summary are the same as those suggested codes used on the Session Notes form. These numerical codes will simplify the data entry and data analysis processes, and will allow your agency to input uniform numerical codes rather than words for each field.

Session Notes Summary Sheet

Client ID: _____ _____ _____   Date Summary Sheet Completed
_____/_____/_____ LC Name: _____

Contacts	General Information					Ref
	Date	Total Time	Persons Involved	Session Location	Transportation (if required, what type was provided)	**Referral Made (Yes or No)?**

Session 1						
Session 2						
Session 3						
Session 4						
Session 5						
Phone contact						
Phone contact						
Mail contact						
E-mail contact						

Total number of scheduled sessions the client missed: No show _____ Canceled _____
Did the client link with a medical care provider? <u>Yes (1)</u>   <u>No (2)</u>   <u>Don't Know (3)</u>
    If yes (1), where did the client link? _____
General Comments (NOT required for data entry):

Case Staffing Form Instructions

The Case Staffing form is designed to encourage you, your Supervisor, and your colleagues to adhere to a strengths approach during the case staffing. Moreover, the form serves as a reminder to <u>always</u> view your clients from a strengths-based perspective, and not only when the client is present.

After each client session, please complete or update the questions below. The *first* question gives you an opportunity to record efforts to meet – both yours and the client's. The *second* question is a brief summary of what encouraged the client to participate in the intervention and follow through with the client session after being diagnosed with HIV. This summary should provide you with insights into the strengths and abilities of the client.

Question 3 asks about the client's strengths. This is not just an exercise to be undertaken. It also serves as a reminder you to view the client from a strengths perspective at all times – regardless if the client is present or not. Furthermore, the discussion will help you understand the client's past or current abilities that will serve the client well in his/her attempt to achieve the goal of linkage to medical care.

Question 4 should include a discussion of the client's barriers – both personal and structural – that s/he sees as interfering with linkage to care. It is important to cast potential deficits or short-comings simply as "barriers" or something that interferes with attaining a goal. The discussion of barriers – rather than problems or pathology – assumes that the client is responsible for and capable of solving them. An emphasis on problems or pathology may create resistance. It is important to check the language you use when speaking to and about your clients – as that may be the source of the problem. This case staffing form is designed to help you get to the source of the problem and assist the client to achieve his/her goal of linkage to care, among others.

Case Staffing Form

1. Describe your early attempts to make contact with the client:

_____

_____

_____

_____

_____

2. Why did the client decide to participate in ARTAS?

_____

_____

_____

_____

_____

3. Please describe at least three (3) of client's most significant strengths:

_____

_____

_____

_____

_____

4. Describe the client's barriers to medical care linkage (individual- and system-level):

_____

_____

_____

_____

_____

5. What are the client's goals in addition to linking with medical care?

_____

_____

_____

_____

_____

6. Did the client link to medical care or express a desire to link to medical care?

_____

_____

_____

_____

_____

Life Domains List

Introduction: The Linkage Coordinator can use the Life Domains List questions as a refresher about various life domains and ways that clients show strengths in those domains. Use these questions only as a reference or stimulus to help the client when s/he may be having difficulties identifying strengths. You do not want the exercise to become a catalog of past failures. Please note: <u>Using while the client is present, and writing down the "answers" to the life domain list is not appropriate</u>.

General Life Skills
Do you:
- Cook meals for yourself and/or others?
- Help others cook meals?
- Shop for groceries or other necessities?
- Ride public transportation?
- Wash your own clothes?
- Keep up-to-date on current events?
- Arrive to your appointments on time?
- Seek out information using the Internet, phone book, or other resources?
- Read the newspaper?
- Take care of others – maybe your kids, parents?

Relationships
Do you:
- Trust others easily?
- Have relationships with other people (either sexual or non-sexual)?
- Have realistic expectations of relationships?
- Resolve conflicts assertively?
- Have a good relationship with family members?
- Have positive relationships with friends?
- Seek out community groups?
- Have a spouse or significant other?
- Have flexibility in your interactions with others?
- Function independently?
- Generally respect other people?

Living Arrangements
Do you:
- Live by yourself and take of the place (apartment, house) on your own?
- Clean and/or provide maintenance on your place?
- Feel as if your living arrangement supports your overall well-being?
- Take pride in your home/apartment?

Health

Do you:

- Generally get enough sleep?
- Exercise regularly? If so, what do you like to do?
- Go for regular medical/dental check-ups? Have you in the past?
- Generally address any health problems as they arise?
- Generally feel comfortable asking questions of your doctor or other health providers?
- Generally take your medicine on time and as prescribed?
- Practice safe sex with your partner(s)?
- Maintain a healthy diet?

What are some things you do to reduce/manage stress in your life?

Have you attempted to change an unhealthy behavior before? If yes, what was it? How did you feel about it?

Internal Resources

Do you:

- Often set goals for yourself?
- Understand how your behavior affects you and others?
- Verbalize your wishes and desires directly?
- Value your strengths and talents?
- Consider the consequences of your actions/behaviors before acting?
- Follow your beliefs and values?
- Value/acknowledge your accomplishments?
- Attend to your spiritual needs (either through church, house of worship, others)?
- Seek help as needed for personal problems?
- Articulate your interests?
- Think you have good decision-making skills?
- Accept responsibility for your actions?
- Express your emotions regularly and appropriately?
- Feel in control of your life?
- Effectively delay gratification or seek instant gratification?
- Generally cope with uncomfortable emotions in a positive way?

For active or past drug users:

Recovery

Have you:

- Sought drug treatment?
- Explored your past/current drug use during treatment?
- Avoided people/places where drug use was prevalent?
- Followed through with aftercare?
- Maintained sobriety in the past?
- Attempted to change drug use behavior in the past?
- Attended support groups?
- Found a sponsor?

- Maintained contact with your sponsor?

ARTAS Client Satisfaction Questionnaire

Linkage Coordinator's Name: _____

Your Name or Client ID (optional): _____

Please circle the best answer to the questions below:

1. How satisfied are you with your experience participating in the ARTAS intervention?

Very Satisfied   **Satisfied**   **Neutral**   **Dissatisfied**   **Very Dissatisfied**

2. How satisfied are you with the services, if any, you were linked to during ARTAS?

Very Satisfied   **Satisfied**   **Neutral**   **Dissatisfied**   **Very Dissatisfied**

3. How satisfied are you with the skills you learned and/or enhanced by participating in the intervention?

Very Satisfied   **Satisfied**   **Neutral**   **Dissatisfied**   **Very Dissatisfied**

4. How satisfied are you with the Linkage Coordinator you worked with over the course of the intervention?

Very Satisfied   **Satisfied**   **Neutral**   **Dissatisfied**   **Very Dissatisfied**

Please write in your answers to the questions below.

5. What did you *like most* about participating in the intervention?

6. What would you *change* about the intervention?

7. Would you recommend ARTAS to anyone you know?
Yes   **No**   **Please explain why or why not?** _____

Thank you for your feedback

Client Session Guide Helpful Tips

As a supplement to the Client Session Guide, the following is an overview of additional helpful tips to consider when implementing ARTAS.

1. Attending a Medical Appointment with the Client

If the client agrees, plan to attend the first medical appointment with him/her. The client should take the lead in the conversation with the health care provider and advocate for himself/herself during the appointment. <u>It is not your role to control the conversation during appointment.</u> Unfortunately, there is no prescribed recipe to balance client involvement with you advocating on his/her behalf. However, two extreme scenarios to be avoided under all circumstances are:

1. You and the medical staff talk about a client, his/her circumstances, or treatment as if the client was not present.
2. You allow the client to struggle significantly while dealing with the provider and let critical issues go unaddressed.

While the goal of ARTAS is to link recently diagnosed individuals to medical care, the desired outcome is for the medical appointment to be successful and for the client to feel comfortable and empowered to continue medical services. The client will judge your status as an effective and trustworthy ally based on the success or failure of the first medical appointment. To be seen as a trustworthy ally, prepare the client to increase the likelihood of a successful outcome.

2. Preparing the Client for the Medical Appointment

Inform the client in advance about what to expect during the visit. This information should be discussed in detail during the client session prior to the medical appointment. You and the client can write down any questions the client would like to discuss during his/her appointment. Writing questions down in advance will ensure the client does not get anxious and forget to ask an important question.

Provide the client with detailed information about the clinic/agency and staff. Much of this information will be available on the appointment card and includes, but is not limited to, the clinic name, doctor's name, address, hours, phone number, and appointment time. Additional information to be provided to the client includes directions to and from the clinic, transportation options provided by your agency, a reminder of where and when to meet, the personalities of various staff, services provided, anticipated wait time, and any other relevant information.

If you accompany the client, the client should know that s/he is expected to participate fully in the medical appointment and represent himself/herself. You are there for support and will only interject if the client asks for assistance and/or appears to need your assistance.

Tips for a Successful First Medical Appointment:
- ► Prior to the medical appointment, provide the client with detailed information about the provider s/he selected.
- ► Help the client prepare a set of questions, such as:
    - How often should I come visit you?
    - If I feel fine, do I still have to take my HIV medications?
- ► Discuss potential problems (such as the client forgetting what medications s/he is taking) that may occur during the appointment and brainstorm possible solutions with the client.
- ► Introduce the client to clinic staff, including screening staff, nurses, pharmacists, physicians, and social workers.
- ► Participate in all meetings between the client and clinic staff, if requested by the client.
- ► Explain the rationale behind different processes (administrative) during the appointment to the client.
- ► Interpret questions and/or information being given to client, as necessary. If necessary, ask clarifying questions of clinic staff.
- ► After the appointment, review with the client what happened during the visit and how the client felt.
- ► Schedule a brief follow-up telephone call with the client to process the visit.
- ► Schedule an in-person session with the client to complete the transition process.

In conclusion, the client must attend the first medical appointment *thoroughly briefed* by you and *empowered to act on his/her own behalf*. During the appointment, you must continually assess the degree to which you should facilitate the client's involvement or act assertively on the client's behalf.

3. Structure of Client Session

You will have to adjust the time of each session to the individual ARTAS client. Due to the intensive, short-term nature of the intervention and the variation in time needed for each client session, you should schedule only two to three clients in a day until you become more familiar with the client and his/her needs. Because a client session may take a few hours, you may want to schedule one client in the morning and one client in the afternoon to allow sufficient time for the session. During the ARTAS-II study, the median number of sessions conducted per client was two sessions. The median time spent on all activities per client was 5.8 hours (the mean was 7.2 hours) and the range was from 0 to 36.7 hours per client.

Your caseload should be kept low (25-30 clients at a given time) to accommodate for long sessions with each client and for extensive follow-up after missed appointments. If the client is late to a session, use it as an opportunity to identify a barrier to effectively linking with medical care as opposed to seeing it as a client weakness. Part of your work with the client can be to help him/her identify the source of his/her lateness and plan to solve the problem.

4. Meeting Space

While meeting each client in his/her environment and outside the office whenever possible is a Core Element of the intervention, your agency may want to create and train you on general safety guidelines. If you are uncomfortable with a meeting place or meeting with a client at night, you may bring a colleague (if approved by the client) or change the meeting time or location while still ensuring the client is comfortable. Suggested locations include: your agency's office, a clinic or hospital, a public library, restaurant, community partner's office or clinic.

5. Telephone Contacts with the Client

Telephone communications between you and client are intended to be used in the following ways:
- ► Initiate the ARTAS intake process, e.g., to discuss the intervention with the client and determine if s/he is interested and eligible to participate.
- ► Reinforce, review, or modify logistics for an upcoming client session, e.g., the meeting time.
- ► Identify any barriers that arose since the last client session and may impact the client's ability to attend the next session, e.g., child care is now a barrier.
- ► Touch base between client sessions, if it is an extended amount of time or if you feel the client needs a little encourage or a reminder of the next client session.

Telephone communications are **not** intended to:
- ► Replace in-person client sessions
- ► Be lengthy
- ► Be used to identify strengths

If telephone communications between you and the client cover any of the items above, approval by the Program Director/Manager or Supervisor is required in advance.

6. Approaches to Completing Paperwork

Completing required paperwork for ARTAS and for your agency's regular administrative and enrollment processes places an additional burden on your time. Moreover, your agency's required paperwork may focus on *inabilities* and, therefore, not adhere to the Core Elements. If your agency's clinical forms are not adjusted in the Pre-Implementation phase to make them more strengths-focused, then the ARTAS Program Director/Manager will have to negotiate possible solutions with the Clinical Director or Executive Director to ensure all required paperwork is completed. In the case of ARTAS paperwork, the strengths perspective must be maintained.

Below are two different options available to complete paperwork with the client. Whenever possible, your agency should try to make the paperwork for ARTAS and other programs as complementary as possible. Choose whichever option best fits your style and/or your agency's needs. The options are:

Option 1: Clearly differentiate the agency-required documents from the ARTAS-required documents and complete the agency-required documents first. Make it a point to differentiate the ARTAS paperwork from the agency-required paperwork during the first client session. By doing so, you clear up any confusion the client may have if the agency-required documents focus on deficiencies or inabilities.

When the agency-required paperwork is finished, tell the client you will now move in a new direction. Set aside the paperwork, and continue with the activities listed in Session One.

OR

Option 2: Emphasize the ARTAS-required documents by addressing them first. Begin the session by very quickly addressing any paperwork that is absolutely essential to complete first, such as consent forms. Continue with the activities listed in Session One. Whenever it feels appropriate, tell the client about the agency-required documents. Since these documents may highlight the client's deficiencies or inabilities, it is important to:

- ► Not overemphasize the client's deficiencies, inabilities, or weaknesses
- ► Maintain good eye contact
- ► Practice effective communication skills
- ► End the session with a summary of the client's strengths

Other than the agency-required documents and forms completed together, complete paperwork after your session with the client.

7. Significant Others

Explore the role of significant others (partners, family, friends, or someone important in the client's life) in either promoting or interfering with a client's linkage to medical care, and be prepared to discuss this issue with client. Significant others can influence a client following through with his/her medical appointment in many ways. In some instances, significant others can assist with linkage; in others, their involvement could interfere with linkage and follow-through.

8. Providing Incentives for Clients

Follow your agency's policies when deciding whether to provide incentives for clients or create an ARTAS-specific policy around this issue. Incentives can be helpful in facilitating client involvement and connecting with him/her. Incentives are a great way to retain clients and keep them involved in the process. Your agency may want to consider creative strategies to get incentives donated. A few examples include: (1) asking a local grocery store to donate gift cards for food purchases; (2) asking the local gas station to donate gas cards; (3) asking a local restaurant to donate gift cards (this could be especially useful if you and the client meet for several hours and it is time for a meal); or (4) asking a phone company to donate calling cards. If the agency does not allow you to transport clients, it may be useful to provide them with transportation money or

vouchers to enable clients to travel to each client session and medical appointment.

9. Finding Clients Who Drop Out

Once you make initial contact with the client, the relationship will last for five sessions or 90 days, whichever comes first. If a client does not follow through with ARTAS or is unable to be reached, you should attempt to contact the client at least through the 90-day period. After this time, you should decide how and whether to pursue the client on a case-by-case basis. A client who has clearly indicated that s/he does not wish to be contacted should be asked why s/he is dropping out but not pursued further.

This section provided in-depth information on the activities and skills that help facilitate effective implementation of ARTAS. The next section will discuss ways to integrate ARTAS into the implementing agency's services and evaluate the intervention.

MAINTENANCE
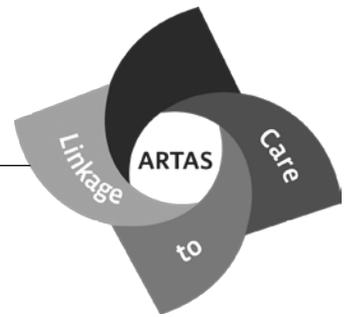
The Maintenance section contains guidance for integrating ARTAS into the implementing agency's existing services. Institutionalization, or embedding the intervention into the implementing agency's mission, hierarchy, standard operation, and budget, is a potential goal at this phase. Maintenance begins after the first client completes ARTAS and continues for as long as the agency implements the intervention. During this phase, process and outcome monitoring data are entered into a database and analyzed. These sets of data may be submitted to appropriate stakeholders. It is this information, along with quality assurance documentation, that will assist the agency in adapting the intervention to meet the needs of the target populations. Below is a list of topics covered in this section:

     I.   Institutionalizing ARTAS
    II.   Quality Assurance
   III.   Monitoring

I. Institutionalizing ARTAS

It is very important that the implementing agency take ownership of ARTAS and incorporate it into existing client services. Institutionalization of ARTAS may include the following:

Incorporating ARTAS and/or a Strengths Approach into the Agency's Mission

To make ARTAS and/or a strengths approach a component of the agency's services to link clients to medical care, agency managers, case managers and/or intervention staff need to have a discussion on the benefits of ARTAS to the agency. This discussion could take place in a regularly scheduled staff meeting, during a brown bag ARTAS presentation, or during an in-service education training. ARTAS staff can make a presentation on the ARTAS intervention and provide handouts that detail the history of the intervention, purpose, core elements, key characteristics, and potential benefits. Having a clear understanding of the ways that ARTAS can complement the agency's current programs can lead to buy-in and ownership by agency staff and result in the intervention becoming a part of the agency's overall mission to assist with institutionalization. It may be helpful to obtain feedback from other agencies that have effectively institutionalized the intervention into existing services.

Securing Continued Funding for ARTAS

A barrier to continuation of the ARTAS intervention could be the lack of long-term funding. To identify sources of continued funding for ARTAS, the implementing agency may want to consult with existing HIV prevention and care funding agencies to determine if this intervention can be supported through existing funding streams, or to

consult with local health departments and Capacity Building Assistance providers to determine what public and/or private funding sources may be available.

Integrating ARTAS Activities into Job Descriptions
Once an agency has made a decision to incorporate ARTAS into existing client services, it should develop a matrix outlining all of the job duties related to ARTAS. This matrix can then be used to make decisions on how to integrate ARTAS into the job descriptions of existing staff and/or create job descriptions for new staff. When ARTAS activities are integrated into agency job descriptions, all intervention staff members should participate in planning, training, and intervention improvement. This process further enhances the institutionalization of ARTAS and the transfer of evidence-based interventions to client services.

II. Quality Assurance
Quality assurance is defined as the steps taken to ensure that an intervention or services are of high quality and meet specified requirements. With respect to ARTAS, it is the process by which a person familiar with the intervention observes its implementation, provides feedback, documents any issues, and makes recommendations for improvements. The aim of the quality assurance assessment will be to determine if the fidelity of the intervention is maintained and clients are being linked to medical care. The agency will know its intervention is working when clients are being referred to the intervention and then linked into care within five ARTAS sessions.

Key questions in the quality assurance assessment questions are:
- Did the agency leadership introduce ARTAS to the agency in a way that resulted in staff buy-in?
- Did the LC build strong referral relationships within the community in order to attract clients to ARTAS? Why or why not?
- Were the client session objectives achieved? Why or why not?
- Did the LC practice good relationship building and communication skills with the client?
- Were the client sessions conducted with fidelity in accordance with ARTAS's Core Elements?
- Were clients linked to medical care within the five sessions? If so, what factors led to the linkage taking place? If not, what factors prohibited the linkage from taking place?

The responsibility of quality assurance falls to the Program Director/Manager and/or Evaluator. The paperwork required to conduct the quality assurance assessment includes an assessment tool with questions such as those identified above. However, it is very likely that the Supervisor will conduct the quality assurance assessment as part of the Shadowing Exercise. Periodically, s/he needs to shadow each LC during client sessions (as discussed in "Shadowing/Coaching Exercises," on page A-6 of the **LC Supervisor Guide** in **Appendix A).**

As a result of the assessments conducted by the Program Director/Manager, Evaluator and/or Supervisor, the information obtained should be used to strengthen staff skills in building strong referral networks, conducting ARTAS, and identifying strategies to help clients address barriers for linkage to medical care.

III. Monitoring and Evaluation

During the Pre-Implementation phase, the implementing agency is encouraged to develop a monitoring and evaluation plan. This plan should be implemented throughout the delivery of ARTAS. The monitoring and evaluation plan consists of formative evaluation, process monitoring, process evaluation, and outcome monitoring. For definitions and sample questions, see "Developing a Monitoring and Evaluation Plan" on page 63.

The implementation of the monitoring and evaluation plan will result in several sets of data to be reviewed and analyzed. These sets of data will help the agency make adjustments to the implementation by addressing the areas where the implementation plan encountered problems. Two specific types of data collected are process monitoring and outcome monitoring data.

Process and outcome monitoring data are best collected in a spreadsheet or database format (e.g., Microsoft Excel™, Microsoft Access™, and SPSS), since they are primarily numerical and are reviewed over time. These sets of data should be reviewed by the Program Director/Manager on a regular basis – at least quarterly.

The following are three examples of the types of monitoring tools to use – either verbatim or a modified version – to document results.

A. Maintaining Fidelity

Fidelity means conducting and continuing an intervention by following the Core Elements, protocols, procedures, and content set by the research study that determined its effectiveness. While the Core Elements cannot be altered, changed, deleted, or added to, implementing agencies can adapt Key Characteristics. The fidelity assessment should be completed by the Supervisor and/or LCs and reviewed by the Program Director/Manager or Evaluator on a quarterly basis. The **Fidelity Assessment Quarterly Report Template** on page 199 is a useful tool to assess the fidelity with which the intervention is being implemented. This template also helps the implementing agency track adherence to each Core Element.

Fidelity assessments are essential to ensure that the implementing agency continues to implement ARTAS – as designed – for the best results and to avoid intervention drift.

Intervention drift is the tendency to revert back to practices prior to the implementation of the ARTAS intervention. The greatest risk for intervention drift to occur is when:
- Intervention staff members do not receive adequate training.
- There is a lack of internal and external buy-in achieved.
- Agency policies and procedures do not support the Core Elements of ARTAS.

- There is a lack of support and supervision for the LC.
- The LC is asked to complete assignments outside the purview of the ARTAS.

ARTAS Fidelity Assessment Quarterly Report Template

Core Elements	Achieved=0 Modified=1 Dropped=2	Explanation (indicate *how* and *why* any of the core elements were modified or dropped)
1. Build an effective, working relationship between the Linkage Coordinator (LC) and each client.		

2. Focus on the client's strengths, not weaknesses by:
   a. Conducting a strengths-based assessment; and
   b. Encouraging each client to identify and use his/her strengths, abilities, and skills to link to medical care and accomplish other goals.		

3. Facilitate the client's ability to:
   a. Identify and pursue his/her own goals, whatever they may be, and
   b. Develop a step-by-step plan to accomplish those goals using the ARTAS Session Plan.		

4. Maintain a client-driven approach by:
   a. Conducting between one and five structured sessions with each client
   b. Conducting active, community-based case management by meeting each client in his/her environment and outside the office, whenever possible
   c. Coordinating and linking each client available community resources, both formal sources (e.g., housing agencies, food banks.) and informal sources (e.g., friends, support groups, spiritual groups.) based on each client's needs
   d. Advocating on each client's behalf, as needed, to link him/her to medical care and/or other needed services		

NOTE: In using this template, please indicate whether any of the Core Elements have been completed, modified, or dropped by putting the appropriate number in the middle column. In the right column, explain how and why any of the Core Elements were modified or why they were dropped. **Remember that the four Core Elements cannot be added to, modified, or deleted. If so, the agency is not implementing the ARTAS intervention.**

If there are zeroes (0) in every row, ARTAS is being implemented with fidelity, and the agency does not have to make adjustments to activities based on the Core Elements. **If there is a one (1) or two (2) in the middle column for any of the rows, ARTAS is not being implemented and changes must be made immediately. Adjust the key characteristics, activities, policies based on the explanations provided in the third column. For additional assistance, please contact the implementing agency's Evaluator, Project Officer, and/or Capacity Building Assistance provider to make the necessary adjustments to successfully implement ARTAS. Be sure to document all adjustments in the monitoring and evaluation plan and data collection activities.**

B. Session Notes and Session Note Summary Sheet

As discussed in the Implementation Section of this manual, the **Session Notes** (on page 173 of the Client Session Guide Forms) and the **Session Notes Summary Sheet** (on page 177 of the Client Session Guide Forms) can be used as process monitoring tools for the intervention. The LC must track the number of client sessions and telephone conversations with each client, the length of each client session and call, a summary of each session, and other process measures determined by the agency's monitoring and evaluation plan.

Other process monitoring tools implementing agencies may want to use for monitoring are called the **ARTAS Performance Process Indicator Form**, in **Appendix F,** and the **ARTAS Partner Tracking and Recruitment Process Indicator Form**, in **Appendix G.** These performance process indicators will help agencies track their contact with partners and the LC's interactions with clients. These forms should be modified to meet the needs of the implementing agency. For example, if the agency has sufficient relationships with all medical and service providers in the community, the agency does not have to add Performance Objective 3 (on the ARTAS Partner Tracking and Recruitment Process Indicator Form) to the monitoring and evaluation plan.

C. Client Feedback

While it is not required, the agency may choose to institute follow-up with clients – regardless of whether they link to medical care – to get their input on the ARTAS process. The **Client Satisfaction Questionnaire**, on page 187 of the Client Session Guide Forms, is a tool the agency may choose to use. It should be filled out by clients immediately after completing the last client session to assess the client's satisfaction with the intervention, his/her experience, and relationship with the LC. This questionnaire can be completed by the client directly or in an exit interview with the Supervisor, if appropriate.

ADAPTATION
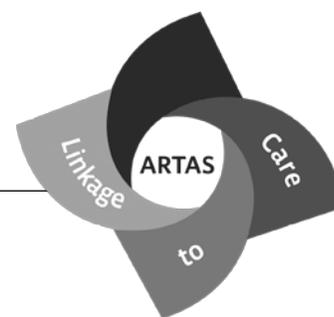
The Adaptation section provides a brief overview of adaptation and examples of past ARTAS adaptations.

Adapting ARTAS involves customizing its delivery to ensure the approaches and activities meet the needs of the implementing agency and of the target population(s) without altering, deleting or adding to the Core Elements. In other words, adaptation refers to the "who," "what," "when," "where," and "how" of the intervention. Before an implementing agency adapts ARTAS, it is important to first:

- Implement the intervention as designed.
- Carefully consider how and why the intervention is being adapted.
- Obtain adaptation-related capacity-building assistance (CBA) services that are available for qualified agencies. Please contact the implementing agency's CDC and/or health department Project Officer to access these services.

Below are a few examples of past adaptations to ARTAS. This is not intended to be a comprehensive list nor is it a guide on how to adapt the intervention. One adaptation example is increasing the period of time given to conduct the client sessions from 90 days (three months) to 180 days (six months) due to additional travel time for the LC and/client. Some implementing agencies may be working with clients within a large geographic region or in rural communities. Clients who live in rural areas may have to travel several hundred miles to the nearest AIDS services organization, and making up to five trips within 90 days may be too burdensome.

Another example of adaptation is expanding the target population to include people who are further out from their HIV diagnosis and/or who were previously linked to medical care. In the original research (ARTAS-I), the target population included people within six months of diagnosis. In the implementation research study (ARTAS-II), the target population was expanded beyond 6 to12 months of diagnosis. Note: Nearly 96 percent of the participants were within six months of diagnosis. It is important to note that expanding the target population may impact the results of the intervention slightly as these populations are typically more difficult to reach and to link with medical care. Individuals who are further out from an HIV diagnosis, especially people who are asymptomatic, may still not be ready to link with medical care and may even be more resistant. On the other hand, they may have accepted their serostatus, and are now ready to link to medical care but still have barriers.

During ARTAS-II, some demonstration sites decided to have clients talk on the phone or meet in person with the LC upon receiving their test results. Literally within minutes of receiving the diagnosis, the client could speak with the LC to begin the relationship

building. On the other hand, some demonstration sites chose to collect the clients' contact information and ask the LC to follow-up with the client after s/he left the testing site. In both scenarios, the testing site discussed the intervention with the clients and obtained their permission to release their test results and contact information to the LC.

Another adaptation took place at a Health Department. The Health Department staff <u>required</u> the STD clinic staff to refer <u>all</u> recently diagnosed patients to the LC. In all three scenarios, the LC pre-screened the clients for eligibility and interest in participating in ARTAS before enrolling them in the intervention.

When adapting ARTAS, it is important to think of the *impact* of adaptation on the clients, community partners, and outcomes of the intervention. **Adaptation does not and should not affect the Core Elements of the intervention**. Adaptation should:
- Enhance the delivery of the intervention.
- Make the information more accessible for the clients.
- Give the agency a chance to be creative with the intervention.

There are numerous ways to adapt ARTAS. Before the agency adapts ARTAS, it should take into consideration the needs of the population, the resources and capabilities of the implementing agency and partners, the Core Elements of the intervention, and should obtain CBA services. Also, it is important to document all adaptations and evaluate them to determine their effectiveness. Once an adaptation occurs, there is always a possibility that the efficacy of the intervention could change. Whether the change is positive or negative, it is important to have clear documentation of the process.

REFERENCES
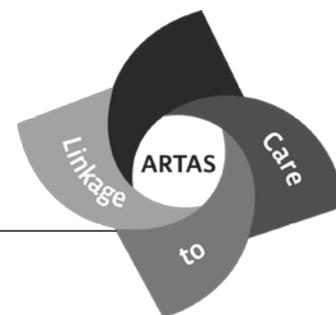
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