FY 2024 Houston EMA/HSDA Ryan White Part A Service Definition **Service Linkage at Testing Sites** (Revision Date: 03/03/14)	
HRSA Service Category Title: **RWGA Only**	**Non-medical Case Management**
Local Service Category Title:	**A. Service Linkage targeted to Not-In-Care and Newly-Diagnosed PLWH in the Houston EMA/HDSA** **Not-In-Care PLWH** are individuals who know their HIV status but have not been actively engaged in outpatient primary medical care services for more than six (6) months. **Newly-Diagnosed** PLWH are individuals who have learned their HIV status within the previous six months and are not currently receiving outpatient primary medical care or case management services as documented in the CPCDMS data system. **B. *Youth targeted Service Linkage, Care and Prevention:*** Service Linkage Services targeted to Youth (13 – 24 years of age), including a focus on not-in-care and newly-diagnosed Youth in the Houston EMA. *Not-In-Care PLWH are Youth who know their HIV status but have not been actively engaged in outpatient primary medical care services in the previous six (6) months. *Newly-Diagnosed Youth are Youth who have learned their HIV status within the previous six months and are not currently receiving outpatient primary medical care or case management services as documented in the CPCDMS data system.
Budget Type: **RWGA Only**	Fee-for-Service
Budget Requirements or Restrictions: **RWGA Only**	Early intervention services, including HIV testing and Comprehensive Risk Counseling Services (CRCS) must be supported via alternative funding (e.g. TDSHS, CDC) and may not be charged to this contract.
HRSA Service Category Definition (**do <u>not</u> change or alter**): **RWGA Only**	***Case Management (non-Medical)*** includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does.
Local Service Category Definition:	**A. *Service Linkage:*** Providing allowable Ryan White Program outreach and service linkage activities to newly-diagnosed and/or ***Not-In-Care*** PLWH who know their status but are not currently enrolled in outpatient primary medical care with information, referrals and assistance with linkage to medical, mental health, substance abuse and psychosocial services as needed; advocating on behalf of clients to decrease service gaps and remove barriers to services helping clients develop and utilize independent living skills

	and strategies. Assist clients in obtaining needed resources, including bus pass vouchers and gas cards per published HCPH/RWGA policies. **B. *Youth targeted Service Linkage, Care and Prevention:*** Providing Ryan White Program appropriate outreach and service linkage activities to newly-diagnosed and/or not-in-care HIV-positive Youth who know their status but are not currently enrolled in outpatient primary medical care with information, referrals and assistance with linkage to medical, mental health, substance abuse and psychosocial services as needed; advocating on their behalf to decrease service gaps and remove barriers to services; helping Youth develop and utilize independent living skills and strategies. Assist clients in obtaining needed resources, including bus pass vouchers and gas cards per published HCPH/RWGA policies. Provide comprehensive medical case management to HIV-positive youth identified through outreach and in-reach activities.
Target Population (age, gender, geographic, race, ethnicity, etc.):	**A. Service Linkage:** Services will be available to eligible persons with HV residing in the Houston EMA/HSDA with priority given to clients most in need. All clients who receive services will be served without regard to age, gender, race, color, religion, national origin, sexual orientation, or handicap. Services will target low income individuals with HIV who demonstrate multiple medical, mental health, substance use/abuse and psychosocial needs including, but not limited to: mental health counseling, substance abuse treatment, primary medical care, specialized care, alternative treatment, medications, placement in a medical facility, emotional support, basic needs for food, clothing, and shelter, transportation, legal services and vocational services. Services will also target clients who cannot function in the community due to barriers which include, but are not limited to, mental illness and psychiatric disorders, drug addiction and substance abuse, extreme lack of knowledge regarding available services, inability to maintain financial independence, inability to complete necessary forms, inability to arrange and complete entitlement and medical appointments, homelessness, deteriorating medical condition, illiteracy, language/cultural barriers and/or the absence of speech, sight, hearing, or mobility. **Service Linkage** is intended to serve eligible clients in the Houston EMA/HSDA, especially those underserved or unserved population groups which include: African American, Hispanic/Latino, Women and Children, Veteran, Deaf/Hard of Hearing, Substance Abusers, Homeless and Gay/Lesbian/Transsexual. **B. *Youth targeted Service Linkage, Care and Prevention:*** Services will be available to eligible Youth (ages 13 – 24) living with HIV residing in the Houston EMA/HSDA with priority given to clients most in need. All Youth who receive services will be served

	without regard to age (i.e. limited to those who are between 13- 24 years of age), gender, race, color, religion, national origin, sexual orientation, or handicap. Services will target low income Youth living with HIV who demonstrate multiple medical, mental health, substance use/abuse and psychosocial needs including, but not limited to: mental health counseling, substance abuse treatment, primary medical care, specialized care, alternative treatment, medications, placement in a medical facility, emotional support, basic needs for food, clothing, and shelter, transportation, legal services and vocational services. Services will also target Youth who cannot function in the community due to barriers which include, but are not limited to, mental illness and psychiatric disorders, drug addiction and substance abuse, extreme lack of knowledge regarding available services, inability to maintain financial independence, inability to complete necessary forms, inability to arrange and complete entitlement and medical appointments, homelessness, deteriorating medical condition, illiteracy, language/cultural barriers and/or the absence of speech, sight, hearing, or mobility. ***Youth Targeted Service Linkage, Care and Prevention*** is intended to serve eligible youth in the Houston EMA/HSDA, especially those underserved or unserved population groups which include: African American, Hispanic/Latino, Substance Abusers, Homeless and Gay/Lesbian/Transsexual.
Services to be Provided:	**Goal (A): Service Linkage:** The expectation is that a single Service Linkage Worker Full Time Equivalent (FTE) targeting Not-In-Care and/or newly-diagnosed PLWH can serve approximately 80 newly-diagnosed or not-in-care PLWH per year. The purpose of **Service Linkage** is to assist clients with the procurement of needed services so that the problems associated with living with HIV are mitigated. **Service Linkage** is a working agreement between a client and a Service Linkage Worker (SLW) for an indeterminate period, based on client need, during which information, referrals and service linkage are provided on an as-needed basis. The purpose of **Service Linkage** is to assist clients who do not require the intensity of *Clinical or Medical Case Management*, as determined by RWGA Quality Management guidelines. **Service Linkage** is both office- and field-based and **may include the issuance of bus pass vouchers and gas cards per published guidelines.** Service Linkage targeted to Not-In-Care and/or Newly-Diagnosed PLWH extends the capability of existing programs with a documented track record of identifying Not-In-Care and/or newly-diagnosed PLWH by providing "hands-on" outreach and linkage to care services to those PLWH who are not currently accessing primary medical care services.

	In order to ensure linkage to an ongoing support system, eligible clients identified funded under this contract, including clients who may obtain their medical services through non-Ryan White-funded programs, must be transferred to a Ryan White-funded Primary Medical Care, Clinical Case Management or Service Linkage program within 90 days of initiation of services as documented in both ECLIPS and CPCDMS data systems. Those clients who choose to access primary medical care from a non-Ryan White source, including private physicians, may receive ongoing service linkage services from provider or must be transferred to a Clinical (CCM) or Primary Care/Medical Case Management site per client need and the preference of the client**.** **GOAL (B):** This effort will continue a program of ***Service Linkage, Care and Prevention to Engage HIV Seropositive Youth*** targeting youth (ages 13-24) with a focus on Youth of color. This service is designed to reach HIV seropositive youth of color not engaged in clinical care and to link them to appropriate clinical, supportive, and preventive services. The specific objectives are to: (1) conduct outreach (service linkage) to assist seropositive Youth learn their HIV status, (2) link Youth living with HIV with primary care services, and (3) prevent transmission of HIV from targeted clients.
Service Unit Definition(s): **RWGA Only**	One unit of service is defined as 15 minutes of direct client services and allowable charges.
Financial Eligibility:	Refer to the RWPC's approved *current fiscal year (FY) Financial Eligibility for Houston EMA Services*.
Client Eligibility:	Not-In-Care and/or newly-diagnosed PLWH residing in the Houston EMA.
Agency Requirements:	**Service Linkage** services will comply with the HCPH/RWGA published **Service Linkage** Standards of Care and policies and procedures as published and/or revised, including linkage to the CPCDMS data system. Agency must comply with all applicable City of Houston DHHS *ECLIPS* and RWGA/HCPH *CPCDMS* business rules and policies & procedures. **Service Linkage** targeted to Not-In-Care and/or newly diagnosed PLWH must be planned and delivered in coordination with local HIV prevention/outreach programs to avoid duplication of services and be designed with quantified program reporting that will accommodate local effectiveness evaluation. Contractor must document established linkages with agencies that serve clients living with HIV or serve individuals who are members of high-risk population groups (e.g., men who have sex with men, injection drug users, sex-industry workers, youth who are sentenced under the juvenile justice system, inmates of state and local jails and prisons). Contractor must have

	formal collaborative, referral or Point of Entry (POE) agreements with Ryan White funded HIV primary care providers.
Staff Requirements:	Service Linkage Workers must spend at least 42% (867 hours per FTE) of their time providing direct client services. Direct service linkage and case management services include any activities with a client (face-to-face or by telephone), communication with other service providers or significant others to access client services, monitoring client care, and accompanying clients to services. Indirect activities include travel to and from a client's residence or agency, staff meetings, supervision, community education, documentation, and computer input. Direct case management activities must be documented in the CPCDMS according to system business rules. *Must comply with applicable HCPH/RWGA published Ryan White Part A/B Standards of Care:* Minimum Qualifications: **Service Linkage Workers** must have at a minimum a Bachelor's degree from an accredited college or university with a major in social or behavioral sciences. Documented paid work experience in providing client services to PLWH/A may be substituted for the Bachelor's degree requirement on a 1:1 basis (1 year of documented paid experience may be substituted for 1 year of college). All Service Linkage Workers must have a minimum of one (1) year paid work experience with PLWH. Supervision: The Service Linkage Worker must function within the clinical infrastructure of the applicant agency and receive ongoing supervision that meets or exceeds HCPH/RWGA published Ryan White Part A/B Standards of Care for Service Linkage.
Special Requirements: **RWGA Only**	Contractor must be have the capability to provide Public Health Follow-Up by qualified Disease Intervention Specialists (DIS) to locate, identify, inform and refer newly-diagnosed and not-in-care PLWH to outpatient primary medical care services. Contractor must perform CPCDMS new client registrations and, for those newly-diagnosed or out-of-care clients referred to non-Ryan White primary care providers, registration updates per RWGA business rules for those needing ongoing service linkage services as well as those clients who may only need to establish system of care eligibility. This service category does not routinely distribute Bus Passes. However, if so directed by RWGA, Contractor must issue bus pass vouchers in accordance with HCPH/RWGA policies and procedures.

FY 2025 RWPC "How to Best Meet the Need" Decision Process

Step in Process: **Council**		Date: **06/13/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Steering Committee**		Date: **06/06/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **Quality Improvement Committee**		Date: **05/14/2024**
Recommendations:	Approved: Y:_____ No: _____ Approved With Changes:_____	If approved with changes list changes below:
1.		
2.		
3.		

Step in Process: **HTBMTN Workgroup #1**	Date: **04/16/2024**
Recommendations:	Financial Eligibility:
1.	
2.	
3.	

FY 2020 PERFORMANCE MEASURES HIGHLIGHTS

RYAN WHITE GRANT ADMINISTRATION

HARRIS COUNTY PUBLIC HEALTH (HCPH)

TABLE OF CONTENTS

Highlights from FY 2020 Performance Measures

Measures in this report are based on the *2021-2022 Houston Ryan White Quality Management Plan*, *Appendix B. HIV Performance Measures*. The document can be referenced here: https://publichealth.harriscountytx.gov/Services-Programs/Programs/RyanWhite/Quality

Service Linkage (Non-Medical Case Management)

- During FY 2020, 8,331 clients utilized Part A non-medical case management / service linkage. According to CPCDMS, 4,048 (49%) of these clients accessed primary care two or more times at least three months apart during this time period after utilizing non-medical case management.
- Among these clients, 50% of clients utilized primary medical care for the first time after accessing service linkage for the first time.
- The median number of days between the first service linkage visit and the first primary medical care visit was 9 days during this time period.

Ryan White Part A
HIV Performance Measures
FY 2020 Report

Service Linkage / Non-Medical Case Management
All Providers

For FY 2020 (3/1/2020 to 2/28/2021), 8,331 clients utilized Part A non-medical case management.

HIV Performance Measures	**FY 2019**	**FY 2020**	**Change**
A minimum of 70% of clients will utilize Part A/B/C/D primary care two or more times at least three months apart after accessing non-medical case management (service linkage)	4,174 (47.9%)	4,048 (48.6%)	**0.7%**
60% of clients will access RW primary medical care for the first time after accessing service linkage for the first time	462 (49.1%)	344 (49.5%)	**0.4%**
Mean of less than 30 days between first ever service linkage visit and first ever primary medical care visit:			
Mean	31	33	**6.5%**
Median	14	9	**-35.7%**
Mode	1	1	**0.0%**
60% of newly enrolled clients will have a medical visit in each of the four-month periods of the measurement year	128 (45.2%)	68 (33.8%)	**-11.4%**

Harris County
Public Health
Building a Healthy Community

Ryan White Part A
Quality Management Program- Houston EMA
Case Management Chart Review FY 2020-21
Ryan White Grant Administration

CUMMULATIVE SUMMARY, DE-IDENTIFIED

Table of Contents

Overview

Each year, the Ryan White Grant Administration Quality Management team conducts chart review in order to continuously monitor case management services and understand how each agency implements workflows to meet quality standards for their funded service models. This process is a supplemental complement to the programmatic and fiscal audit of each program, as it helps to provide an overall picture of quality of care and monitor quality performance measures.

A total of 624 medical case management client records were reviewed across seven of the ten Ryan White-Part A funded agencies, including a non-primary care site that provides Clinical Case Management services. The dates of service under review were March 1, 2020- February 28, 2021. The sample selection process and data collection tool are described in subsequent sections.

Case Management is defined by the Ryan White legislation as a, "range of client-centered services that link clients with health care, psychosocial, and other services," including coordination and follow-up of medical treatment and "adherence counseling to ensure readiness for and adherence to HIV complex treatments." Case Managers assist clients in navigating the complex health care system to ensure coordination of care for the unique needs of People Living With HIV. Continuous assessment of need and the development of individualized service plans are key components of case management. Due to their training and skill sets in social services, human development, psychology, social justice, and communication, Case Managers are uniquely positioned to serve clients who face environmental and life issues that can jeopardize their success in HIV treatment, namely, mental health and substance abuse, poverty and access to stable housing and transportation, and poor social support networks.

Ryan White Part-A funds three distinct models of case management: Medical Case Management, Non-Medical Case Management (or Service Linkage Work), and Clinical Case Management, which must be co-located in an agency that offers Mental Health treatment/counseling and/or Substance Abuse treatment. Some agencies are also funded for Outreach Services, which complement Case Management Services and are designed to locate and assist clients who are on the cusp of falling out of care in order to re-engage and retain them back into care.

The Tool

A copy of the Case Management Chart Review tool is available in the Appendix of this report.

The Case Management Chart Review tool is a pen and paper form designed to standardize data collection and analysis across agencies. The purpose of the tool is to capture information and quantify services that can present an overall picture of the quality of case management services provided within the Ryan White Part-A system of care. This way, strengths and areas of improvement can be identified and continuously monitored.

The coversheet of the chart abstraction tool captures basic information about the client, including their demographics, most recent appointments, lab results, and any documented psychological, medical, or social issues or conditions that would be documented in their medical record.

The content of the second sheet focuses on coordination of case management services. There is space for the chart abstractor to record what type of worker assisted the client (Medical Case Manager, Service Linkage Worker, Outreach Worker or Clinical Case Manager) and what types of services were provided. It is expected that any notes about case management closure are recorded, as well as any assessments or service plans or documented reasons for the absence of assessments or service plans.

The Sample

In order to conduct a thorough and comprehensive review, a total of 624 client records were reviewed across seven agencies for the 2020-2021 grant year. This included sixty-one (61) Clinical Case Management charts at a non-primary care site. In this Case Management Chart Review Report, any section that evaluated a primary care related measure excludes the sample of the non-primary care site. Minimum sample size was determined in accordance with *Center for Quality Improvement & Innovation* sample size calculator based on the total eligible population that received case management services at each site.

Agency	A	B	C	D	E	F	G
# of Charts Reviewed	79	85	91	105	105	98	61

TOTAL 624 (563 excluding non-Primary Care site)

For each agency, a randomized sample of clients who received a billable Ryan White- A service under at least one (1) of eleven (11) case management subcategory codes during the March 1, 2020- February 28, 2021 grant year was queried from the Centralized Patient Care Data Management System database. Each sample was determined to be comparable to the racial, ethnic, age, and gender demographics of each site's overall case management patient population.

Cumulative Data Summaries

APPOINTMENTS & ENCOUNTERS

The number of HIV-related primary care appointments and case management encounters in the given year were counted for each client.

HIV-RELATED PRIMARY CARE APPOINTMENTS

For this measure, the number of face-to-face encounters and virtual telehealth visits for an HIV-related primary care appointment with a medical provider was counted. Each encounter was assessed for a minimum of 3 medical appointments. Any Viral Load that accompanied the appointment was also recorded.

HIV MEDICAL # appt	A	B	C	D	E	F	TOTAL	PERCENT
0	1	4	11	31	8	4	59	**10%**
1	5	23	9	40	42	10	129	**23%**
2	18	27	10	26	38	15	134	**24%**
3	55	31	61	8	17	69	241	**43%**
Total	*79*	*85*	*91*	*105*	*105*	*98*	*563*	

The overall sample trends towards a higher number of primary care appointment in the year, with most of the case management review clients having at least 3 appointments in the year (43%), followed by (24%) of the clients having 2 appointments in the year.

CASE MANAGEMENT ENCOUNTERS

Frequency of case management encounters were also reviewed. The number and types of the encounters (face-to-face vs. phone), as well as who provided the service (Clinical, Medical, or Non-Medical Case Manager) were also recorded.

The distribution of frequency of case management encounters could be described as evenly distributed across encounters.

CASE MGMNT # appointments	A	B	C	D	E	F	G	TOTAL	PERCENT
1	19	23	17	35	19	32	8	153	**25%**
2	21	17	13	12	30	23	6	122	**20%**
3	9	10	12	12	22	24	15	104	**17%**
4	17	19	16	22	10	10	13	107	**18%**
5	13	16	33	24	24	9	19	138	**22%**
Total	*79*	*85*	*91*	*105*	*105*	*98*	*61*	*624*	

VIRAL SUPPRESSION

Any results of HIV Viral Load laboratory tests that accompanied HIV-related primary care appointments were recorded as part of the case management chart abstraction. Up to three laboratory tests could be recorded. Lab results with an HIV viral load result of less than 200 copies per milliliter were considered to be virally suppressed.

Upon coding, clients who were suppressed for all of their recorded labs (whether they had one, two, or three tests done within the year), were coded as "Suppressed." Clients who were unsuppressed (>200 copies/mL) for all of their labs were coded as "Unsuppressed." Clients who had more than one laboratory test done and were suppressed for at least one and unsuppressed for at least one were coded as "Mixed Status," and clients who had no laboratory tests done within the entire year were coded as "Unknown."

SUPPRESSION STATUS	A	B	C	D	E	F	TOTAL	PERCENT
Suppressed for all labs	32	31	43	72	72	33	283	**50%**
Mixed status	0	0	0	3	10	0	13	**2%**
Unknown (no recent labs on file)	44	51	37	21	10	55	218	**39%**
Unsuppressed for all labs	3	3	11	9	13	10	49	**9%**
Total	*79*	*85*	*91*	*105*	*105*	*98*	*563*	

Across all primary care sites, the case management clients reviewed for these samples had a viral load suppression rate of 50%. In contrast, this result is much lower than what is typical for the Ryan White Part A Houston Primary Care Chart review, which has hovered around 85% for the past several years. This difference may be due to several factors, mainly the Covid-19 pandemic and reduction of in-person labs due to telehealth visits. The Primary Care chart review sample is collected from a pool of clients who are considered *in care*, or have at least two medical appointments with a provider with prescribing privileges in the review year. Additionally, "fluctuating viral load" is one of the eligibility criteria for medical case management, so clients who have challenges maintaining a suppressed viral load are more likely to be seen by case management and be included in this sample.

CARE STATUS

The chart abstractor also documented any circumstances in the record for which a client was new, lost, returning to care, or some combination of those care statuses. A client was considered "New to Care," if they were receiving services for the first time at that particular agency (not necessarily new to HIV treatment or the Houston Ryan White system of care). "Lost to Care" was defined as not being seen for an HIV-related primary care appointment within the last six months and not having a future appointment scheduled, even beyond the review year. "Re-engaged in Care" was defined as any client who was previously lost to care, either during or before the review year, and later attended an HIV-related primary care appointment.

CARE STATUS	A	B	C	D	E	F	TOTAL	PERCENT
New to Care	11	5	11	1	2	5	35	**6%**
Lost to Care	11	2	1	15	11	2	42	**7%**
Re-engaged in Care	0	0	0	1	0	0	1	**1%**
Both New and later Lost to Care in the same review year	8	2	20	3	17	15	65	**12%**
Re-engaged and later lost again	0	0	0	1	1	0	2	**<1%**
N/A	49	76	59	84	74	76	418	**74%**
Total	*79*	*85*	*91*	*105*	*105*	*98*	*563*	

Overall, 6% of the sample was considered New to Care, 7% was Lost to Care, and <1%was Re-engaged in Care.

When a client's attendance met one of the above care statuses, their medical record was reviewed to understand if case management or other staff was involved in coordinating their care. Activities that counted as "Coordination of Care" were any actions that welcomed the client into or back into care or attempted to retain them in care, such as: reminder phone calls, follow-up calls, attendance, or introduction at the first appointment, or home visits.

COMORBIDITIES

To understand and document common comorbidities within the Houston Ryan White system of care, co-occurring conditions were recorded, including mental health and substance abuse issues, other medical conditions, and social conditions. This inventorying of co-morbidities may prove particularly helpful for selecting future training topics for case management staff.

MENTAL HEALTH & SUBSTANCE USE DISORDER (history or active)

Any diagnosis of a mental health disorder (MH) or substance use disorder issue (SUD) was recorded in the chart review tool, including a history of mental illness or substance use. All Electronic Medical Records include some variation of a "Problem List" template. This list was often a good source of information for MH and SUD diagnoses, but providers sometimes also documented diagnoses or known histories of illness within progress notes without updating the Problem List. Clients sometimes also self-reported that they had been diagnosed with one of the below conditions by a previous medical provider. Any indication of the presence of mental illness or SUD, regardless of where the information was housed within the medical record, was recorded on the chart abstraction tool. Clients could also have or have had more than one of the MH or SUD issues. Any conditions other than alcohol misuse, other SUD, depression, bipolar disorder, anxiety, or schizophrenia were recorded as "Other." The most common types of condition coded as "Other" was Post-Traumatic Stress Disorder.

Diagnosis or Issue	A	B	C	D	E	F	G	TOTAL	PERCENT
Alcohol abuse/dependence	3	2	5	1	13	6	20	50	**9%**
Other Substance dependence	14	1	5	0	15	7	19	61	**10%**
Depression	16	11	32	14	42	33	37	185	**32%**
Bipolar disorder	6	5	7	1	5	10	14	48	**8%**
Anxiety	9	12	14	51	28	22	32	168	**29%**
Schizophrenia	1	1	0	14	1	2	7	26	**4%**
Other	2	0	11	2	12	9	10	46	**8%**

Overall, 93% of the sample had either an active diagnosis or history of a mental health or substance abuse issue documented somewhere within their medical record. This is inclusive of the Clinical Case Management site, for which diagnosis with or clinical indication of a MH or SUD issue is an eligibility criteria.

MENTAL HEALTH & SUBSTANCE USE DISORDER REFERRALS

For clients with an *active* diagnosis of a mental health or SUD issue, the chart abstractor recorded if they were referred or already engaged in MH/SUD services.

MH referral	A	B	C	D	E	F	TOTAL	PERCENT
N/A	75	82	55	100	97	88	497	**88%**
Yes	3	3	13	5	8	10	42	**7%**
No	1	0	23	0	0	0	24	**4%**
Total	82	85	91	105	105	98	563	

Overall, 88% of the sample would not have been appropriate for a MH or SUD referral based on the information available in their medical record. An additional 7% either did receive a referral or were already engaged in treatment and 4% did not receive a referral.

MEDICAL CONDITIONS

Medical conditions other than HIV were also recorded in an effort to understand what co-occurring conditions may be considered commonly managed alongside HIV within the case management population. Sexually Transmitted Infections and Hypertension were common, at 33% and 25% prevalence within the sample, respectively. The site visit tool does not list obesity as a medical condition however, obesity was the most common co-occurring condition that was coded in the "Other" category.

Medical Condition	A	B	C	D	E	F	TOTAL	PERCENT
Smoking (hx or current)	10	7	12	11	33	10	83	**16%**
Opportunistic Infection	0	0	3	6	0	0	9	**2%**
STIs	38	16	48	3	39	31	175	**33%**
Diabetes	5	11	8	4	20	22	70	**13%**
Cancer	0	3	1	6	0	1	11	**2%**
Hepatitis	7	5	1	7	9	9	38	**7%**
Hypertension	12	37	21	11	22	28	131	**25%**
Other	2	3	5	0	8	1	19	**4%**

SOCIAL CONDITIONS

Any indication within the medical record that a client had experienced homelessness/housing-related issues, pregnancy/pregnancy-related issues, a release from jail or prison, or intimate partner violence at any point within the review year was recorded in the chart abstraction tool. Homelessness and housing issues were the most commonly identified "Social Condition" within the sample.

Social Issue	A	B	C	D	E	F	G	TOTAL	PERCENT
Homelessness or housing-related issues	5	0	3	4	15	1	10	38	**6%**
Pregnancy or pregnancy-related issues	6	2	0	0	0	0	0	8	**1%**
Recently released	0	0	1	0	2	0	0	3	**<1%**
Intimate Partner Violence	3	0	0	0	5	0	10	18	**2%**

COMPREHENSIVE ASSESSMENTS

A cornerstone of service provision within case management is the opportunity for the client to be formally assessed at touchpoints throughout the year for their needs, treatment goals, and action steps for how they will work with the case manager or care team to achieve their treatment goals. Agencies need to use an approved assessment tool and service plan, which may either be the sample tools available through Ryan White Grant Administration or a pre-approved tool of the agency's choosing.

The Ryan White Part-A Standards for medical case management state that a comprehensive assessment should be completed with the client at intake and that they should be re-assessed at least every six months for as long as they are receiving medical case management services. A more formal, comprehensive assessment should be used at intake and annually, and a brief reassessment tool is sufficient at the 6-month mark. In other words, the ideal standard is that every client who receives case management services for an entire year should have at least two comprehensive assessments on file. A service plan should accompany each comprehensive assessment to outline the detailed plan of how the identified needs will be addressed with the client.

# of Comp assessments	A	B	C	D	E	F	G	TOTAL	PERCENT
0	62	85	78	100	89	83	0	497	**79%**
1	17	0	13	3	16	15	15	79	**13%**
2	0	0	0	2	0	0	9	11	**2%**
N/A	0	0	0	0	0	0	37	37	**6%**
Total	79	85	95	105	105	98	61	624	

The client was considered "N/A" for a comprehensive assessment if they did not work with a medical case manager throughout the year. As outlined above, 6% of the sample did not work with a Medical Case Manager within the year. 79% of the sample received zero comprehensive assessments, 13% received one, and 2% received two.

SERVICE PLANS

As mentioned, each comprehensive assessment should be accompanied by a service plan, otherwise known as a care plan, to outline what action(s) will be taken to address the needs identified on the comprehensive assessment. A service plan can be thought of as an informal, working, contract between client and social worker for accountability of needed actions, and in what order, to meet a client's determined treatment goals. As with the comprehensive assessment, each completed service plan was recorded in the chart abstraction tool, along with any documented justification for why a service plan was missing if it should have been completed.

# of service plans	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**TOTAL**	**PERCENT**
0	65	82	91	102	95	98	7	540	**87%**
1	14	3	0	2	10	0	10	39	**6%**
2	0	0	0	1	0	0	7	8	**1%**
N/A	0	0	0	0	0	0	37	37	**6%**
Total	79	85	91	105	105	98	61	624	

It is notable that less service plans are completed than comprehensive assessments, even though the two processes are intended to occur together, one right after the other. RWGA experienced a transition in CM chart review auditors midway through the chart review process. As a result, it is unclear what the criteria for determining a client was "N/A" at agency "G".

BRIEF ASSESSMENTS

Like Medical Case Management, Non-Medical Case Management is guided by a continuous process of ongoing assessment, service provision, and evaluation. Clients should be assessed at intake using a Ryan White Grant Administration approved brief assessment form and should be reassessed at six-month intervals if they are still being serviced by a Non-Medical Case Manager.

# of Brief assessments	**A**	**B**	**C**	**D**	**E**	**F**	**TOTAL**	**PERCENT**
0	52	73	55	56	30	80	346	**61%**
1	24	12	34	38	54	18	180	**33%**
2	3	0	2	7	1	0	13	**2%**
N/A	0	0	0	4	20	0	24	**4%**
Total	79	85	91	105	105	98	563	

Completion of brief assessments were recorded. 4% of the sample would not been applicable for a brief assessment, as they did not receive services from a Non-Medical Case Manager. 61% of the sample received zero brief assessments, 33% received one, and 2% received two.

ASSESSED NEEDS

All data from assessment tools was captured in the chart review tool. A total of 624 Comprehensive Assessments and 563 Brief Assessments were reviewed and recorded to quantify the frequency of needs. The count recorded is a raw count of how many times a need was recorded, encompassing both comprehensive and brief assessments and including clients who may have had the same need identified more than once at different points in time.

The most frequently assessed needs were: 1) Medical/Clinical, 2) Dental Care, 3) Vision Care, 4) Medication Adherence Counseling, 5) Mental Health, and (6) Insurance. It should be noted, however, that there are no universal standards or instructions across case management systems on how to use these tools or how these needs are defined. Anecdotally, some case managers reported that they automatically checked "Medical/Clinical" and "Medication Adherence Counseling" as a need, regardless of whether or not the client needed assistance accessing medical care, because it was their understanding that this section *always* needed to be checked in order to justify billing for medical case management services. Therefore, this compilation of comprehensive and brief assessments should not be considered representative of *true need* within the HIV community in Houston, but rather, as representative of issues that case managers are discussing with clients.

Need identified on assessment	A	B	C	D	E	F	G	TOTAL	PERCENT
Medical/Medication	42	12	41	37	24	35	8	199	8%
Vaccinations	10	7	0	44	22	0	6	89	4%
Nutrition/Food Pantry	10	8	16	0	18	1	4	57	3%
Dental	31	11	18	16	29	14	8	127	5%
Vision	19	11	31	12	14	13	5	105	4%
Hearing Care	15	9	26	1	0	12	1	64	3%
Home Health Care	10	3	8	0	1	2	0	24	1%
Basic Necessities/Life Skills	41	9	28	4	5	32	5	124	5%
Mental Health	33	9	45	16	24	44	14	185	7%
Substance Use Disorder	43	12	37	4	5	35	6	142	6%
Abuse	27	11	17	1	12	15	2	85	4%
Housing/Living Situation	41	12	35	9	10	34	8	149	6%
Support Systems	47	12	42	3	3	33	1	141	6%
Child Care	14	6	4	0	0	4	0	28	1%
Insurance	52	11	31	3	9	46	4	156	6%
Transportation	36	12	55	11	6	35	6	161	6%
HIV-Related Legal Assistance	25	8	21	0	1	27	0	82	3%
Cultural/Linguistic	28	1	12	0	0	20	0	61	3%
Self-Efficacy	40	1	12	0	0	40	4	97	4%
HIV Education/Prevention	21	12	40	3	4	36	0	116	5%
Family Planning/ Safer Sex	9	11	7	0	4	2	1	34	2%
Employment	39	7	39	0	4	33	4	126	5%
Education/Vocation	35	10	30	0	0	10	0	85	4%
Financial Assistance	8	10	12	21	15	8	13	87	4%
Medication Adherence Counseling	44	9	43	19	27	43	17	182	7%
Client Strengths	1	0	0	1	0	0	3	5	1%

Conclusion

The 2020-2021 Case Management chart review highlighted many trends about the case management client population, strengths in case management performance, and areas identified for future attention and improvement. This report also gives consideration to challenges and barriers related to Covid-19 pandemic.

The most common co-occurring conditions were: Sexually Transmitted Infections (33%), Depression (32%), and Hypertension (25%). Diabetes and Obesity were also relatively common and providing overview information on nutrition counseling may be a useful topic in frontline case management trainings. The prevalence of complex co-morbidities emphasizes the unique benefit that case managers contribute to the HIV treatment setting.

There were also areas of high performance displayed in this chart review. Most (43 %) of the clients in the sample had at least three HIV-related primary care appointments within the review year. Case Management staff demonstrated a high level of coordination of care in areas. For example, 90% of the clients who were New, Lost, or Returning to Care (or some combination) received coordination of care activities from case management to retain them in care.

Appendix (Case Management Chart Review Tool)

CASE MANAGEMENT CHART REVIEW TOOL
Chart Review Date _____/_____/_____
Agency: ☐ AHF ☐ AH ☐ Ave360 ☐ HHS ☐ Legacy ☐ SHF

Review Period:
3/1/20__ - 2/28/20__

CLIENT INFORMATION

Pt. ID # _____ Race: _____

Client Case Status: ☐ Open/Active ☐ Closed ☐ Unk. Gender: _____

Last OAMC Appts:	Virally Suppressed?	← If No, linked to CM?
1.	☐ Y ☐ N ☐ Unk.	
2.	☐ Y ☐ N ☐ Unk.	
3.	☐ Y ☐ N ☐ Unk.	
☐ No appts. during review period		

Last CMngmt. Contact:	Type (F2F/PC/Consult.) + short description)	Signed/Dated/Clear?
1.		
2.		
3.		
4.		
5.		

During the review period, was the client: ☐ New to care ☐ Lost to care ☐ Re-engaged in care ☐ NA
If yes…. was there documentation of coordination of care or contact attempts? ☐ Y ☐ N ☐ NA

Does the client have an active diagnosis of the following diagnoses? (Check ALL that apply)
☐ Alcohol abuse/dependence
☐ Other substance abuse/dependence: _____
☐ Depression
☐ Bipolar disorders
☐ Anxiety disorders
☐ Schizophrenia
☐ Other: _____

Was the client referred or already engaged with MH/SA services?
☐ N/A ☐ Yes ☐ No

Does the client have any co-morbidity?
☐ Opportunistic Infection
☐ Sexually Transmitted Infections (STIs) : _____
☐ Diabetes
☐ Cancer
☐ Hepatitis
☐ Hypertension
☐ Other: _____

Was the client reported to have any of the following conditions?
☐ Homelessness
☐ Pregnancy (or other pregnancy-related conditions)
☐ Recently released
☐ IPV

INSURANCE, BENEFITS, AND INCOME INFORMATION

Health Insurance: ☐ Uninsured ☐ Medicaid _____ ☐ Medicare_____ ☐ Commercial _____
☐ VA ☐ Other? _____

Spouse/partner:	Children:	Other Dependents:	TOTAL HOUSEHOLD SIZE 1 2 3 4 5 6 7 8 9 10 Unk
Client Income $:	Spouse Income $:	Other Income $:	TOTAL HOUSEHOLD INCOME $:

Did the client lose insurance or coverage during the review period? ☐ Y N ☐ Unk. ☐
If so, were they provided with information/education or assistance? ☐ Y N ☐ NA ☐

CASE MANAGEMENT SERVICES

What types of services were provided by a **Medical Case Manager** (MCM?)	What types of services were provided by a **Service Linkage Worker** (SLW?)	Was the client referred for **Clinical Case Management** services in the review period?
☐ **NA (Client not assisted by MCM)** ☐ Comprehensive assessment ☐ Service Plan ☐ Medication adherence counseling ☐ Coordination of medical care ☐ Transportation ☐ ADAP/medication assistance ☐ Eligibility ☐ Community resource/benefits brokerage ☐ Other _____ Did client meet criteria for MCM? Y ☐ N ☐ Unk. ☐	☐ **NA (Client not assisted by SLW)** ☐ Brief assessment ☐ SLW referred client to OAMC ☐ OAMC visit scheduled by SLW ☐ SLW accompanied client to OAMC ☐ SLW called client to remind about OAMC visit ☐ Client did not keep OAMC appt. and SLW contacted them ☐ ADAP/medication assistance ☐ Transportation voucher ☐ Eligibility Were any of the above services provided by an Outreach Worker? Y ☐ N ☐ Unk. ☐	☐ **No- not applicable** ☐ No- applicable, but no referral documented ☐ Yes- and there is evidence of coordination of services ☐ Yes- and there is no evidence of coordination of services ☐ Yes- but client refused services or is already engaged in treatment

Was the case discharged/closed for CM during the review period?		Y ☐	N ☐	NA ☐	Unk. ☐
If yes.....	Client met agency criteria for closure?	Y ☐	N ☐	NA ☐	Unk. ☐
	Client completed treatment program (CCM)	Y ☐	N ☐	NA ☐	Unk. ☐
	Date and reason noted?	Y ☐	N ☐	NA ☐	Unk. ☐
	Summary of services received?	Y ☐	N ☐	NA ☐	Unk. ☐
	Referrals noted?	Y ☐	N ☐	NA ☐	Unk. ☐
	Instructions given to client at discharge?	Y ☐	N ☐	NA ☐	Unk. ☐

ASSESSMENTS & SERVICE PLANS

		If no assessment or plan:		
Brief Assess. Date 1:	Brief Assess. Date 2:	☐ evidence of one just outside of review period	☐ reason documented	☐ enough info to complete
Comp. Assess. Date 1:	Comp. Assess. Date 2:	☐ evidence of one just outside of review period	☐ reason documented	☐ enough info to complete
Service Plan Date 1:	Service Plan Date 2:	☐ evidence of one just outside of review period	☐ reason documented	☐ enough info to complete

COMPLETED ASSESSMENTS

	MOST RECENT ASSESSMENT TYPE (circle one) Comprehensive Brief					NEXT MOST RECENT ASSESSMENT TYPE (circle one) Comprehensive Brief				
Domain	Assessed?	Need Identified?	Accounted for in Service Plan?	Accounted for in progress notes?	Follow-up (referral, action, etc.)	Assessed?	Need Identified?	Accounted for in Service Plan?	Accounted for in progress notes?	Follow-up (referral, action, etc.)
Medical/Clinical										
Vaccination										
Nutrition/Food Pantry										
Dental Care										
Vision Care										
Hearing Care										
Home Care Needs										
Basic Necessities/Life Skills										
Mental Health										
Substance/Alcohol Use										
Abuse History										
Housing/Living Situation										
Support System										
Child Care/Guardianship										
Insurance Benefits										
Transportation										
HIV-Related Legal										
Cultural/Linguistic										
Self-Efficacy										
HIV Education/Prevention										
Family Planning/Safer Sex										
Employment/Income										
General Education/Vocation										
Financial Assistance										
Medication Adherence										
Client Strengths										
Other										

Providing Innovative Interventions to Support Linkage, Re-engagement, and Retention in Care to Help End the HIV Epidemic

May 12, 2021

Shanice Bailey (/member/shanicebailey), National Alliance of State and Territorial AIDS Directors

National Alliance of State & Territorial AIDS Directors' (NASTAD) Center for Innovation and Engagement (CIE)

As public health professionals, educators, and HIV care providers, it is imperative that we develop truly innovative approaches to address the health and social needs of communities and advance health equity. NASTAD, a leading non-partisan non-profit association that represents public health officials who administer HIV and hepatitis programs in the U.S, is committed to dismantling systemic barriers to care, recognizing social justice as a vital tool in our mission to end the intersecting epidemics of HIV, hepatitis, and other related conditions.

To achieve this goal, linkage, re-engagement, and retention in care are essential. There's no need to reinvent the wheel: as the COVID-19 pandemic has shown us in myriad ways, historical knowledge is an invaluable asset for public health – and when it comes to HIV care, there is a wealth of knowledge and years of interventions to revisit. Ryan White HIV/AIDS Program providers are uniquely positioned to consider the replication of these interventions to enhance care outcomes of people with HIV.

Over the last three years, NASTAD has worked with Northwestern University's Center for Prevention Implementation Methodology and Howard Brown Health to tap into this collective knowledge. The Center for Innovation and Engagement (https://ciehealth.org/about/) (CIE) is a HRSA Special Projects of National Significance (SPNS)-funded collaboration that identifies and catalogs evidence-based (EB) and evidence-informed (EI) interventions, and transforms them into actionable tools, innovative frameworks, and adaptable resources for engaging and retaining people in HIV care.

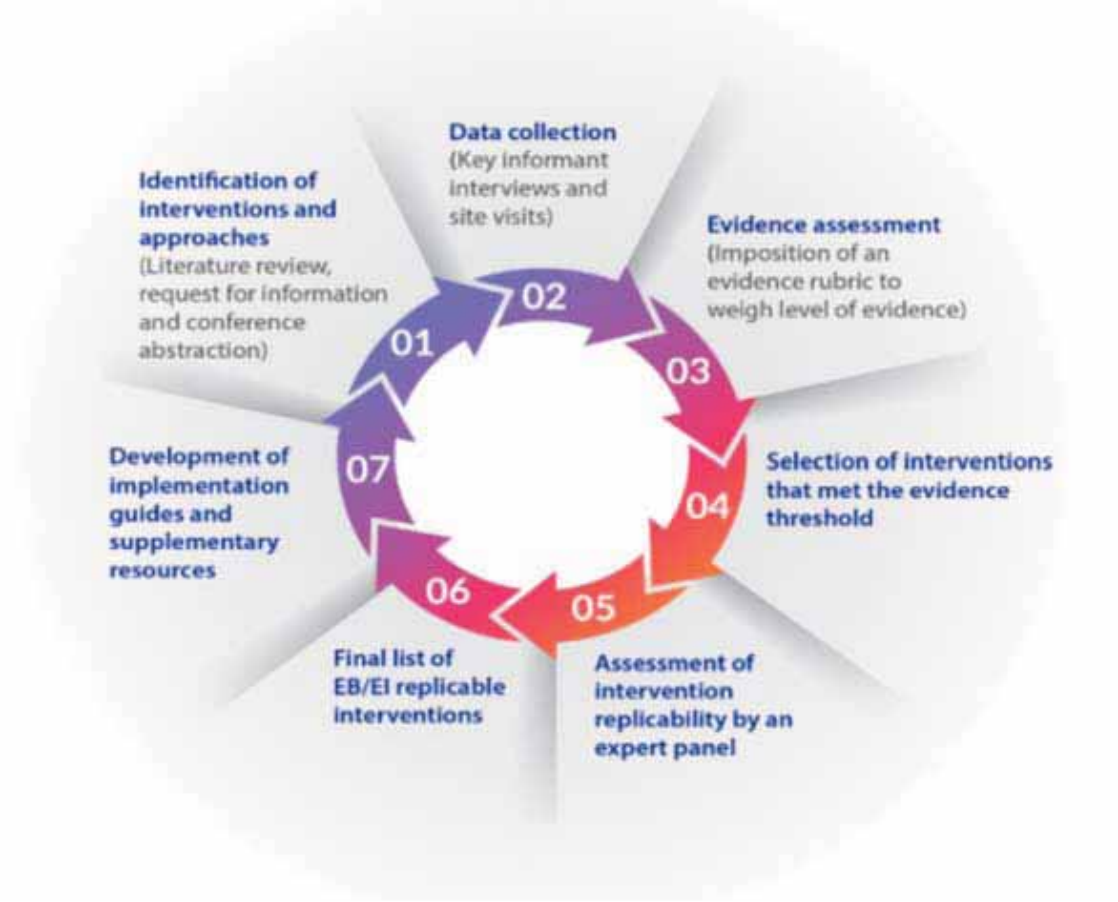
The recently launched CIE website (https://ciehealth.org/) details the process of identifying and cataloging these interventions and serves as a resource inventory that supports real-world replication. The Interventions (https://ciehealth.org/interventions/) section houses implementation guides and background summaries based on EB/EI interventions that were vetted by researchers and public health professionals. This section provides 14 "ready to replicate" interventions for clinicians looking to integrate new approaches to support people with HIV. The CIE website also features the Innovations Lab (https://ciehealth.org/innovations-lab/), which highlights tools to help providers innovate while they replicate, such as tip sheets, blogs, and a cost calculator. Resources are also available on https://targethiv.org/CIE (https://targethiv.org/CIE).

The development of CIE is a result of a rigorous three-year process. Throughout this time, NASTAD collaborated with external partners to:

- identify EB/EI interventions; gather information from intervention developers and program staff through in-depth key informant interviews;
- weigh the level of evidence through an evidence rubric;
- assess replication feasibility; and
- package the data gathered into replicable tools.

The diagram below depicts this journey.

Development of the Center for Innovation and Engagement (CIE) Resources



For example, the Bilingual/Bicultural Care Team intervention (https://ciehealth.org/intervention/bilingual-bicultural-care-team/) is a service delivery model based out of Kansas City, MO aimed at increasing retention in care and viral suppression for people with HIV who identify as Hispanic/

Latinx and speak Spanish as their primary language. The intervention featured Latinx providers who provided comprehensive culturally and linguistically responsive HIV primary care and services to the client population, highlighting the efficacy of engaging with most impacted communities in ways that suit their needs.

We invite you to explore the other interventions currently detailed on the CIE website and join our listserv (https://ciehealth.org/contact/) to be the first to know about the additional interventions, implementation guides, and supplementary resources. Check out our CIE welcome video (https://www.youtube.com/watch?v=kIN2GHYLAyo&t=15s) to get started exploring.

CIE is a HRSA Special Projects of National Significance (SPNS)-funded project that identifies, catalogs, disseminates and supports the replication of evidence-informed approaches and interventions to engage people with HIV who are not receiving care, or who are at risk of not continuing to receive care.

About Shanice Bailey (/member/shanicebailey)

National Alliance of State and Territorial AIDS Directors
Senior Associate, Health Equity

View all posts by Shanice Bailey (/user/4756?qt-user_profile=sharespot-posts)

nam aidsmap
HIV & AIDS – sharing knowledge, changing lives

Improving HIV care

Medical mistrust is linked to discrimination, poor care engagement, and low adherence among Black adults in the US

Oğuzhan Nuh | 21 March 2022

Monkey Business Images/Shutterstock.com

Perceived discrimination due to race, HIV status and sexual orientation combined with mistrust of healthcare organisations, physicians and HIV information were found to be negatively associated with adherence to HIV treatment and engagement in care among Black adults in the US. According to the study by Dr Lu Dong of the RAND Corporation and colleagues, recently published in the *Journal of Behavioral Medicine*, healthcare providers and organisations need to address medical mistrust to improve the health and well-being of Black Americans living with HIV.

According to the Centers for Disease Control and Prevention (CDC), 42% of new HIV infections in 2019 in the US were among Black Americans. However, compared to other races and ethnicities, Black Americans are less like to receive and stay in HIV care, adhere

to antiretrovirals, and be virally suppressed. Studies show that one of the reasons for these HIV-specific inequities is the intersectional stigma associated with structural discrimination based on race, gender, sexual orientation, and HIV status.

The researchers collected data from 304 Black Americans living with HIV from Los Angeles County, who were also participants of an ongoing randomised control trial. The data collected between 2018 and 2020 was analysed to examine the mediating role of medical mistrust between discrimination and HIV care engagement, and between discrimination and treatment adherence.

Glossary

stigma

randomised controlled trial (RCT)

virological suppression

Participants were asked to fill out a questionnaire measuring medical mistrust and experiences of discrimination. Medical mistrust was measured in three categories. Mistrust towards health organisations was measured by their level of agreement with seven statements such as “patients have sometimes been deceived or misled by health care organizations” and "mistakes are common in health care organizations”. Mistrust towards one’s physician was measured with eleven items such as “I trust my doctor so much I always try to follow his/her advice" and “I sometimes distrust my doctor’s opinions and would like a second one”. Mistrust in HIV-specific information was measured with the HIV conspiracy beliefs subscale consisting of statements like "HIV is a man-made virus" and "The medication used to treat HIV causes people to get AIDS."

Perceived discrimination was measured based on experiencing ten different events due to three types of stigma: being Black, living with HIV and being gay. Treatment adherence was measured using a Medications Event Monitoring System (MEMS), which collects the time and date of the medication bottle being opened for a month. Lastly, being engaged in HIV care was defined as having one or more visits and no more than one missed appointment in the past six months.

The majority of the participants (81%) were men; 89% were single; 56% identified as gay, 26% as heterosexual, and 13% as bisexual. Average time since HIV diagnosis was 16 years. Only 16% of participants reported working full-time or part-time, and 52% said they had had unstable housing in the last 12 months.

Participants reported experiencing the most discrimination due to being Black, followed by sexual orientation and HIV status. Mistrust towards health organisations was rated higher among participants than mistrust towards HIV-specific information and one's physician.

In their first analysis, the researchers found that each type of discrimination was significantly associated with each type of medical mistrust.

Then they examined the relationships between discrimination, mistrust and engagement in care. Each type of discrimination was found to be associated with poor engagement in care, and in each case this was mediated through medical mistrust (a combined measure of the three types). Therefore, the researchers suggest that interventions targeting all three types of medical mistrust may increase engagement in care.

Each type of discrimination was also associated with poor engagement in care, mediated through mistrust towards one's

physician. This indicates that mistrust towards a physician may influence and determine the effects of perceived discrimination on engagement in care. In addition, discrimination due to HIV status was associated with poor engagement in care, mediated through mistrust towards HIV information. This suggests that experiences of discrimination due to HIV status may increase mistrust towards HIV information and reduce care engagement in turn.

Similar analyses were done for adherence. Each type of discrimination was associated with poor adherence, again mediated through the three types of medical mistrust. In addition, perceived discrimination due to sexual orientation was also directly associated with poor adherence.

Although there has been a number of interventions aiming to increase the trust in physicians by increasing providers' cultural competency and empathy, researchers note that "these interventions have not specifically addressed medical mistrust and have generally not shown effects on increasing trust, nor are they specifically tailored for HIV care."

They conclude: "Interventions at the provider level as well as healthcare organisation level are needed to reduce patients' experience of discrimination within healthcare settings and increase providers' ability to acknowledge and address medical mistrust in a sensitive manner, thereby improving patients' health-related outcomes such as medication adherence, care engagement, and clinical outcomes."

References

Dong L et al. *Discrimination, adherence to antiretroviral therapy, and HIV care engagement among HIV-positive black adults: the mediating role of medical mistrust.* Journal of Behavioral Medicine, online ahead of print, 13 January 2022.

https://doi.org/10.1007/s10865-021-00277-z

The Community Health Worker Role on the HIV Care Continuum

A Community Health Worker (CHW) is a member of the health care workforce who reduces the burden and stress of large caseloads and enhances traditional Ryan White HIV/AIDS Program care teams. This fact sheet is an introduction to CHWs. It defines CHW, lists other titles by which CHWs are referred, describes how CHWs enhance HIV care teams, and identifies the roles CHWs perform.

CHW Defined

As defined by the American Public Health Association, a "CHW is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities, such as outreach, community education, informal counseling, social support, and advocacy."[1]

CHWs Are Also Known As . . .

CHWs are known by a variety of titles. Some of the most common are:

- Peer Educators
- Outreach Workers
- Patient/Peer Navigators
- Peer Counselors
- Health System Navigators
- Linkage to Care Coordinators

How CHWs Enhance HIV Care Teams

CHWs enhance HIV care teams by working in partnership with case managers, nurses, doctors, social workers, and other service providers to address the medical, social, and economic needs of people living with HIV (PLWH). CHWs are often referred to as a bridge between the client, the community where the client lives and medical clinics or community-based organizations. As such their work is bi-directional. CHWs have a role in improving the health of clients and their communities and they also influence the program and the clinical setting in which they function. CHWs unique ability to connect with the community can have an impact on all aspects of the *Triple Aim*: "improving client experience, improving health care, and lowering cost."[2]

Within HIV care, CHWs are a bridge between HIV clinics and support service agencies and health care organizations.

CHW Roles

The *Community Health Worker Core Consensus Project* (C3) developed 10 core CHW roles. Although these roles are not HIV-specific, they can be used to develop tasks and responsibilities for CHWs on your HIV care team.

The following table lists the CHW roles developed by C3 and provides an example of how each role is performed in one or more stages of the HIV Care Continuum.

CHW Role[3]	How the Role is Performed Across the HIV Care Continuum
1. Cultural Mediation Between Individuals, Communities and Health and Social Systems	Support and increase linkage to and retention in care and adherence to treatment by educating clients about treatment and the appropriate use of services
2. Providing Culturally Appropriate Health Education and Information	Improve adherence to treatment by providing structured educational sessions on topics such as HIV, viral life cycle, treatment, and side effects
3. Care Coordination, Case Management, and System Navigation	Support retention in care by assisting clients with referrals for transportation, housing, behavioral health treatment, and other support services
4. Providing Coaching and Social Support	Support retention in care and treatment adherence by providing emotional support to clients
5. Advocating for Individuals and Communities	Support the entire HIV Care Continuum by serving on Ryan White Planning Councils
6. Building Individual and Community Capacity	Support retention in care and reduce barriers by collaborating with medical, behavioral health, and social services providers
7. Providing Direct Service	Support treatment adherence by picking up prescriptions for clients and educating them on the medication and its side effects
8. Implementing Individual and Community Assessments	Support linkage to and retention in care by working with case managers to assess clients' needs and develop care plans
9. Conducting Outreach	Support linkage to and retention in care by re-engaging clients lost to follow-up
10. Participating in Evaluation and Research	Document activities in electronic health records

References

[1] American Public Health Association. n.d. Community Health Workers. Available at: https://www.apha.org/apha-communities/member-sections/community-health-workers

[2] Berwick DM, Nolan TW, and Whittington, J. (2008) The Triple Aim: Care, Health Cost. *Health Affairs*. 27(3):759–769

[3] Amended from Rosenthal EL, Rush CH, and Allen CG. (2016) Understanding Scope and Competencies. A Contemporary Look at the United States Community Health Workers Field. Progress Report of the Community Health Worker (CHW) Core Consensus Project. Building National Consensus on CHW Core Roles, Skills, and Qualities. Available at: http://www.chwcentral.org/understanding-scope-and-competencies-contemporary-look-united-states-community-health-worker-field