

The Department of Health

To promote and protect the health and safety of all Floridians



MINORITY AIDS INITIATIVE- ANTIRETROVIRAL TREATMENT ACCESS STUDY

Standards & Guidelines

Handbook

2007



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MAI-ARTAS Standards and Guidelines Acknowledgements

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MAI-ARTAS Standards and Guidelines

Introduction

Strengths-Based Care Coordination reflects a tradition begun by practitioners at the University of Kansas working with people suffering from mental illness who returned to the community. Under strengths-based care coordination, the care coordinator and client collaborate to assist the client in achieving goals that he or she identifies as valuable or important. It emphasizes client strengths as a way of achieving these goals. After successful demonstration with the de-institutionalized population for which it was developed, Wright State University (Dayton, Ohio) researchers and practitioners utilized this approach with substance abusers to help retain them in aftercare services. Evaluation of the Wright State methods demonstrate success with resistant substance abusers in the areas of diminished drug use, access to better employment, and less post-treatment criminality.

The Strengths-Based Care Coordination, known as Antiretroviral Treatment Access Study (ARTAS) was originally a pilot program completed by the Centers for Disease Control and Prevention (CDC). The pilot program was in four cities: Miami, FL; Atlanta, GA; Baltimore, MD; and Los Angeles, CA. The study was published in *AIDS* 2005, 19:423-431. Four sites enrolled newly diagnosed HIV-infected clients to study their adherence needs. It determined that a higher percentage of persons who received the strength-based intervention remained in care than those who did not receive it.

In October 1998, President Clinton declared HIV/AIDS to be a severe crisis in racial and ethnic minority communities. The Department of Health and Human Services held discussions with the Congressional Black Caucus (CBC) about ways to enhance the fight against HIV/AIDS – especially in African American communities. The CBC is an organization representing African American members of the Congress of the United States founded in January 1969. The Caucus describes its goals as "positively influencing the course of events pertinent to African Americans and others of similar experience and situation," and "achieving greater equity for persons of African descent in the design and content of domestic and international programs and services."

Championed by the CBC, President Clinton announced and Congress funded an initiative to address this crisis through increased funding and outreach. In response, the Department announced a special package of initiatives aimed at reducing the disproportionate impact of HIV/AIDS on racial and ethnic minorities. In 2000, the Minority AIDS Initiative was created to include all communities of color.

Initially, MAI was not a part of the Ryan White CARE Act (RWCA), but the CBC worked to get MAI into the RWCA. The MAI in the RWCA expands and strengthens the capacity of minority community-based organizations (MCBO) to deliver high-quality HIV/AIDS healthcare and supportive services to underserved groups. It addresses disparities by providing funding for the creation/improvement of HIV service capacity in minority communities and enables MCBO to deliver culturally competent and linguistically appropriate healthcare.

Since 2004, the Florida Department of Health (Department) has implemented the ARTAS methodology under the MAI through Ryan White Title II. MAI-ARTAS uses strengths-based case management to target recently diagnosed HIV clients or those that know of their positive HIV status and have not accessed available care. Once we identify the client, the client meets with a care coordinator. The ultimate goal of ARTAS is to have the client access medical care services. Other expected outcomes for the

client are to identify treatment-supporting goals, such as becoming their own medical advocate, obtaining stable housing (if applicable), and achieving a more stable lifestyle.

We can generally divide the MAI-ARTAS intervention into three phases. In Phase I, the emphasis is on client engagement by assessing client strengths and developing plans based on the strengths identified by the client. Phase II is built on effecting the elements of the plan. Phase III recognizes that disengagement from MAI-ARTAS is imminent and assists the client in obtaining care and social services.

Assessment and planning activities will occur throughout the client's involvement with the project. Modification is necessary depending upon emerging needs. We anticipate however, that the focus of Phase I and perhaps Phase II will be identifying and then reducing external and internal barriers to medical care engagement and retention. Phases II and III will focus on the achievement of client-defined goals, such as finding stable housing and substance abuse treatment or mental health services. A further focus of Phase III will be on disengagement from the MAI-ARTAS care coordination and transition to a productive alliance with appropriate case management agencies.

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Chapter 1 - General Information

Objective	<p>The objective of MAI-ARTAS is to target recently diagnosed HIV clients or those that have known of their positive HIV status and have not accessed care for six months or greater, and effectively link these clients with medical care. According to an ARTAS assessment completed by the Centers for Disease Control & Prevention, Division of HIV/AIDS Prevention, “a brief intervention by a case manager was associated with a significantly higher rate of successful linkage to HIV care. Brief case management is an affordable and effective resource that can be offered to HIV-infected clients soon after their HIV diagnosis” (Anderson-Mahoney et al., 2004).</p> <hr/>
Strengths-Based Case Management Defined	<p>Strengths-Based Case Management establishes a partnering relationship between client and care coordinator. The care coordinator and the client collaborate to assist the client in achieving goals that he or she identifies as valuable or important. It emphasizes <i>client strengths</i> as a way of achieving these goals.</p> <hr/>
Target Population	<p>Recently diagnosed HIV clients or those that have known of their positive HIV status and have not accessed care for at least six months. In Florida, there is an estimate of 125,000 individuals infected with HIV; of these 20-25% or 25-31,250 people are aware of their HIV status and have still not accessed available care.</p> <hr/>
Eligibility Requirements	<p>The minimum eligibility for the MAI-ARTAS Program includes the following:</p> <ul style="list-style-type: none">• Infected with HIV• Not in care for 6 months or more• Living in Florida• 18 years of age or older <hr/>
Intake Defined	<p>The intake is separate from the assessment. We use it to obtain personal and contact information from the client. It can be completed during the visit/contact if the care coordinator or agency chooses.</p> <hr/>

MAI-ARTAS Standards & Guidelines
Chapter 1 - General Information

Security Procedures

The Department of Health has written security policies, protocols, and procedures to ensure the security of information and protect confidentiality, data integrity, and access to information. This policy is titled, Information Security, Policy DOHP 50-10-05, and is effective as of April 15, 2005. To review this information in more detail, visit dohiws.doh.state.fl.us/Training_Opportunities/Security.

ARTAS providers shall comply with all state and federal laws, including but not limited to, Florida Statutes, 384.29, 392.65, 456.057, 381.004(3)(e), and 381.004(6). ARTAS providers' policies and procedures must ensure the protection and confidentiality of all matters related to the client and must be consistent with the Department of Health Information Security Policy, DOHP 50-10-05.

Examples of security procedures are as follows:

- Locked briefcase or container
 - Dead bolt lock on door
 - Locked file cabinet (bar lock recommended)
 - Limited access to records
 - Log for room entry
-

**MAI-ARTAS Standards & Guidelines
Chapter 2 - Personnel**

General

ARTAS providers are required to update, in writing, the Department of Health contract manager upon any change or addition in ARTAS personnel, within seven (7) days.

**Care Coordinator
Qualifications**

Applicants for the position of Care Coordinator must hold a Bachelor's degree in a human services field or equivalent experience. The applicant for this position must be open and receptive to the strengths-based approach and learning new ways of helping people. In addition, the applicant should have basic counseling skills and understand the situations of potential clients. Applicants should be able to communicate effectively both verbally and in writing.

Supervisor Qualifications

Applicants for the position of Supervisor must hold a Bachelor's degree in a human services field, or equivalent experience. The applicant for this position must understand and be receptive to the strengths-based approach.

**Clerical Support Staff
Qualifications**

Applicants for the position of Administrative Support Staff should possess at least a high school diploma and must have experience in data entry. In most cases, the support staff is the first person the client is in contact with when they visit the agency. For this reason, the applicant for this position should be warm, courteous, and accepting of individuals from diverse backgrounds. Keep in mind the applicant for this position will be handling confidential information and should have thorough knowledge of the laws pertaining to the handling of this type of information.

**Employee-Client
Confidentiality**

Employees must maintain the confidentiality of all client records, correspondence, and conversations. Florida law provides penalties for those who breach the confidentiality of a person who has taken an HIV test, is HIV-infected, has a case management record, or medical record. ARTAS providers shall comply with all state and federal laws, including but not limited to, Florida Statutes, 381.004(3) (e), and 381.004(6).

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Phone Calls

Make all telephone calls discussing confidential information from an area that ensures confidentiality.

- Cell phones are not secure, so do not use them for confidential phone calls, unless the client consents.
- Inform the call recipient that the call is taking place on a cell phone.
- Employee must determine the identification of the caller and disclose only the information that is legal to disclose (does not violate client confidentiality).

Mail

Use a secure mail intake site to receive incoming confidential information.

- Mailrooms and mailboxes must be secure to prevent unauthorized access to incoming and outgoing mail.
- Double enveloping is required for mailing confidential information. The outside envelope is addressed to the recipient. The inside envelope must be marked confidential and include the recipients name.

Faxes

Only fax confidential information in a medical emergency or with the written consent of the client.

- Fax machine must be in a secured area.
- Fax Cover Sheets must have the appropriate language written on them. This language should state, "This transmission may contain material that is confidential under federal law and Florida Statutes and is intended to be delivered only to the named addressee. Unauthorized use of this information may be a violation of criminal statutes. If the recipient of this information is anyone other than the addressee, the recipient shall immediately notify the sender at the address or telephone number above and obtain instructions as to the disposal.

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Chapter 2 - Personnel

Under no circumstances shall the material be shared, retained, or copied by anyone other than the “named addressee”.

- If staff faxes medical information, there must be a permanent copy in the record and documentation in the client notes.

Email

The use of email to correspond or to communicate with clients or about clients requires specific precautions in order to avoid a breach of confidentiality.

- Confidential emails must be encrypted (alter information using a code as to be unintelligible to unauthorized readers).
 - Confidential information attached to emails must be encrypted.
-

MAI-ARTAS Standards & Guidelines

Chapter 3 - Care Coordinator Training

Training Objective

The objective of Care Coordinator Training is to provide opportunities for training in all aspects of HIV/AIDS, the strengths-based approach, and cultural competence. This training should create a better understanding of the needs of ARTAS clients, familiarity with required contractual documentation, accurate completion of monthly reports, understanding of the monthly reporting process, and the importance of confidentiality.

Training Requirements

At a minimum, Care Coordinators must participate in the following:

- Initial orientation on the MAI-ARTAS Standards & Guidelines to include a special orientation into the aspects of the strengths-based approach
- Introduction to the applicable federal, state, and local referral resources and programs
- Completion of HIV/AIDS 500 & 501 courses, in order to gain an understanding of the basics of HIV/AIDS, counseling, testing, and linkage
- Attendance at annual meetings

In addition, ARTAS staff should receive routine training pertaining to agency policies and practices and should have access to community training that is necessary for professional development.

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Chapter 4 - Client Files

Client File Organization

ARTAS providers' client record system should include files, which securely hold and organize materials. Label all ARTAS client files, at a minimum, in the following order:

- Intake/Eligibility
 - Strengths Assessments
 - Contact Plan
 - Contact Notes
 - Referrals
 - Discharge/Termination
-

Client File Storage

ARTAS providers shall provide an appropriate storage system for the hard copy client files. At a minimum, the system should include files that securely hold and organize materials. Place these files in a cabinet or room with a lock on the door where there is no public access. Security suggestions for file storage are as follows:

- Locked briefcase or container
- Secure lock on door
- Locked file cabinet (bar lock recommended)
- Limited access to records

ARTAS providers shall comply with all state and federal laws, including but not limited to, Florida Statutes, 384.29, 392.65, and 456.057. ARTAS providers' policies and procedures must ensure the protection and confidentiality of all matters related to the client and must be consistent with the Department of Health Information Security Policy DOHP 50-10-05.

Client File Retention

ARTAS providers must retain records in accordance with the Department of State, Bureau of Archives and Records Management storage and retention procedures as mandated in Florida Statutes 119 and 257. ARTAS providers will retain client files for five (5) years from the date of completion or termination of their contract with the Department of Health. Upon completion or termination of the contract, the providers will cooperate with DOH to facilitate or duplicate all records upon request from DOH.

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Chapter 4 - Client Files

Electronic/Computer Files

The use of electronic files to gather and collect client information requires specific precautions to avoid a breach of confidentiality. ARTAS providers' policies and procedures regarding electronic files must ensure the protection and confidentiality of all matters related to the client and must be consistent with the Department of Health Information Security Policy, DOHP 50-10-05. The Department of Health Information Security Policy, DOHP 50-10-05 includes, but is not limited to, the following guidance pertaining to electronic files and information:

- Electronic information must be stored in areas with limited access.
- Encrypt all electronic mail before transmission.
- Position computer monitors as to prevent unauthorized viewing.
- Use a password to protect all computers, including laptops, and encrypt the data in accordance with Department of Health Information Security Policy, DOHP 50-10-05.
- Do not fax HIV/AIDS information except in case of medical emergency or with the written consent of the client.

Active Files

When the care coordinator meets with the client and the client agrees to enroll in the ARTAS program, the care coordinator should open the client's file.

Closed Files

Close client's file after 90 days of service *OR* after completing five (5) visits with the care coordinator, *OR* at the client's request.

Follow-Ups

Care coordinators are required to perform one (1) follow-up assessment with each client. This follow-up shall be completed at three (3) months after client file closure. There are two ways to complete follow-up. The care coordinator can contact the client or medical provider. Be sure to receive consent from the client (get in writing) to speak with his or her medical provider. In completing follow-up, the care coordinator wants to know if the client has seen a physician, the date of the last appointment, and if the client is enrolled in ADAP. Follow-up is very important because it provides us with the data we need to determine how many clients get linked to medical care and other programs, such as,

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Chapter 4 - Client Files

ADAP. This information also assists in evaluation of programs to ensure interventions are effectively reaching the targeted population.

Re-enrollment

A client may re-enroll in the ARTAS program only one time after the client has been out of care for a period of six (6) months or greater.

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Chapter 5 - Strengths Assessments

Strengths Assessment Objective

The strengths assessment is the entrée into the care coordinator-client relationship. It is the first step in forming a therapeutic alliance between the two. Use the assessment to identify and highlight the potential strengths that the client can apply to help resolve problems or barriers that might impede linkage with medical care. It allows the care coordinator to begin steering the client away from inaction brought on by thoughts of problems and failures that may be dominating their perceptions of their current situation. The objective is for the care coordinator and client to collaborate to assist the client in achieving goals that he or she identifies as valuable or important. By emphasizing client strengths as a way of achieving these goals, the client can link to and engage medical care effectively.

Strengths Assessment Introduction

The MAI-ARTAS Strengths Assessment is modeled after the strengths assessments used with persons who have substance abuse and mental health problems. A strengths assessment is a comprehensive summary of a client's life across multiple life domains. The MAI-ARTAS Strengths Assessment has a more limited focus on areas that will encourage contact, engagement and retention in medical care. Despite the different emphasis, the steps involved in initiating it are similar to other strengths assessments. The concept of the strengths-based approach of case management places self-determination as the central value and helps clients identify strengths to achieve the outcomes they desire. This contrasts with the medical model of case management, where the client and their problem resolution are dependent on professional expertise. The differences between the strengths-based approach and the medical model of case management are outlined in detail in Appendix E. The strengths assessment form is an optional tool for the care coordinator to use in assisting with the strengths assessment. Keep in mind that the tool should not be used by the care coordinator to simply ask the client every question (like an interview), but to arrive at the answers to the questions during regular conversation with the client.

Conducting Strengths Assessments

The strengths assessment will begin in the first or second contact and continue, to varying degrees, as the relationship between client and care coordinator unfolds. The care coordinator will set the stage for what is to follow, which is an emphasis

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Chapter 5 - Strengths Assessments

on the client's past and present abilities, skills, assets, and strengths to handle difficult situations.

The care coordinator should acknowledge difficulties and failures, but the main purpose of the assessment is to help the client focus on past successes. This assessment is important for the client and may be helpful to the care coordinator who may be new to the strengths-based approach. Although the specific introduction will be guided by the client's particular characteristics, e.g., reading level, cognitive ability, and previous experiences, an introduction to the Strengths Assessment might proceed as follows:

(Care Coordinator) "One of the activities that can help guide you in identifying your needs and creating your goals is called a 'strengths assessment'. This assessment is very different from past assessments that you might have participated in. It will help you to recognize your strengths, skills, abilities, and things that you are good at doing. We have found that when people recognize what they are good at, it helps them complete difficult tasks to get what they need for themselves and their families. Again, knowing where you have been successful in the past can help you be successful in the future as you begin making changes. You may already know of these strengths or they may be something that you have not thought about for a long time. It may be difficult to keep the focus on strengths because society tells us that it is boasting or bragging to talk about what we have done right. I do not think that is the case. I think it reminds us of how we can get what we need. A good example of a strength is your decision to participate in this program. It will involve some time on your part and sharing information about yourself. Those steps take courage and a sense of responsibility to you and your community. Those are the kinds of actions and thoughts that you can use to help achieve your goals."

Clients may respond to this opening statement in many ways. They may tell the care coordinator that they are here only because a nurse or counselor told them to be. They may be suspicious of the care coordinator's intentions in stressing strengths or may be appreciative of positive observations made. The care coordinator's goal is to help the client recognize that for anything to get accomplished, it has to be done by the client and it is more useful to start from strengths rather than weaknesses.

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Chapter 5 - Strengths Assessments

Documentation (Also see Chapter 7)

When the client and care coordinator agree on the client's strengths and abilities, the care coordinator should record them on the Strengths Assessment form and give the client a copy (Appendix A). Strengths recorded at this time could include concern about self or others; the fact that the client has met obligations to his family and has been able to care for himself or herself in difficult times; and strengths, assets, skills, and abilities shared by the client. Be sure the client identifies strengths and not the care coordinator. The care coordinator should simply assist the client with identifying strengths.

A care coordinator can take two approaches in conducting the strengths assessment; both can accomplish relationship building, information gathering, and encourage the client to begin thinking in terms of positive resources they can utilize.

In the first approach, the care coordinator may initiate the discussion with very general 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?"
- "Was there a time that you felt like most things were going well? What were you doing to make them go well?"

A general discussion will allow both the care coordinator and the client to note a wide range of strengths, many of which will be applicable to the client's goals of linkage and adherence to medical treatment.

The second approach allows the care coordinator to use the MAI-ARTAS Strengths Assessment to explore potential areas of strengths with persons who are reticent to talk about themselves or are very concrete in their thinking. The care coordinator could introduce this approach by:

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(Care Coordinator) "I've found that some of the following strengths are valuable to a person who is facing a situation like yours. We can go through part of the list and see what fits for you."

The Strengths Assessment (Appendix A) contains a list of strengths, assets, and skills in six areas. This list should help to stimulate discussion. This should help to establish a positive relationship and lead clients to believe they possess the ability to maintain medical treatment adherence. This list does not cover strengths in all areas of life. The care coordinator and client need not address every item on the list and can certainly add items to the list. Remind the client that there are no correct answers and that some of the items on the list may not apply to them.

In either of the options, the care coordinator should engage the client in a discussion of relevant items. The goal of the discussion is not to complete a list, but to help the client remember how they were able to solve problems, based on their own abilities. The care coordinator should record the necessary information on the client's contact plan.

Remember the strengths assessment is an on-going process rather than a single event. Clients will choose to share information and experiences on their own terms, possibly at times when they and the care coordinator least expect it. For this reason, the care coordinator should continue to emphasize the search for strengths and abilities in every contact with a client, whether working on the contact plan or while engaging in general conversation. By conducting the strengths assessment in a *flexible, conversational manner*, the care coordinator provides the client with every opportunity to pick his or her own time to share.

Disclosure

Disclosure of their HIV-infection, may be one of the hardest things to do and could be a barrier to achieving other goals. Be sure to assist clients in determining who to tell and how to tell others about their status. Include how to deal with reactions from family and friends. This should be discussed carefully and with sensitivity toward the client.

Disengagement

During the first year of the MAI cycle, providers

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identified disengagement as one of the most difficult issues for successful implementation of the program. Strengths-based case management is different from traditional case management in that the client's enrollment is not indefinite. For this reason, care coordinators must emphasize to the client on the first face-to-face contact what they can and cannot expect from the ARTAS program. For example, the care coordinator should concretely describe that there are only five (5) face-to-face contacts and the initial face-to-face visit counts as the first contact. The care coordinator should also explain in detail that this is temporary/short-term case management designed to prepare the client to be more self-reliant and transfer to other case management as needed. Care coordinators should be aware of and avoid the tendency for client and care coordinator to cling to each other, thus enabling the client to feel he or she needs the care coordinator.

General Observations

Consider the following points when conducting the strengths-assessment:

- The care coordinator must believe in the search for strengths and abilities. This does not mean stretching for strengths, but simply assisting the client to develop ways of identifying their strengths and how to use them to become self-sufficient in medical care. Many clients are extremely adept at spotting someone who is being condescending or patronizing. Do not diminish or trivialize client-identified strengths.
- Many people have to confront different negative events in their lives. These events may involve being a victim of violence, condemnation of their lifestyle, or a serious life-threatening disease. The strengths assessment stands out as a significantly different approach for addressing needs. It may be necessary to re-focus clients back to strengths and away from an endless discussion of problems and deficiencies.
- Care coordinators should remind themselves and their clients that they are not ignoring important problems in doing the strengths assessment. The focus on strengths and abilities will prepare them for the next step: identifying objectives that are important to them to help link them to medical care, as well as

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taking important steps to obtain stable housing and/or mental health services.

- Be careful about reaching too far to find strengths. For instance, it would not be appropriate to suggest this: "You've been a successful sex worker, let's talk about your strengths in that area." If a client suggests this type of strength, make sure to prompt them to identify those generic strengths and abilities that can be readily adapted to an activity like seeking HIV medical care.
- The care coordinator need not cover every item listed on the Strengths Assessment and the client should feel free to add other points.
- Periodically summarize strengths that you have heard, even if the client has not explicitly stated these as strengths and check with the client to see whether they perceive those actions, thoughts, or feelings as strengths. Do not merely impose your view of something as a strength, but assist the client in making that decision. Ultimately, it is the client's perception of something as a positive in their life that will mobilize them to solve current problems.
- Avoid acting as "inquisitor" or "investigator." Assume a role as "consultant" and "facilitator" in the search for abilities.
- Keep the goal of the strengths assessment oriented toward identifying goals of obtaining and adherence with medical treatment, getting the most out of it and looking towards maintaining their health and bettering their employment, economic and family/social situation.
- The client should identify each goal.

Non-Strengths Assessment Information

Good clinical practice requires that care coordinators collect assessment information that is not "strengths based", but is important in helping the client and care coordinator identify barriers to treatment and the need for referral to various resources.

When collecting this type of information, the care coordinator should remember to treat the client as an individual and not just as a member of a group with problems. Handle questions regarding safety as dictated by agency protocol. Be sure to follow state laws, such as reporting suspected child abuse. If possible, convert other information reported by

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the client into goals, barriers to achieving them, and plans to overcome the barrier. It is important to be sensitive to individuals with risk factors for suicidal ideations, harm to others, and domestic violence.

This information includes:

- Suicidal ideation, attempts, or prevention
- Domestic violence or risk to do harm to others
- Physical problems associated with substance abuse, including risk of overdose, delirium tremens, or drug withdrawal
- Inherent limitations such as not being able to read, having learning difficulties, physical impairments, etc.
- Take into consideration any other medical and/or mental health problems.

Strengths Assessment Requirements

Policies and Procedures for Assessments

- 1) Five (5) face to face contacts, with a minimum of two (2) face-to-face contacts **OR** ninety (90) days of service may be provided to each ARTAS client.
- 2) The second face-to-face contact must include an educational component that emphasizes medical treatment adherence, transmission of HIV/AIDS to sex and needle sharing partners, and healthy lifestyle choices (*see educational session*).
- 3) The initial assessment must be completed within five (5) days of first contact.
- 4) The care coordinator and client may have phone contact as needed with no limitations.
- 5) During the initial assessment, the care coordinator must provide the following information to the client:
 - a) Provider information
 - b) ARTAS Clients rights and responsibilities (Appendix D)
 - c) Client's right to confidentiality
 - d) Clear explanation of ARTAS guidelines regarding assessments and disengagement
- 5) Complete strengths assessment form upon client discharge/termination and update after every client contact.
- 6) Contact plan- *see Chapter 6* (Appendix B)
- 7) Contact notes (Appendix C)
- 8) An agency may re-enroll a client in the ARTAS program once, but only after the client has been out of care for a period of six (6) months or greater.

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Chapter 5 - Strengths Assessments

Educational Session

As a new requirement, the second face-to-face contact has to include an educational component. This includes counseling on the transmission of HIV, the importance of medical adherence, and making good choices for a healthier lifestyle. Handing out brochures, PowerPoint presentations, role playing, articles (newspaper, magazines, health journals, etc.) and other educational materials may accompany this counseling. Other information as it pertains to HIV/AIDS may also be discussed. It is very important to document this contact and exactly what type of educational materials were used (if any). Please be specific in documenting what was covered, that is discussed, during this contact.

Important note: Be sure to record this on the monthly demographic reports.

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Chapter 6 - Contact Plan

General Information

The Contact Plan (Appendix B) provides the client and care coordinator with a tool to guide their work together. It reminds both of the intended goals of the care coordination: i.e., to link with and get the most out of medical care services and to maintain health through medical adherence. In order to improve the chances of this happening, the care coordinator will help clients identify: 1) barriers that could interfere with that goal and 2) personal objectives that will help the client to follow through. Activities are those specific steps that will help the client and care coordinator achieve objectives and goals.

Use the contact plan to guide all activities between client and care coordinator. The contact plan is especially useful for those clients who have little experience at identifying goals and developing manageable steps to accomplish them.

In keeping with the strengths approach, the plan should be primarily a reflection of the client's (not the care coordinator's) view of what they want to accomplish. The essential goal of linkage with an HIV provider may not be an immediate goal for the client. The challenge for the care coordinator is to avoid making linkage to medical care a barrier that will interfere with client-case manager engagement, while still promoting its necessity and its importance as the reason for the relationship.

Introducing the Contact Plan

Introduce the contact plan (Appendix B) as a simple but effective tool that will help clients and care coordinators focus their efforts. Thus, as an introduction to the planning process the care coordinator might say:

"It is the goal of the project and its care coordination to help you link to community-based medical services, get the most out of the services, adhere to the provider's recommendations, and improve the likelihood of ongoing care by enhancing education. We believe that services and other activities we will discuss can help. One of the tools that will guide you in accomplishing your goals and the program's goal will be for us to write everything down on a contact plan. This plan will help organize our work together and make sure we are anticipating everything we need to work on.

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We have found that when people can recognize what they are good at it helps them accomplish difficult goals. We will put your goals in writing to remind us of what we are working on. You will always receive a copy of your most current contact plan."

Using the Contact Plan

The contact plan is straightforward. At the top of the plan is a reminder of the goal for the relationship, "Link and engage with medical services". Organize the remainder of the form around the following sections:

- Objectives
- Activity to address the barrier or meet the objective
- Responsible Person(s)
- Target Date

For the "**Objectives**", the care coordinator should write in a specific objective that the client has decided is important to address.

"**Activities**" constitute those specific steps that care coordinator, client, or other persons (e.g., family members) take to help the client achieve individual goals.

The "**Responsible Person**" line identifies what person (e.g., care coordinator or client) is responsible.

"**Target Date**" is a date by which the barrier or objective and specific activities (steps) to accomplish them are due to be completed.

Planning for the next session

The care coordinator uses the contact plan to plan for the next contact. This will help the client and care coordinator anticipate any barriers to the next session and identify a plan to resolve those barriers.

Planning for accomplishing the goal of linkage to medical treatment and adherence

The care coordinator discusses with the client why consistent medical care and adherence are important. Specific external barriers, such as need for childcare or lack of transportation, internal concerns (a fear of the disease or of treatment), or

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even self-disclosure are some examples of barriers. The contact plan is a way of summarizing the discussion and clearly outlines what the perceived barriers are, plans for overcoming them, who is responsible for the activity, and the date of its completion.

For example, an objective might be as general as "Go to a clinic at Third and Main." Further discussion might reveal that the client does not have proper identification, childcare, or transportation to the clinic. This reveals three barriers to linkage. This will prompt the care coordinator and client to discuss alternatives to resolve both the client's concerns about obtaining medical care and barriers to the first visit. The care coordinator should bring up the strengths that the client has demonstrated in the past to deal with these types of barriers and/or accomplish a goal, such as accessing medical services.

Planning to accomplish client objectives

This use of the contact plan can be much wider in scope than the previous use. Here, the client and care coordinator will identify and plan for long-term client-defined objectives that will be addressed by the client and community-based case managers when medical care linkage is accomplished. This constitutes the more typical case management activities. The care coordinator should relate these client-defined objectives to the project goals and develop specific objectives for helping the client effectively use community-based resources. The care coordinator emphasizes client strengths and encourages the client to use them when working with community-based resources.

General Points

Consider several other points when completing the contact plan. These include:

- Be precise in helping a client define concrete, observable objectives and the activities necessary to accomplish those objectives. Encourage the client to be specific, so they will think of alternative

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solutions they can use to influence their situation.

- Be careful of unrealistic goals identified by the client.
 - Be attentive to the client's ability to effectively think through a plan, commit to it in writing, and then successfully carry it out. While some clients may indeed be very competent at achieving goals, others will engage in dreaming, procrastination, rationalization, and other processes that interfere with linkage to a provider and community-based services.
 - Remember to encourage clients to use the strengths they have identified and discussed as the starting point for planning how to accomplish objectives. The care coordinator should periodically summarize strengths identified by the client. Then, confirm with the client whether they perceive those actions, thoughts, or feelings as strengths. Unless the client seems unable to recognize or acknowledge strengths, do not simply impose your view of something to be their strength. Ultimately, it is the client's perception of something as a positive in their life that will mobilize them to solve current problems.
 - Avoid acting as "director," or even "disinterested party"; instead, assume the role of "traveling companion" in achieving the objectives that the client has identified.
 - Be creative with the client and try to come up with a solution that resolves or addresses several objectives at once. Many clients may perceive multiple goals to be overwhelming and they will greatly appreciate your ability to help them deal with several issues at the same time.
-

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Chapter 7 - Documentation

Documentation

Careful, consistent documentation is vital to all human services delivery. It establishes a running record of who may be seeking and/or receiving services, what kinds of services to deliver, and the outcomes of receiving those services. This kind of information has value for elected officials charged with allocating scarce resources, program planners and evaluators who have to anticipate changes in service delivery needs, and front-line practitioners who use their records to help deliver high-quality services.

The initial and updated strengths assessment (Appendix A) and contact plan help the frontline practitioner keep the intervention on track by highlighting that each client is special and an individual. The contact plan (Appendix B) can help both the care coordinator and client see where they have been and what still needs to be completed.

View record keeping or documentation as a *professional tool* to help provide effective services to those who need and receive them, which may also help shape future services.

This is especially important when an agency is introducing a new approach or technique, such as MAI-ARTAS linkage care coordination. Careful documentation allows the practitioner to reflect on the success of the method and makes it possible to see if their delivery is parting from the intervention's protocols.

Reporting

MAI-ARTAS providers funded by DOH should complete monthly demographic and names reports. Submit these reports to the contract manager and linkage program specialist for the previous month, by the 10th day of the following month.

Important Note: Be sure to count all races/ethnic groups enrolled as outlined on the report. This includes Caucasians (white people). This is different from previous directions that stated not to count them. Although the department will include this information in our database, these numbers will not be reported or included in reports to HRSA.

MAI-ARTAS Standards & Guidelines
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Saleebey, Dennis. (2002). *The Strengths Perspective in Social Work Practice*. (3rd ed.). Boston, MA: Allyn & Bacon, A Pearson Education Company.

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Appendices

Appendix A Strengths Assessment

MAI/ARTAS STRENGTHS ASSESSMENT

Please list the dates client's strengths were discussed and identified:

Contact # : 1 date _____ 2 date _____ 3 date _____ 4 date _____ 5 date _____

Client Name _____ Care Coordinator Name _____

LIFE DOMAINS

GENERAL LIFE SKILLS

- Cooks and/or participates in completing meals _____
- Shops for groceries/necessities _____
- Can use/rides public transportation _____
- Washes own clothes _____
- Appearance appropriate _____
- Driver's license and other documents kept current _____
- Maintains personal hygiene _____
- Knowledge of current events _____
- Uses alarm clock; prompt appointments _____
- Able to use resources; phone book, library _____
- Reading level up to and/or above daily paper _____
- Other _____

RELATIONSHIPS

- Able to trust others _____
- Establishes non-sexual, other sex relationships _____
- Realistic expectations of relationships _____
- Resolves conflict positively _____
- Aware of social resources; where to meet people _____
- Avoids isolating behavior _____

- Family interaction is maintained _____
- Sober/positive friend relationships are maintained _____
- Community groups are sought _____
- Spouse/significant other relationships are maintained _____
- Cooperative and flexible in relating to others _____
- Ability to function independently _____
- Involved with his/her children _____
- Other _____

LIVING ARRANGEMENTS

- Maintains positive living situation _____
- Provides upkeep on place of residence _____
- Living arrangement promotes overall well-being _____
- Uses institutional living situation _____
- Other _____

HEALTH

- Medical/dental check-ups are regularly scheduled _____
- Health problems are attended to _____
- Attempts to change unhealthy behaviors _____
- Maintains adequate, healthy diet _____
- Other _____

FINANCE

- Has used or uses checking account constructively _____
- Maintains savings _____
- Credit card used appropriately _____
- Debts maintained within income _____

- Saves toward specific goal(s) _____
- Income source legal and consistent _____
- Knows how to pay bills _____
- Other _____

NON-WORK ACTIVITIES

- Hobbies/leisure activities are identified and initiated _____
- Participates in team/group activities _____
- Participates in leisure activities with family _____
- Attends place of worship _____
- Has developed a relationship with pastor/minister _____
- Involvement with faith community _____
- Participated in volunteer activities _____
- Other _____

OCCUPATIONAL/EDUCATIONAL

- Positive, productive work ethic _____
- Personal satisfaction in occupation/educational activities _____
- Generally gets along with employers, co-workers, fellow students _____
- Demonstrated skills for employment _____
- Prepares for job interviews/application _____
- Pursued/found employment _____
- Participated in educational and/or vocational training _____
- Consistently punctual for job/school _____
- Working up to ability _____
- Enjoys being busy _____
- Other _____

INTERNAL RESOURCES

- Goal directed; sustained activities _____
- Understand how own behavior affects others _____
- Wishes and needs verbalized positively _____
- Strengths and talents can be identified _____
- Considers consequences of behaviors before acting _____
- Beliefs and values are followed _____
- Accomplishments can be identified _____
- Spiritual needs are attended to through church, etc. _____
- Seeks help as needed for personal problems _____
- Decision-making abilities _____
- Accepts responsibility when appropriate _____
- Developed/worked toward personal goals _____
- Expresses emotions appropriately _____
- Feels in control of own life _____
- Effectively delays gratification _____
- Generally copes with uncomfortable emotions in constructive manner _____
- Keeps promises _____
- Other _____

OTHERS

Appendix B

Contact Plan

Appendix C
Client's Rights and
Responsibilities

Client's Rights and Responsibilities

- You have the right to be treated with respect by the ARTAS staff.
- You have the right to confidentiality.
- You have the right to make your own decisions and choose what is best for you.
- You have the right to use your strengths to achieve your goals and dreams.
- You have the right to expect fair treatment and services from ARTAS staff.
- You are responsible for assisting your care coordinator in developing your contact plan.
- You are responsible for keeping scheduled appointments and adhering to medical care treatment, including medical appointments and taking prescribed medications.
- You are responsible for working cooperatively with your care coordinator in an effort to achieve your goals.
- You are responsible for demonstrating behavior that is cooperative and respectful of others.
- You are responsible for notifying your care coordinator when you have problems in obtaining services or when you are dissatisfied with your care.
- You have the responsibility to be open to the strengths-based approach and work towards living in an independent manner.

My care coordinator explained my rights and responsibilities to me and I agree to follow these guidelines to the best of my abilities.

Client's/Guardian's Signature

Date

Care Coordinator's Signature

Date

Appendix D
The Strengths-Based
Approach to Case Management
versus the Medical Model

Factor	Strengths-Based Approach	Medical Model
<i>Value Base</i>	Self-Determination Strengths of client and environment Client's potential to grow, heal, and learn Client's ability to identify desires and strengths Individuality and Uniqueness May not work well for clients with lower IQ	Problem resolution dependent on professional expertise Compliance with prescribed treatment Clients with lower IQ may not be able to access or interpret the health care delivery system to the best of their advantage, so this model works better for them
<i>Objective</i>	Emphasizes client strengths as a way of achieving goals Establishes a partnership between the client and the case manager to identify strengths as a way to achieve goals Efficiently link client with medical care	Client compliance with prescribed treatment To increase the quality of care and quality of life of PLWHA To improve service coordination, access, and delivery To reduce costs of care through coordinated services which keep PLWHA out of the hospital To provide client advocacy and crisis intervention services
<i>Solution to Problems</i>	Emphasizes goals & dreams and the utilization of client's strengths and community resources to achieve goals	Problem resolution dependent on professional expertise and availability of service delivery
<i>Social Environment</i>	Client's ability to identify strengths and work towards living in an independent manner in the community	Client's need for support systems to take care of them
<i>Case Management Relationship</i>	Establishes a partnership between the client and the case manager to identify strengths as a way to achieve goals Client makes own choices and decisions Client works cooperatively with case manager to achieve goals and dreams Client is open to the strengths-based approach Case manager emphasizes client strengths as a way of achieving goals Case manager works toward disengaging client so that they may live in an independent manner in the community	Clients are passive recipients Professional contact limited to assessment, planning, evaluative functions Provider-directed decision making and interventions Length of relationship is not predetermined, but indefinite
<i>Case Management Tasks</i>	Identifying strengths and resources Rejuvenating and creating natural helping networks Developing relationships Effectively linking client with available medical care	Teaching skills to overcome deficits Monitoring compliance Medical management of identified problems