Re-engagement to care manual

Updated November 2023

Utah Department of
Health & Human
Services

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- Re-engagement to care (RTC)
- University of Utah Health (UUH)
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Introduction to re-engagement to care (RTC)

The Utah Department of Health and Human Services (DHHS) RTC Program, helps HIV-positive clients who have fallen out of treatment and care for HIV disease to re-engage, and maintain, medical care and take the medication as prescribed. This manual serves as a resource for re-engagement to care (RTC) staff. It outlines guidelines and activities for re-engagement to care, including evaluation, data collection, field safety, and the re-engagement flow of events.

The goals of the program include a reduction in the number of HIV-positive Utahns who are not in care and increase viral suppression among this population. We also hope to cut new HIV diagnoses by 90% by reconnecting HIV clients to care, and keep them in care. RTC works to provide care connections to clients in a coordinated manner, educate clients to adhere to treatment, and works closely with local services and specialists.

RTC staff will link at least 50% of individuals identified and contacted by the program to medical care and make sure they attend their first appointment within 30 days of initial RTC interaction.

Eligibility

For clients to qualify for this program, they must meet one of the following criteria:

1. DHHS has not received an HIV-related lab in the last 12 months.
2. An antiretroviral therapy (ART) prescription has not been filled in the past year.
3. The individual's last viral load test was more than 6 months ago and was >200, and/or CD4 <500, and/or CD4% <32.
4. Newly diagnosed clients must be linked to care within 30 days of diagnosis. If DHHS has not received any HIV-related labs within that period to indicate they have engaged in care, they are eligible for the RTC program.

Re-engagement to care staff tasks

- Complete the peer navigator training provided by DHHS, University of Utah Health, and other agencies and obtain certification before starting their roles.
- Record all steps of work in appropriate databases and communicate with the DHHS staff, as clients are re-introduced to care.
- Contact eligible clients from the not in care (NIC) list created by DHHS.
- Make sure the client understands the role of the RTC program, particularly its short-term and transitive format. The client should know that the purpose of the program is re-engagement in medical and case management services with whom they will engage in the long term.
- Conduct an RTC interview to determine what medical and support systems the client needs to be engaged in.
- Ask the client's permission to follow up at a minimum of 3 months, then 6 months, then a year to check on their current enrollment status and offer additional help if necessary.
- Meet with newly diagnosed clients and those re-engaging in care according to the DHHS eligibility protocols. Talk through the client's concerns and assess their needs.
- Help clients navigate Utah's Ryan White Program (RWP) and AIDS Drug Assistance Program (ADAP) eligibility process.

- Guide clients through each step of care initiation or re-initiation.
- Help clients navigate the medical care system and access needed services.
- Accompany clients to medical and other appointments, when feasible and appropriate.
- Help with transportation (bus passes, gas vouchers) when needed and available.
- Talk about how important it is for them to take the medication as prescribed and why it's so important.
- Provide realistic advice to help them integrate prescription requirements and wellness practices into daily life.
- Provide one-on-one and/or group-level social and emotional support.
- Use motivational interviewing and strength-based counseling techniques to determine what barriers to accessing medical treatment and long-term case management the individual experienced and what steps can be taken to overcome those barriers at re-engagement.
- Help clients with appointment reminders for eligibility, ADAP, case management, health care/primary care, and lab appointments to augment care.
- Contact clients who missed appointments and identify barriers that prevent engagement in care.
- Follow up with clients to overcome barriers to obtain and remain in care.
- Work collaboratively with primary care providers and case management to identify newly diagnosed clients who can benefit from RTC staff and resources.
- Provide active referrals for needed supportive services.
- Attend/facilitate peer-led support groups, if applicable.
- Provide HIV and health education.
- Conduct new client orientation.
- Provide training to new staff.

Rights and responsibilities

RTC client rights

1. Always be treated with respect.
2. Have their personal information protected.
3. Be treated equally with all others, regardless of race, color, religion, sex, national origin, ancestry, sexual orientation, or physical or mental ability.
4. Not be abused or threatened.
5. Receive the services to which they are eligible.
6. Receive high quality care that follows national guidance.
7. Actively participate in service plan development.
8. Make decisions and have them respected.
9. Stop services at any time.
10. File a complaint about services without losing access to services.

RTC Program staff responsibilities

1. Treat people with respect, including clients, staff, and health care providers.
2. Not abuse or threaten others.
3. Maintain confidentiality, even beyond employment, as RTC staff.
4. Provide the RTC program, RTC staff, providers, and additional agencies with accurate information.
5. Provide updated contact and emergency contact information to RTC staff.
6. Keep appointments with clients. If they are unable to keep an appointment, RTC staff will notify the client at least 60 minutes prior.
7. Align with the RTC plan and complete all agreed-upon tasks.

Confidentiality and records

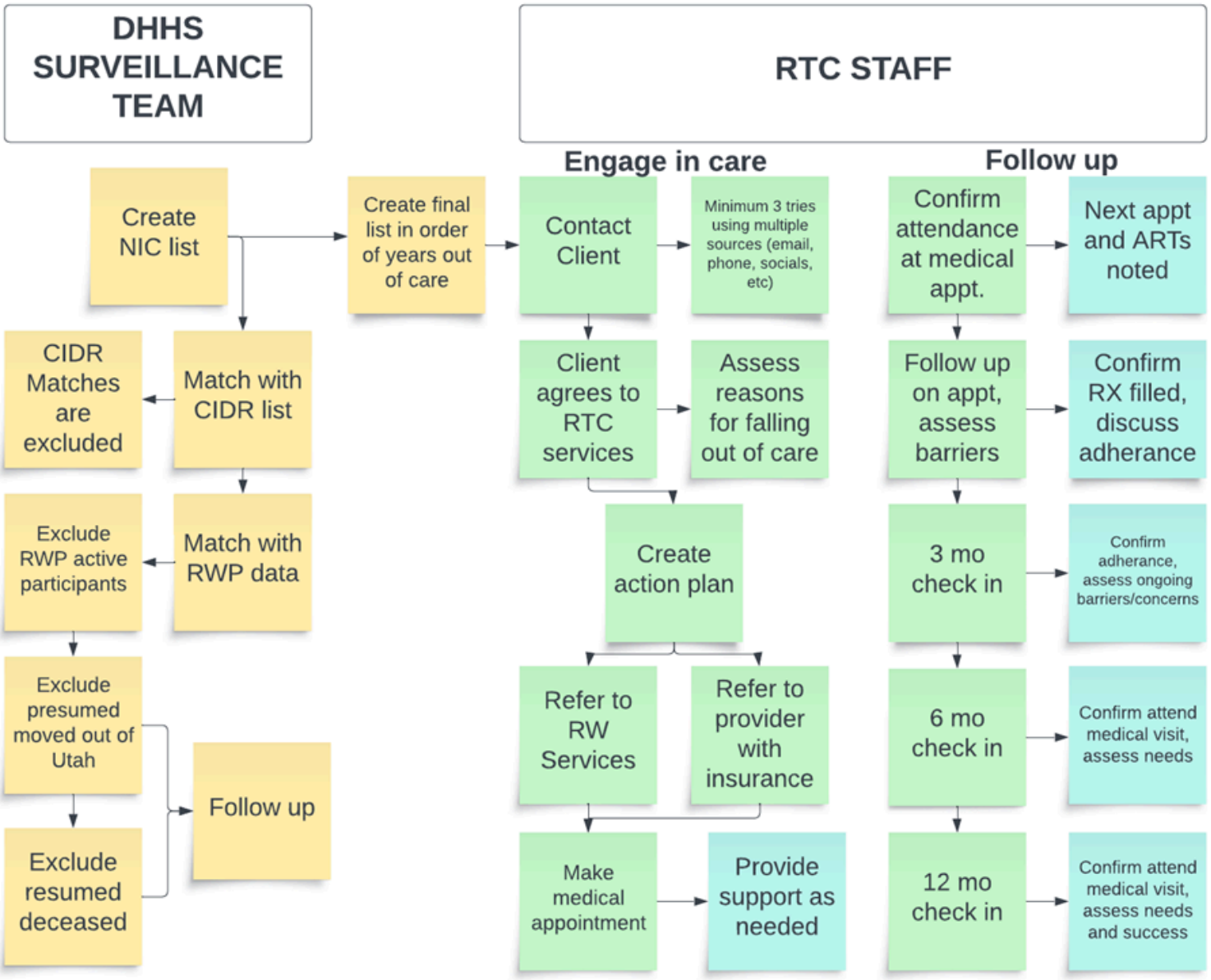
Field records must be safeguarded against disclosure. Field records are defined as any information held by DHHS about health status, provision of health care, payment for health care, or other protected information that can be linked to an individual. It also includes health information with data items, which reasonably could be expected to allow individual identification.

Upon hire, all RTC staff are required to sign a DHHS Confidentiality access and confidentiality directive agreement (Appendix B).
This agreement requires all RTC staff to:

- Read and fully understand their responsibility to implement DHHS's confidentiality policies and procedures regarding confidential information.
- Agree to observe DHHS confidentiality policies and procedures.
- Agree they have an ethical and legal obligation to protect the right of privacy of the persons whose records the DHHS maintains.
- Will not relate or discuss any information that identifies a specific client, physician, or hospital with anyone other than the source from which the information originated, health care providers involved in the client's care, or other persons needed to carry out the program's responsibilities.
- Understand that any confidential information received while employed as RTC staff will remain confidential even after termination of employment.
- Understand that failure to observe these confidentiality policies will be grounds for immediate disciplinary action and could constitute justification for termination.

All RTC staff are also responsible for data security. They will maintain proper workstation security, office access, and access to confidential information as outlined in the DHHS Confidentiality access and confidentiality directive agreement. RTC staff will not remove confidential information, including paper or electronic information, from the worksite unless it is required for a field visit, meeting, or otherwise necessary for work-related purposes. Appropriate measures must be taken in each instance to make sure confidential information removed from the work site is secured from unauthorized access and not left unattended and unsecured.

Re-engagement to care process and guidelines



DHHS surveillance team

Surveillance will generate a NIC list each quarter for RTC staff using surveillance databases: ClientTrack, eHARS, and UT-NEDSS. The list will identify all clients who live in Utah who are diagnosed with HIV and identified as being out of care. The list will include the variables below:

- Name
- Date of birth (DOB)
- Race and ethnicity
- Most recent address and phone number
- Date of diagnosis
- Facility and provider
- Date of most recent lab, ordering provider, and provider's facility
- Lab test results and collection date for the most recent CD4/viral load
- Number of unique lab collection dates

After the NIC list is created, DHHS surveillance staff will identify the clients by the local health jurisdiction believed to be the individual's current and/or last known jurisdiction of residence. RTC surveillance staff will use 'number of unique lab collection dates' variables as an indicator to identify how strongly people were engaged in care before they fell out of care.

RTC staff

Once the NIC list is received from DHHS, the goal is to contact everyone on the list and RTC staff should prioritize the contact list.

- High
    - Clients who are not on ART or have run out of medications recently
    - Contacts named with an STD, or HIV case
    - Clients who have low CD4 or high viral load
- Normal
    - Clients who still seem to take their ART medications

    - Clients who are in contact with a case manager or provider but have not been seen by the provider
    - Clients who have not had labs drawn in the past year.
- None
    - Truly out of care, in care already, deceased, moved out of state, or are unable to contact.

Engaging out-of-care clients

RTC staff will contact eligible clients. If a client opts out of RTC services, they should be provided with standard referrals for re-engagement in medical services and long-term medical case management. RTC services are customized to meet the needs of the client.

- Make or attempt to contact the client within 30 days of starting an investigation into the client's case.
- Make sure at least 50% of individuals who are identified and contacted by the program, are linked to medical care and attend their first appointment within 30 days of initial RTC interaction.
- The minimum number of cases investigated and closed is 30 per month.

Clients may have encountered different barriers to engaging in HIV care since their initial diagnosis and need different levels of support to accept their diagnosis and access care.

General RTC guidelines for engaging out-of-care clients are outlined below.

- The RTC staff should make sure the client understands the role of the RTC program, particularly its short-term and transitive format. The client should be aware that the purpose of the RTC program is re-engagement into medical and case management services with whom they will engage in the long term.
- The RTC staff should conduct an RTC assessment to help determine what medical and support systems the client may need.

- The RTC staff shall review pertinent program information with the client, including an overview of the client's rights and responsibilities while engaging in RTC services.
- Motivational interviewing and strengths-based counseling techniques should be used to determine what barriers to accessing medical treatment and long-term case management the individual experienced at initial diagnosis and what steps can be taken to overcome those barriers at re-engagement.
- Staff should record their work in a secure database (there is a form available). This summary and data variables not only guide the re-engagement process but serve to provide continuity of care if the client transitions to long-term case management services.
- All RTC referrals should be active. Active referrals mean the RTC staff works with the client to schedule appointments, complete mandatory paperwork, arrange transportation, and, if requested, attend meetings and appointments with the client.
- The RTC staff should look into what insurance or public funding the client currently has. If they don't have insurance or public funding, look into what is possible such as RW Part B or client resources.
- During the last RTC interaction, the RTC staff should conduct the RTC standard assessment again to determine what progress was made in client education and linkage to medical care and support services during the RTC program. The amount of RTC interactions is determined based on the client's individual needs.
- During the last RTC interaction, the RTC staff will ask permission to follow up with the client approximately 3 months after their final interaction to check on their current enrollment status and offer additional help if necessary.

Social media

Social media may be used to gather contact information and to identify clients before in-person meetings. Contact should be made from official agency accounts and via private messaging, not on public forums.

The following is a sample message:

Hello _____, my name is [name] and I work with [agency]. I am reaching out to you because you may not be receiving the medical care you need. My goal is to provide you with support in meeting with a health care provider and accessing other services you might find helpful. Contact me at your earliest convenience at [phone number] or [email address] and I would be happy to talk with you about the services you might be eligible to receive.

Closing cases of clients unable to contact

An RTC case may be closed when the following occurs:

- It has been determined the client is deceased. This should be documented by entries in electronic medical records, obituaries, social media searches, etc. Document in a secure database how you determined this is the case.
- Document at least 10 attempts to contact the person. This can be less if fewer contact sources are available. Document in a secure database what and how the attempts were conducted.
- A client is determined to have moved out of state. This can be done by investigating case management notes, provider notes, or by contacting the client. Records in electronic medical records must be investigated and contact made with the client whenever possible.
- The client does not respond to your attempts to contact and there is no evidence the client has moved out of state, has no entries in electronic medical record, is deceased, or getting care from a facility in Utah. These facilities include the University of Utah, UAF Legacy Health, and other medical facilities in the state. A case manager or RTC staff member should visit the last known address to attempt to contact the client before closing this type of case.

Add to a secure database when to follow up on these cases with the maximum amount of time of 6 months.

Client interview

Contact the client in advance of the scheduled first appointment to:

- Remind them of the upcoming appointment.

- Ask where the client would like to meet.
- Assess client needs or barriers to attending the session. Offer assistance with transportation if this is an identified barrier.
- Ask the client if they would like to have someone attend the session with them. This would need to be preempted with a discussion about the content of each of the sessions. Some sessions may be more appropriate for a "guest" than others.

The initial RTC interview

Make sure to have a computer or a printout of the variables being collected along with space to take notes ready just in case the client wants to interview by phone.

1. Explain the program and discuss the purpose of the call/visit.
2. Identify barriers to receiving HIV care and taking ART. Explore the priority barriers and possible solutions in depth.
3. Develop an action plan tailored to the client.
4. Wrap–up.

Before you begin the interview, talk about privacy and confidentiality. If it is the first time to speak with the client, ask them to confirm information such as their birth date, or current or past addresses to verify the identity of the client.

1. Explain the program and set expectations for the call.

The client needs to understand the reason for the call and the RTC program. It is important to thoroughly explain all components of the program and the role of RTC staff so the client can make an informed decision on whether they would like to participate.

Some items to cover:

- Role of the RTC staff and the reason for the call.
- An overview of the RTC program and why it's important.
- How they might benefit from the program.

- An overview of the potential duration of the program.
- Incentives associated with enrollment in the program.

2. Identify barriers to receiving HIV care and taking ART

There are many reasons why an individual falls out of care. It is crucial to understand the barriers clients face to appropriately address the barriers and help clients re-engage in medical and case management care. The RTC staff member may want to start by asking a more general question and then focusing on specifics the client identifies. It is essential to explore the client's priority barriers. Staff may begin to explore possible solutions with the client as they go or may choose to wait for later in the session.

The following topics should be used as a guideline with language adjustments per the client's needs. The details are in the interview sheet in Appendix A.

- Barriers to medical system
- Barriers to case management
- Barriers to ART
- Social history

3. Develop an action plan

When you develop an action plan, it's important to summarize what you talked about. The client should be actively engaged in the creation of an action plan. There should be an agreement to what they identified as their main concerns as well as the next actions both the client and RTC staff hope to take.

During the summary, cover the following:

- Client concerns about HIV, personal health, and their risk of transmitting HIV.
- Major thoughts on the benefits and risks of ART.

- Reasons for not taking ART.
- Barriers of highest concern or importance.

Below are some sample questions to make sure you and the client are on the same page.

"Let me see if I understand your main concerns. Of the issues we talked about, it sounds like the biggest concerns for you are/have been,_____and_____.
Is that right? Is there anything you'd like to add?"

"Do you feel like that's a good summary? Did I miss anything?"

Part of developing an action plan is identifying the next steps both the RTC staff and the client will take toward re-engaging them into care. The amount and intensity of the steps will be different for each client and RTC staff should adjust them accordingly. What may seem like a small step may be a major step for the client. RTC staff should bolster self-efficacy by defining potential challenges, outline strategies for success, and rehearse the next steps to help encourage them.

Some possible action plan steps include:

- Schedule a medical care or case management appointment for the client
- Agree to attend the medical appointment with the client
- Address the specific barriers the client has expressed
- Refer them to RWP if they lack health insurance
- Provide active referrals to substance abuse or mental health
- Give the client a list of providers so they can pick one if they don't have one

4. Wrap-up

When you wrap up the interaction, the main goal is to outline and outline the next steps both the RTC staff member and the client will take. During this time, the RTC staff will also let the client know how important follow up is to evaluate their progress, adjust the plan if needed, and provide more help as needed or requested.

If the RTC staff member will not attend a medical appointment with the client, they will get consent from the client to contact their provider or case manager (as relevant). Reiterate confidentiality and stress the importance of working together with both their provider and case manager to ensure the greatest success for them.

Follow-up calls and communication

The client needs to be contacted for follow-up every 3, 6, and 12 months after the initial appointment is completed.

The following questions should be asked to assess how the client is doing in the RTC program at each follow-up appointment.

1. Barriers with the medical system. Are they getting their needs met by their medical provider of choice?
2. Barriers in case management. Are there resources they are interested in that haven't been discussed? Do they meet regularly with their case manager?
3. Barriers to ART. Do they get their meds on time? Do they follow their regimen? What barriers keep them from staying compliant? Talk about how you can help them with barriers. Offer automated bottle caps, pillboxes, or whatever else they need. Perhaps they only need some coaching on how important it is to take their medications as prescribed.
4. Social history. Did their living arrangements change? Are they still in the same relationship? How are their relationships with family, partners, and friends going? Do they need housing, finances, or food?

5. Ask for permission to follow up in the next 3 months.

Field safety

Safety equipment

All RTC staff must carry fully operational, charged cell phones which should be left "ON" during field visits. It is strongly recommended that RTCs also carry a backup phone charger with them.

Safety risk assessments

Assess each field encounter and situation for potential risk. Review all available client information before you meet with a client for the first time to determine if the case has been flagged with a risk warning. Document any newly discovered safety concerns in a secure database and inform DHHS staff to help the next worker. Flag the top of the notes field with the word “warning” (WARNING) in all capital letters.

If a client has a history of assault or other violent behavior, or if a client has previously been aggressive toward an agency representative, use greater caution when you work with the client. Discuss a plan and approach with a supervisor. Talk with other staff who have had prior experiences with the client to obtain a better understanding of the circumstances. Notify DHHS staff so they can update client notes in the notes field in UT-NEDSS.

The following are questions and indicators staff may find helpful in conducting safety risk assessments for individual clients. Responses may indicate the level of personal risk for staff involved. This assessment is important to determine the level of support that may be warranted when you work with certain clients and/or situations.

- Is the client actively violent or hostile?
- Does this situation involve domestic violence, such as spousal or child abuse?

- Does the client have a history of mental illness associated with violence or sexual assault? Does the client exhibit behaviors to indicate mental illness now?
- Does the client have a known history of criminal/gang activity?
- Does the client have a history of substance use, or is the client presently using substances?
- Is the client's geographic location potentially dangerous? Is the area known for high crime/drug activity? Is the housing or neighborhood of high concern for personal safety?
- Will staff be going to an area with limited available support resources (rural/isolated)?
- Does the client have a previous history of violence, multiple referrals, or have there been previous threats made to the staff? Search the available records.
- Will the client contact start or continue after normal working hours?
- Are there any other potential risk factors?

Early warning signs

The need to assess risk starts early and continues throughout the working relationship between staff and the client. Observation of client behaviors, including verbal communication and body language, is critical to determining risk and responding to clients.

- Voice (raised volume, negative tones, nervous pitch)
- Clenched fists or jaw
- Sudden change in behavior or mood
- Invasion of personal space
- Agitated behavior: pacing, getting up and down
- Active state of substance abuse (drugs or alcohol)
- The presence of weapons
- The person's eyes (intense or no eye contact)
- Appropriate dress (sexually revealing clothing, use of hoods to obscure the face, etc.)

Potentially dangerous clients

In collaboration with a supervisor, formulate a safety plan regarding potentially dangerous clients and geographic areas. A safety plan may include working with a partner (tandem fieldwork), re-assigning cases to a male, a female, or another more "acceptable" worker, having a male worker accompany a female worker or vice versa, providing services by phone, meeting the client at an identified "safe zone," providing limited direct or indirect services or not providing any services. The supervisor should make the final decision after a review of available information and with input and recommendations from the RTC staff. In some situations, it should be left to the discretion of the RTC staff and ID staff to independently determine and request what support is needed.

To determine the best approach for reaching the client and to assist in the development of a safety plan ask the following questions:

- How high a priority is the client?
- Would a tandem approach or case transfer increase the safety level?
- Could the situation be handled over the phone?
- What would be the best location for the client contact?
- What would be the best time for the phone call or visit?

Document final decisions and safety plan and inform the DHHS staff for the reference of supervisors and as a reference for future investigations.

During a client session

- Identify yourself and why you're there. Wear/carry your work ID badge and show it to verify your identity and purpose if questioned.
- Use the client's name to personalize and humanize the situation.
- Encourage client participation. Ask the client for opinions, suggestions, and solutions.
- Allow clients to de-stress and vent about their situation; let them know you can understand how the situation might cause frustration or anger.
- Give clients time to think and get their feelings under control.

- Be honest.
- Use active listening and reflection.
- Be aware of your own and the client's non-verbal cues.
- Remain courteous.
- Use intuition. If you feel uneasy, leave. "When in doubt, get out!"
- Leave the situation immediately, if threatened in any way.
- Do not argue.
- Leave if the police enter the area or approach the client unless you are specifically directed by the police to stay. Maintain confidentiality. Police do not have a "need to know." If asked by the police, identify yourself and where you work (show your work ID). Do not resist the police, if they want to take you, go. Phone your supervisor as soon as you can.

Minimize non-physical and physical safety risks

When you conduct case and fieldwork, be aware of what is going on in the immediate environment. Continually, take notice of the surroundings. Avoiding complacency may come from encountering the same events and situations repeatedly. Pay attention to your comfort level. When the level of discomfort rises, end the meeting and arrange to finish at another time, by phone or in tandem.

Site selection

Use a room in a government agency or partner agency building. Choose to meet clients in a structured environment where you can be observed and there is an understanding of your purpose and role (such as a clinic, health department, or hospital). As an alternative, meet clients in a public place, where there is privacy, but accountability (library, retail store, or restaurant). Use caution when you meet a client at their residence. Be aware of your surroundings.

Safety in the field

While in the field

- Act with assertiveness and confidence.
- Use good eye contact and walk purposefully.
- Be aware of your surroundings.
- When necessary, let area residents know that you are in the area to help someone and that you will leave as soon as you're finished. Minimize the perceived threat caused by your presence. Enlist allies among residents in conveying the message that you are not a threat.
- Anticipate the unexpected and formulate a tentative plan of action.
- Conduct fieldwork in the mornings. People are more likely to be less active than later in the afternoon, evening, or at night.
- Plan your route; use GPS when you are unfamiliar with routes and locations.
- Do not stand directly in front of a door after knocking. Stand to the side closest to the hinges of the door.
- Be aware of dogs. You may consider rattling the gate before you enter a fenced yard.
- Leave gates open until you have completed the field visit.
- Wear sensible non-restrictive shoes and clothing.
- Conceal cell phones.
- Position yourself closer to the exit than the client to prevent a client from blocking your way out of a building or room.
- Do not sit outside a client's home to look at maps or to complete case notes. Pull away and park elsewhere.

Make sure you don't

- Appear afraid or unsure
- Fail to identify yourself and role to the client
- Use negative, non-verbal signals
- Use overly harsh statements
- Assume a parental role
- Use judgmental statements
- Use intimidation

- Become defensive
- Argue
- Apologize for conducting the work
- Make threats
- Corner the client physically or psychologically
- Change attire to try to blend in with the neighborhood
- Wear or carry articles that look valuable
- Shoulder through a sidewalk crowd
- Go into a home unless invited
- Give too much information about yourself or your family
- Possess any weapon during work hours

Field accountability

To help supervisors and staff make sure there's a reasonable measure of accountability regarding the whereabouts of each staff member throughout the workday, you are required to follow these measures:

- Indicate in writing where you are going, with a specific address if possible, and your estimated time of return to the office; write legibly.
- Pay attention to time. You MUST notify your supervisor and relevant coworkers if you will not be back in the office by the time you indicated on the in/out log.
- It is strongly recommended that staff conclude their workday at the office so records containing protected health information (PHI) can be stored according to the security and confidentiality policy. If an RTC staff needs to conclude their workday in the field, they should carry only the minimum number of records necessary and store them securely.
- Please keep in mind: Your colleagues in the office need to know you are safe. If by 5:00 pm you are still in the field and no one can establish contact with you, they could reasonably assume you are missing. In the

unfortunate case where an RTC staff provider is presumed missing, law enforcement must be contacted and they may initiate a search.

Field accountability in rural areas

Because some Utah locations are remote with limited communication and emergency services, it is recommended staff appointments conducted in rural areas are done in tandem with one case manager. If another staff member is not available to travel, the RTC staff member must call their supervisor or another co-worker frequently to check-in. It is not recommended for staff members to request other non-staff members accompany them in the field unless they have training and experience in field-based disease investigation and interviewing. If the RTC staff member does not feel safe conducting fieldwork alone in a remote community they should notify their supervisor and develop a safety plan.

Missing RTC staff

If an RTC staff or accompanying team member is determined to be missing; has missed a check-in time or is late returning to the office based on the return time indicated on the in/out log, the following procedure should be used:

- Call any RTC staff or accompanying staff when they are 30 minutes late for their check-in or return to the office, as indicated on the in/out board.
- If the RTC staff or accompanying staff does not respond within 10 minutes, call them again. In addition, call the RTC staff or accompanying staff at home or on their cell phone (if they are not already using their cell phone in the field).
- If they do not respond to this second attempt at contact, notify a supervisor immediately.
- Gather the following information: 1) the last time they called in, 2) the last known area of the staff member and/or accompanying staff, 3) the planned destination of the team 4) their license plate number and a description of their car, and 5) any other pertinent information.

- If available, the program supervisor needs to call the police and report the staff members as missing. Otherwise, any staff person can contact law enforcement to report a missing staff member(s). Local law enforcement agencies should advise at that time about their next steps and actions.

Incident de-briefing and documentation

- Any incident where an RTC staff member feels unsafe must be discussed with a supervisor within 24 hours of the incident. Management will determine if the incident should be reviewed with all staff. Incidents deemed necessary for an all-staff review should be presented to all staff within 14 days of the incident report.
- All critical incidents should be documented in a "memo to the record" and copies submitted to the immediate program supervisor. A critical incident is defined in this document as a violent or imminent threat or an event that interrupts normal procedures or precipitates a crisis.
- Fear in and of itself is not an incident unless the fear is the result of a verbal or physical threat to a person or property.

Vehicle safety

Safe and defensive driving guidelines recommend the following:

- Keep doors locked, windows up, and gears engaged at intersections in unsafe areas.
- On city/town streets drive in the middle lane rather than the curbside lane.
- Pull over to answer or make cell phone calls.
- Always lock the car doors after you park.
- Park in well-lit areas.
- Check around and under the car and rear seat before you get back in.
- Keep the car keys readily available.
- When you stop at a light or stop sign, always maintain a good distance from the car in front. This allows for swinging around the other vehicle in either direction if someone approaches.
- Don’t leave valuables and confidential information in view inside of a vehicle.

- Lock purses or briefcases in the glove box, center console, or trunk before you leave the office and not after you arrive at the destination.
- Avoid parking in areas where a car could be blocked. Park facing the direction needed to exit an area quickly and efficiently.
- In the case of car trouble, raise the hood, get in the car, lock the doors, and turn on emergency flashers. Use your cell phone to call for needed assistance. Wait for emergency road service or the police. If your cell phone is not working, attach a sign or drape a cloth from the window or door handle.
- If someone stops to offer help, open the window slightly, but do not get out of the car. Ask the person who stops to call a service truck or police.
- If your vehicle is hit from behind by another automobile, drive to the nearest well-lighted public place before you stop. If possible look for a police or fire station for assistance.
- Always use a well-fueled, reliable vehicle. Do not leave the vehicle low on gas.

Professionalism

Professionalism can be a safety strategy. When you conduct yourself in a professional manner and with a sense of purpose, the need for other safety strategies is minimized. RTC staff should conduct work professionally as an ethical standard of conduct. Staff should also be aware of establishing and maintaining appropriate boundaries with clients.

Communication

Adapt language and word choice to the client to the extent that professionalism and appropriateness are not compromised. Avoid profanity. Some words necessary to discuss sex acts may be profane, as defined by some. The use of these words may be necessary and therefore appropriate. Use a respectful tone, pace, pitch, cadence, and voice modulation.

Appendix A—Interview form.

First interview

Client name: _____ Date of birth: _____

Date if interview: _____

Barriers in medical system

1. What do you know about HIV and HIV care?

2. Do you have a medical provider for your HIV-related concerns?
    a. How is/was your relationship with your provider?

3. Have you had difficulty finding a medical provider?
    a. What made it difficult for you to find a medical provider?

4. What has prevented you from seeing an HIV doctor or remaining on treatment?

5. What about the medical system has made it hard for you to get care for your HIV (insurance, transportation, timely appointments, lack of provider empathy)?

Barriers in case management

1. When you were first diagnosed with HIV, did you meet with an HIV case manager?

2. If yes, what was your experience with case management like?

3. Did you have any concerns/barriers around case management?

Barriers to ART

1. Have you ever been prescribed medication to treat HIV (ART)?

2. If yes, are you currently taking them?
    a. Have you had any issues taking your medications consistently?

3. If no, is there a particular reason you are currently not on ART? Do you have any concerns about them such as potential side effects, cost, obtaining medications, etc.?

Social history

1. Has depression or your mood ever prevented you from seeking medical care or from taking your medications?

2. Has your drug or alcohol use ever prevented you from seeking medical care or from taking your medications?

3. How did you find out you have HIV? How long have you been living with HIV?

4. Where were you last seen by a doctor/clinician for your HIV? Have you received care in the last year? What makes it hard for you to attend your appointments?

5. Where are you living now/what is your living situation? Does anyone live with you? What is your relationship with them? Are they aware of your HIV status?

6. Is your living situation stable?

7. How is your diet? Do you get the nutrition you need on a regular basis?

8. Do you have anyone in your life that provides social or emotional support? Who else knows you have HIV?

9. How do you feel about your diagnosis?

During follow-up calls RTC staff may choose to talk to the client about their sexual activity. The purpose of these questions is to prevent the further transmission of HIV. These questions should not be asked during the initial encounter.

Sexual activity

1. Are you sexually active?

2. Do you choose to tell your sexual partners about your HIV status?
    a. If yes, what has telling your sexual partners about your HIV status been like for you?

3. Do you have any concerns about transmitting HIV to others? Why or why not?

4. Are you concerned about acquiring STIs?

Appendix B—Confidential access and confidentiality directive

Directive

1. As a Grantee of the Department you may have access to confidential information. This access may be part of your direct job duties. It also includes access incidental to your primary job duties. Confidential information is protected by federal and state law. Confidential information may take many forms, including paper, electronic, and verbal. Confidential information includes medical, personnel, financial, and demographic information about individuals, health care providers, and facilities, Department employees, and information proprietary to other companies and agencies or persons.
2. Department operations rely heavily on the gathering and proper use of confidential information. Improperly using or disclosing confidential information harms public health efforts and may expose you or the Department to legal liability.
3. You may only access and use confidential information when you have a need to know to do your work.
4. You may not discuss confidential information, including the names of individuals, health care providers and facilities, Department employees, and information proprietary to other companies or persons, except as necessary to do your work and you must take reasonable measures to safeguard confidential information from improper disclosure.
5. You may not in any way divulge, copy, release, sell, loan, review, alter, or destroy any confidential information except as properly authorized by your supervisor.
6. This document may not cover all restrictions on your access to or use of confidential information. Your employing agency and other law or Department policy may also apply to the confidential information provided by the Department. Your employing agency may provide specific training concerning

confidential information to which you have access.

7. You are responsible to know the policies and laws governing information to which you have access, including information provided to you by other programs within the Department, and if you have any questions about the confidentiality of information or the appropriateness of its disclosure, it is your responsibility to ask your immediate supervisor and contract manager. Specific policy and law that apply to information to which you may have routine access are attached to this agreement.
8. You must safeguard and not disclose any personal access code, password, or other authorization that allows you to access confidential information.
9. You are encouraged to speak to other employees to promote safeguarding confidential information if you see that their activities or practices may compromise confidential information.
10. A breach of this confidentiality directive may result in corrective or disciplinary action, up to and including, termination of contract agreements, as well as possible civil and criminal liability for you and the Department. Your obligations under federal or state law and this agreement continue after termination of your employment.

I have read and understand the above information and agree to abide by the requirements of this agreement.

_____	_____
Signature	Date
_____	_____
Printed name	Agency name
_____	_____
Witness signature and printed name	Date

DISTRIBUTION: One signed copy to the individual **AND** one signed copy filed at DHHS.