

# HIV Linkage to Care

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## Denver Public Health

**A successful linkage to medical care is an on-going process during which the client comes to assimilate his/her HIV diagnosis, to understand the implications of that diagnosis for self and others, to opt for appropriate care and services, and to commit to a regimen that enhances one's own health and protects that of others.**

## Protocols and Procedures





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### Acknowledgements

We would like to specifically acknowledge and thank the following people.

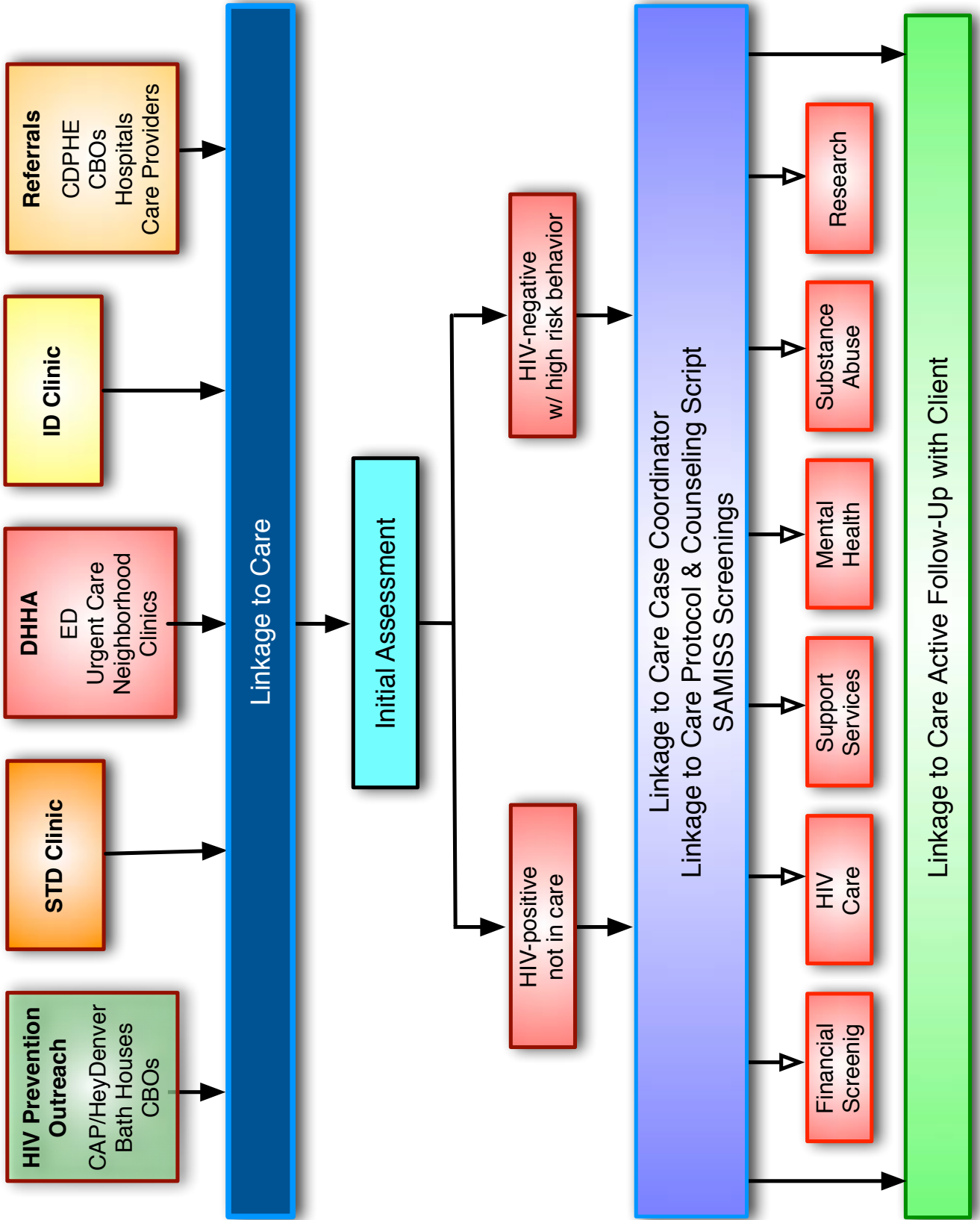
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# DENVER LINKAGE TO CARE PROTOCOL FLOW CHART





## Linkage To Care Protocol and Counseling Script

### **STANDARD POLICIES AND PROCEDURES**

#### **I. Purpose:**

To describe the policies at Denver Public Health for providing care for patients/clients who are:

- HIV Positive
  - Newly diagnosed HIV positive
  - Not newly diagnosed HIV positive but currently out of care
  - HIV positive and presenting with newly acquired STD's
- HIV Negative
  - HIV negative with indications of high risk sexual or needle sharing behaviors

#### **II. Goals and Objectives**

It is the goal of the Linkage to Care program:

- To effectively link into appropriate medical care every referred patient/client with a new HIV+ diagnosis and every HIV+ patient/client who is currently out of care.
- To provide HIV prevention risk reduction counseling to every patient/client.
- To provide appropriate substance abuse and mental health assessment [Substance Abuse and Mental Illness Symptom Screening (SAMISS)], for all HIV+ clients who are referred for services because of high-risk behaviors that would facilitate the transmission of HIV.
- To provide appropriate referrals to address identified patient/client issues and needs.

### **III. Populations served:**

- A. All persons who are newly diagnosed HIV positive, or found to be living with HIV but not currently in care should be offered care through the DPH Linkage-to-Care program. Also persons who are HIV positive presenting with a new STD.
- B. All persons found to be HIV negative with self-identified high risk sexual or needle sharing behaviors should be offered follow-up care through DPH Linkage-to-Care. Services will emphasize client-centered risk-reduction messages related to HIV and STD risks.

### **IV. Procedure:**

- A. The notifying or referring entity will provide Linkage to Care staff the names, dates, medical records numbers, contact information, and appropriate information for all patients/clients who are to be provided services.
  - i. The Linkage to Care office will provide a monthly on-call schedule. A Linkage to Care counselor will be on call Monday through Friday 8:00am-5:00pm
  - ii. The Linkage to Care office will also have a centralized phone message line (303-602-3652) for use during weekends and after hours.
- B. Linkage to Care will assign a specific staff member to each patient/client identified or referred. The assigned staff person will be responsible for providing appropriate care to patient/client as defined by LTC Protocol. Services will be tailored to suit individual patient/clients' situation and need.

The assigned staff person will:

- Collect or confirm accurate demographic and location information.



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- Conduct an assessment to ascertain the types of services that will be offered. Assessment will include emotional, psychological, material, and medical care needs.
- Ensure that Western Blot, CD4 and viral load labs are drawn and sent to laboratory, as indicated.
- Provide required post-test counseling, including interpretation of WB, CD4, and viral load labs.
- Provide HIV prevention risk-reduction counseling
- Actively connect patient/client to HIV partner counseling and referral services
- Assess patient/client for substance abuse and mental health issues using the Substance Abuse and Mental Illness Symptom Screener (SAMISS).
- Provide referrals and information for study enrollment.
- Provide ongoing services to assist patient/clients in successfully accessing medical care.
- Assure linkage into an HIV primary care setting.
- Complete all appropriate documentation of patient/client encounters.
- Provide follow-up care and support services to patients/clients to enhance adherence during the first year after having initiated medical care.
- Report to referring clinic all encounters, assessments, and referral services provided to patient/client.

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## C. Contact Information:

CDPHE [Colorado Department of Public Health and Environment]:  
303.692.2771  
DPH [Denver Public Health] – Linkage-to-Care: 303.602.3652  
Financial Screening: 303.602.2300  
Laboratory – Main Hospital: 303.436.6944  
ID Clinic: 303.602.8710  
Primary Care Clinic: 303.436.4727  
STD Clinic: 303.602.6540

## **COUNSELING SCRIPT**

Note: Counseling script is meant as a guide for use with all Linkage to Care patients/clients, however it is written with emphasis on those newly identified as HIV positive. Content should be adapted, as appropriate, to each individual situation.

### **Visit 1: Initial Assessment**

General Objective:

During the first encounter with all new patients/clients, the LTC staff will make an initial assessment for care and service needs.

Specific Objectives:

- Provide reassurance and support,
- Assess client's emotional state and support system,
- Collect client's contact information/demographics,
- Inform client in simple terms about what happens now,
- Set follow-up appointment.

During the initial visit with a newly diagnosed HIV positive client, it is important to remember that the client will probably be able to process limited information; consequently, that which is provided needs to be basic, simple, focused. It is essential to communicate to the newly diagnosed client a sense of reassurance and support; this is achieved both verbally and non-verbally through active listening, eye contact, and compassionate tone when speaking. It is equally important to assess the client's emotional state, identify her/his support system, obtain contact information, set date/time for follow-up appointment and provide basic information to client.

- The LTC staff will assess client's emotional status and inquire about support network (family, friends, partners, etc.) that will be available in the coming hours/days.
- The LTC staff will provide support and reassurance to newly diagnosed client.
- The LTC staff will provide information about the subsequent steps that will be followed as the client moves into medical care. The LTC staff will also answer any questions that the client may have at this time.

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- The LTC staff will obtain contact information and record it in the LTC electronic chart (Healthdoc).
- A follow-up appointment will be made with the client to discuss the CD4 and viral load test results.
- The client will be introduced to the state DIS representative.
- The CD4, Western Blot and viral load samples will be drawn, labeled and sent for lab processing with completed requisition slips according to HIV lab protocol.
- The LTC staff will enter information into the electronic charting system (Healthdoc).
- The LTC staff will complete the Subjective Objective Assessment Plan (SOAP) / Progress Note.

## **Reaction:**

***"Let's talk a little about what you are feeling right now."***

- What can you do to deal with your \_\_\_\_\_ (fear, anger, disappointment, etc.)?
- Who can you talk to?
- What are you going to do when you leave here?
- Is there someone you can be with?
  - Reinforce how normal any (and all) these reactions are.
  - Assess need for crisis intervention.
  - Identify client's support network in the next 24 – 48 hours.
  - Explain briefly what will be happening next:
    - Blood Tests: additional lab tests
      - Western Blot.
      - CD4, viral load
    - Follow-up appointment

## **Blood Tests:**

***"It is important to run some tests in order to better understand what the virus is doing and how your body is responding to the virus."***

- A **Western Blot** is a confirmatory test which looks for the presence of HIV antibodies in the blood. It is a required test to confirm the preliminary HIV results already obtained.

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- A **T-Cell** or **CD4** test will indicate your current level of T-Cells which are a type of cell the body uses to fight off infections.
- A **viral load** test is designed to measure the amount of HIV virus in your body at this time.

## **Referrals:**

***"The primary focus of meeting with you today is to make sure you have whatever you need to deal with receiving these positive results."***

What can I help you with today?

- Doctor's note?
- Talking to partner/friend(s)/family?
- Testing partner(s)?
- What referrals do you need or will you need?

## **Mental Health / Emotional Support:**

***"What kind support or assistance are you needing but not receiving at this time?"***

- How do drugs and alcohol impact your life?
- Offer Referrals:
  - Support groups / Substance abuse programs?
  - Housing / job / transportation issues?
  - Individual counseling?

## **Prevention:**

***"Let's talk for a moment about the opportunities and responsibilities to prevent further transmission of HIV."***

- What are some of the ways HIV is spread...?
- Do you understand the risk of transmission and re-infection?
- What can you do during the next couple weeks to eliminate or reduce the risk of transmission to your partner(s)?
- What questions do you have...?
- Let me introduce you to CDPHE / DIS staff. S/he is someone who can assist you with notifying and talking to your sexual and/or drug-use partners.

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## **Closure:**

***"I would like to meet with you again soon."***

- At our next meeting we will:
  - Review lab results.
  - Talk about risk reduction for yourself and your partner(s).
  - Follow-up Referrals.
  - Begin to identify the most appropriate option for medical care.

## Second Visit

### General Objective:

During the second encounter with all new clients, the LTC staff will make an assessment of how well the client is beginning to assimilate the HIV diagnosis. Additionally, the LTC staff will assist in identifying and selecting appropriate medical care option(s).

### Specific Objectives:

- Provide reassurance and support,
  - Assess client's special needs through SAMISS screenings,
  - Collect information about testing history, insurance (if any), disclosure, risk reduction and prevention steps taken since last encounter,
  - Inform client of lab results and their significance, study opportunities, care options, subsequent steps in linkage to care, answering questions/doubts,
  - Set follow-up appointment.
- 
- The LTC staff will reassess the client's well-being. The LTC staff will inquire about what has transpired since the first encounter and the level of disclosure to partner(s), family, and friends.
  - The LTC staff will make special note of the degree to which the client has begun to assimilated the HIV+ diagnosis.
  - The LTC staff will conduct client screenings through SAMISS.
  - The LTC staff will complete the Locator Information Page and Demographic page, if not completed previously.
  - The LTC staff will complete the Testing History Questionnaire, if not completed previously.
  - The LTC staff will offer client information about current research opportunities that may be beneficial and provide the client with other additional supportive services.
  - The LTC staff will assess the client's accessibility to care:
    - If the patient has private insurance or Medicaid/Medicare, explain care options:
      - Actively assist client to access medical care that meets their need.

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- Verify if private insurance is accepted at Denver Health and if so, inform client of the option for care through Denver Health.
  - If the client has Medicaid/Medicare, explain that care options include Denver Health.
  - Refer client to their own primary care physician (PCP) for appropriate referral to HIV specialist, or identify appropriate medical care resources that are within the private insurance network.
- If the client has no insurance or Medicaid/Medicare and lives **WITHIN** the City/County of Denver...
    - Explain to client the need for financial screening in order to access care at Denver Health.
    - Assist client in making an appointment for financial screening through the services of either the ID Clinic or other Denver Health financial screening options.
  - If the client has no insurance and lives **OUTSIDE** the City/County of Denver...
    - Facilitate an active referral with client to University Hospital. Referral will include assisting client with scheduling financial screening and ID Clinic appointments, etc....
  - The LTC staff will inform the client of the options for care available at Denver Health (the ID Clinic and the Primary Care Clinic) and the benefits that each offers. The LTC staff will attempt to match clients to one of the two care options based on client preferences when possible.
    - Any client with CD4 count  $\leq 200$  will be directed to the ID Clinic for medical care.
  - The LTC staff will update information in the electronic chart (Healthdoc) after each encounter.
  - The LTC staff will complete a SOAP progress note after each face-to-face encounter and make a note in comments section of Healthdoc after all phone calls with client.



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## **Check-In:**

### ***"How have things been going?"***

- Who have you been able to share this information with?
- What have you been doing since we last met?
- Do you have any immediate concerns that you want to talk about?
- Anything else you want to discuss before we proceed?

## **Laboratory Results:**

### ***"Let's take a look at the results of your blood tests..."***

- Provide a general explanation of the purpose for and results of each of the lab tests performed: Western Blot, CD4, viral load.

## **Medical Care:**

### ***"What are your thoughts about getting into medical care?"***

- Where would you like to be seen (ideally and practically)?
  - Discuss the purpose of care.
  - Discuss the options for care.
  - What can I do to help facilitate getting you into care?
- Define steps to identify preferred care options.

## **Mental Health / Emotional Support:**

### ***"What kind support or assistance are you needing but not receiving at this time?"***

- Assess client's well-being and identify needs.
- How do drugs and alcohol impact your life?
  - SAMISS Screening
- Offer Referrals...
  - Support groups / Substance abuse programs?
  - Housing / Job / Transportation issues?
  - Individual counseling?

## **Prevention:**

### ***"Did you know you were at risk for HIV infection?"***

- What were the circumstances? What was going on in your life? What feelings do you have about this time?
- Have you shared needles since our last visit?
- Tell me about your sexual activity since that time (or during the past year).
- What about other STD's?
  - What steps are you currently taking to protect yourself and your partner(s) from STD and HIV?
  - What have you tried in the past?
  - Is there a need for STD screening and hepatitis vaccinations?
- Do you understand how HIV is transmitted from one person to the next?
- Have you been engaged in any sexual activity since our last encounter?
- Did you disclose your HIV+ status? Was that easy to do?
  - What facilitated disclosure?
  - What made it more difficult?
- Did you and/or your partner(s) use condoms? Do you need more?
  - Was that easy to do?
  - What did you say to your partner(s)?
- Let's do a little role playing exercise now; maybe then the next time it will be a little easier.

## **Research Studies:**

### ***"Are you interested in participating?"***

- Provide information about current research opportunities.
- Ask client to state interest or lack of interest in research studies and request signature on appropriate document.
- Make notations in appropriate charts of client's willingness or not to participate in studies.

## **Closure:**

### ***"I would like to meet with you again during the next couple weeks."***

- Review any additional lab results.
- Talk about your progression in assimilating the HIV+ diagnosis.
- Following up on identifying the most appropriate option for medical care.
- Make follow-up appointment.

## Third and Subsequent Visits

### General Objective:

During the third encounter with all new clients, the LTC staff will assess how the process is going to obtain medical care. LTC staff will work with client in identifying and overcoming any barriers to accessing care.

### Specific Objectives:

- Provide reassurance and support,
  - Assess client's progress in assimilating HIV+ diagnosis,
  - Collect information about disclosure, risk reduction and prevention steps taken since last encounter, and client's thoughts about medical care,
  - Inform client of procedures for linking into care at Denver Health, or at another site, and provide active assistance as requested or required,
  - Set follow-up appointment.
- 
- The LTC staff will reassess the client's well-being during each visit to determine any new needs or concerns.
  - The LTC staff will review the client's channeling into medical care, providing assistance as needed or requested.
  - The LTC staff will update visit information in the electronic chart (Healthdoc) for each visit.
  - The LTC staff will complete SOAP / Progress Note for each visit.

### Check-In:

#### ***"How have things been going?"***

- What have you been doing since we last met?
- Do you have any immediate concerns that you want to talk about?
- Anything else you want to discuss before we proceed?

### Medical Care:

#### ***"What are your thoughts about getting into medical care?"***

- What have you done about getting into care since we last met?
  - Have you encountered any problems?
  - Are you in need of financial assistance for medical care?

- Have you made gathered necessary documents for appointment for Colorado Indigent Care Program (CICP) or DenverHealth Financial Assistance Program (DFAP)?
- Has a CICP appointment been scheduled? Can we schedule (or reschedule) that now, while you are here, as needed?
- Do you need to apply for ADAP? Can I refer you to the Social Worker to assist in the ADAP application?
- What can I do to help facilitate getting you into care?
- Are you having any problems with obtaining the required documentation?

## **Mental Health / Emotional Support:**

***"What kind support or assistance are you needing but not receiving at this time?"***

- Tell me about your relationships and support systems.
- Tell me about your family and your current relationships with them.
- Tell me about your friends and your current relationships with them.
- Tell about your partner(s) and your current relationship(s) with him/her/them.
- What level of support do you currently have? How can that be improved?
- Have you followed up on any of the referrals from our last encounter?
- Do you need any new or additional referrals...
  - Support groups / Substance abuse programs?
  - Housing / Job / Transportation issues?
  - Individual counseling?

## **Prevention:**

***"What have you tried, to maintain safety with your sexual partners?"***

- Do you understand how HIV is transmitted from one person to the next?
- Have you been engaged in any sexual activity since our last encounter?
  - What were the circumstances? How do you feel about them?
- Did you disclose your HIV+ status? Was that easy to do?
  - What facilitated disclosure?
  - What made it more difficult?
- Did you and/or your partner(s) use condoms? Do you need more?
  - Was that easy to do?
  - What did you say to your partner(s)?
- Do drugs or alcohol impact your sexual activity?

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- How can you avoid risky behaviors that put your partner(s) at risk for infection and you at risk for re-infection?

## **Closure:**

***"I would like to meet with you again during the next couple weeks."***

- Talk about your progression in linking in to medical care.
- Following up on any referrals.
- Make follow-up appointment.

## **Long Term Follow-Up and Discharge from Linkage to Care Program**

- Additional visits may be necessary and can be conducted on an as needed basis. Though the program is meant to be short term and time limited, should steps toward linkage still be in process, additional face-to-face sessions are acceptable.
- Discharge from active LTC program occurs after the patient/client attends a first HIV specialty medical care appointment.
- Patients/clients who have not yet linked to medical care but disengage from LTC staff are encouraged to reinitiate contact at any time in the future for further support and assistance.
- LTC counselors should obtain patient/client assent to call, email, text in the future to check on status.
- The LTC staff will conduct follow-up encounters with all patients/clients to assess adherence and address newly identified needs. These encounters will occur at intervals of one, three, six and twelve months.
  - Encounters are defined as either face-to-face meetings or phone calls.
  - Encounters will be documented in the client's chart and in Healthdoc.



## Protocol for Processing Labs

### **STANDARD POLICIES AND PROCEDURES**

#### **Protocol for Processing Western Blot, CD4 and Viral Load**

Blood samples are drawn on all newly diagnosed HIV+ clients. These initial labs are provided only one time. Initial labs may also be drawn for a not new positive in limited situations.

#### Registration:

- Registration is a two-step process:
  - Clients are registered in Invision under code "DPH".
    - STD clerks or Invision trained LTC staff member can complete registration. If client is being seen for an STD clinic visit, the Invision registration will already be completed.
  - Clients are registered in Invision under code "GPH".
    - STD clerks or Invision trained LTC staff member can complete registration.

#### Ordering CD4 and viral load tests:

- Order CD4 count and viral load in HealthDoc
  - Print labels from the Invision registration screen.
    - STD clerks or Invision trained LTC staff member can print labels.
  - Label tubes with printed labels
  - Hand write time of blood draw on each tube and initial
- Fill out requisition slip
  - Place sticker in upper right corner of requisition slip
  - Indicate on form which test is being ordered
  - Take properly labeled tubes with requisition (rec) slips to lab for processing

#### Ordering Western Blot test:

- Order in HealthDoc, label tubes, fill out CDPHE (state lab) WB rec slip, place sample and rec slip in tackle box in STD clinic at reception desk. Fill in collection number (serology number), fill in patient demographic info, specify which test, collection date and time.

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## Obtaining Lab results:

- When available, results can be found under patient's medical record number in Misys/Invision and also in LCR.
- LTC staff will need to manually enter TCell and viral load results into patients' HealthDoc record.
- Lab charges will be routed based on the "GPH" code to the Public Health grants staff. The grants staff will divert the bill and patient will not be charged for labs ordered using the "GPH" code.



## Writing a Progress Note Using Subjective Objective Assessment Plan (SOAP) Format

### **Introduction to Writing a SOAP Note**

#### **Purpose:**

To record information from the patient in order to accurately ascertain the information which you need to know about the patient and their disease process so that you can make an appropriate linkage to medical care. The written record also provides a means of communication between you and your professional colleagues. It should be written in a manner which allows the reader to see what you observed, performed, discussed and plan to do for and with the patient.

Sometimes it is helpful to make background notations before beginning to complete a SOAP note. For example, if the patient is late to his/her appointment, if the STD clinician provides information about the client before you enter into the exam room (client is angry, non-responsive, crying, etc.), any information or circumstance that might influence your encounter with the client.

#### **Subjective:**

In this section notations are made of what the client said. The client knows best how s/he feels. Active listening is a skill not easily achieved.

In working with HIV clients, especially newly diagnosed clients, you are seen as the professional and the client is the novice. You likely know more than the client about the virus and its effects; you represent the medical community. However, knowledge is useless unless it can be appropriately offered and shared at a time and place where it can be adequately heard and understood. That moment will vary from patient to patient and unless the skill of active listening is practiced and refined, it will never be recognized.

Let the subject (client) speak. Listen to the subject. Make note here of what the subject says. Try to recreate the conversation and include in this section of the SOAP note everything the client said, though it may seem irrelevant and unimportant. By doing so,

the care provider learns to listen more closely and hear precisely what the client has to say; often times, unfortunately, actively listening is substituted by opportune listening, i.e., looking for an opportune moment to interject one's own thoughts, ideas, and suggestions into the client's conversation.

Verbatim recordings are excellent tools in refining listening skills. A verbatim, re-creates word-for-word a portion of the client's conversation. Write it down as if it were a movie script; make it no longer than one and one half pages. Make notations of what the client did as s/he spoke. In addition to improving listening skills, writing and studying verbatims help identify issues that very frequently present themselves but are not immediately recognized.

## **Objective:**

Observations. What was observed during the encounter? How was the client dressed? Did s/he maintain eye contact? How was their breathing? Shallow, deep, rapid, slow? Was the client alert? Was the client engaged in the conversation or did was the conversation carried by you? Were there pauses? Were they frequent? Did the client seem to communicating something that was not verbalized? Did the client seem at ease or worried? Did the client seem comfortable or uncomfortable? What did the client do to communicate this?

Observations of non-verbal actions/activity can frequently communicate as much information to the care provider, if not more, than what was said.

## **Assessment:**

Assessment includes the different challenges and opportunities for linking the client into HIV care in the most appropriate site and into ancillary services as required. Identifying challenges and opportunities will help prepare for and facilitate follow-up appointments.

## **Plan:**

Identifying a care plan is helpful for both client and care provider. The client will often experience relief and support if s/he has a sense of what comes next and/or down the road. An HIV diagnosis is particularly distressing for many because they don't know what the future holds. Including them in elaborating or explaining the plan can be extremely reassuring. For the care provider, a care plan will help be useful in identifying additional

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services and agencies that the client may require as well as determining the appropriate site for medical care.

<b>Linkage to Care SOAP Note</b>	
Participant ID:	Visit Date:
Session #:	Staff:

*Subjective: What did the patient say?*

*Objective: What did you observe?*

*Assessment: What is your evaluation?*

*Plan: What was decided and what will happen next?*



## Protocol for Anonymous Testing

### **STANDARD POLICIES AND PROCEDURES**

#### **Anonymous Testing in the STD Clinic through HIV Counseling and Testing Services (CTS)**

Advise clients at the beginning of the pre-test counseling that:

- a. Anonymous testing is only available to those clients who do not desire any additional STD screenings. If additional screenings are desired at the time of this visit, the HIV testing will be confidential.
  
- b. If the results of anonymous testing for HIV are positive, then no additional lab work, except for the confirmatory Western Blot, will be done without the client providing personal identifying information.

If the client chooses to provide identifying information, then the anonymous testing registration will be converted to a confidential testing registration.



## Code of Ethics for HIV & STD Prevention Providers

### Appendix A

#### Code of Ethics for HIV & STD Prevention Providers (Adopted From Colorado Department of Public Health and Environment)

This Code of Ethics is intended to set a standard for exemplary conduct for paid staff and volunteers providing HIV prevention services, hereafter referred to as "HIV prevention practitioners." This Code is intended to outline the responsibilities of HIV prevention practitioners to the public at large, to their clients, and to their colleagues. This code is guided by core values and a commitment to honor, even at the sacrifice of personal advantage. It is divided into five key principles: non-discrimination, competence, integrity, relationships with clients, and confidentiality.

#### **1) Non-Discrimination**

An HIV prevention practitioner shall not discriminate against clients or colleagues based on HIV serostatus, race, ethnicity, country of origin, age, gender, substance use, socioeconomic status, sexual orientation, linguistics, disabilities, or geographic settings (including migrant, seasonal or resort workers). An HIV prevention practitioner should strive toward proficiency in regard to culture and other aspects of diversity.

#### **2) Competence**

An HIV prevention practitioner shall adhere to approved standards of practice when implementing HIV prevention interventions and shall strive continually to improve personal competence and quality of service delivery. Competence is derived from a synthesis of training and experience. It begins with a mastery of knowledge and skill competencies. The maintenance of competence requires a commitment to learning and professional improvement and must be ongoing.

**a)** An HIV prevention practitioner should be diligent and practice due care in providing HIV prevention services. Diligence involves rendering services in a careful and prompt manner, observing applicable technical and ethical standards.

Due care involves adequate planning and supervision of any activity for which they are responsible.

**b)** An HIV prevention practitioner should recognize the limitations and boundaries of their competence and refrain from using techniques or offering services beyond their competence. Each practitioner is responsible for assessing his/her competence for the responsibilities assumed.

**c)** When an HIV prevention practitioner is aware of unethical conduct or practice on the part of an agency or another practitioner, they have an ethical duty to report the conduct or practices to appropriate authorities.

### **3) Integrity**

To maintain and broaden public confidence, an HIV prevention practitioner should perform all responsibilities with the highest sense of integrity. Integrity can accommodate the inadvertent error and honest difference of opinion; it cannot accommodate deceit or subordination of principle.

**a)** Personal gain and advantage should not subordinate service and public trust.

**b)** An HIV prevention practitioner should conduct prevention activities fairly and accurately, resisting pressures to unduly censor or mislead.

**c)** HIV prevention practitioners in positions of authority should exercise compassion and wisdom to prevent harm to those whom we are pledged to serve: people affected by, infected with, or at risk of being infected with HIV.

**d)** An HIV prevention practitioner should not misrepresent, directly or by implication, professional qualifications or affiliations.

**e)** An HIV prevention practitioner should not be associated directly or indirectly with services or products in a way that is misleading or incorrect.

### **4) Relationships with Clients**

Above all, HIV prevention practitioners should do no harm. Practices must be respectful and non-exploitative.



## **5) Confidentiality**

**a)** HIV-related confidential information (including HIV serostatus and other potentially sensitive information, etc.) that is acquired while rendering HIV prevention service must be safeguarded against disclosure, including - but not limited to - verbal or written disclosure, unsecured maintenance of records, or recording of an activity or presentation without appropriate releases or consent. Statute and regulations explicitly govern circumstances under which HIV-related information may be disclosed. Professional ethics or personal commitment to the preservation of trust may impose even stricter confidentiality guidelines than those reflected in the law.

**b)** Where there is evidence of child or other abuse, an HIV prevention practitioner is expected to comply with statutory reporting requirements, which is governed by their professional affiliations.

**c)** HIV prevention practitioners should develop and implement methods by which client confidentiality protections and rights are communicated and consent for the service is obtained. Such methods must be appropriate to the intervention type.

## **6) Other Professional Standards of Practice**

In some cases, HIV prevention practitioners have other professional affiliations (nursing, social work, psychology, etc.) that require adherence to a separate code of professional conduct. The five principles listed above are not intended to override such codes of professional conduct, but to augment them and provide insight into areas that are unique to the field of HIV prevention.



## Characteristics of a Successful HIV Prevention Program

### **Appendix B**

#### **Characteristics of Successful HIV Prevention Programs and Theoretical Considerations**

##### **General Characteristics**

1. They are based in behavioral and social science theory and research. Widely recognized theories include: Health Belief Model, Theory of Reasoned Action, Social (Cognitive) Learning Theory, Transtheoretical Model (Stages of Change), AIDS Risk Reduction Model, Theory of Gender and Power, and Ecological Systems Theory.
2. They have clearly defined target groups, objectives, and interventions.
3. They have their basis in real, expressed needs of the community and individuals, and are designed according to the results of a comprehensive assessment of those expressed needs as well as an assessment of the level of motivation of the target population to change risk behaviors.
4. They are easy to access by the target populations.
5. They are culturally competent and their prevention messages are linguistically appropriate and tailored to the audience members in terms of culture, gender, age, sexual orientation, and educational level, with accommodations made for disabled participants.
6. They address the social and community norms of the target population so that program participants receive consistent messages and reinforcement for the prescribed behavior change.
7. They are offered to the target group as part of a continuum of health care (e.g. substance abuse treatment, STD testing and treatment, family planning, other physical and mental health services, etc.).
8. They address other basic needs of the targeted population (e.g. housing, food, etc.) in order for HIV prevention to be considered a priority.

9. They provide appropriate referrals that may include, but are not limited to: substance abuse treatment, HIV counseling and testing, family planning services, STD testing and treatment, hepatitis-related services, risk-reduction or relapse prevention counseling, mental health counseling, tuberculosis testing, women's health services, and HIV early intervention services.
10. They focus on behavioral skills that include how to carry out safer behaviors as well as how to avoid and cope with high-risk situations.
11. They do not provide messages that are judgmental, moralistic, or that attempt to instill fear.
12. They have ample duration and intensity to achieve lasting behavior change, and provide the support and skills necessary to maintain behavior change.
13. They incorporate quality assurance measures and adherence to plans.
14. They use evaluation findings to make timely adjustments to the programs, in order to better meet the needs of the target population.
15. They have realistic financial, human, and material resources to carry out the program.
16. They have a plan on how services will be accessible and appropriate to people who are deaf, hard-of-hearing, visually impaired, developmentally disabled, mentally disabled, or physically disabled.
17. They have protocols in regard to the safety of staff, volunteers, and clients.

## **Theoretical Considerations**

HIV prevention programs that are most likely to succeed are based on a clear understanding of the targeted health behaviors of a well-defined target population as well as their environmental context. Theories of behavior change can and should be used to understand the "prerequisites" or necessary components for change within a target population. They can be used to help planners and educators better understand the influences upon human behavior that need to be addressed in HIV prevention interventions. They can guide the development and management of strategic planning models by providing planning groups with a checklist of factors to consider in assessing needs and in designing an intervention. They can also guide the appropriate evaluation of an intervention as they suggest what to monitor and how to measure effectiveness.

## **Theory and Its Importance to Health Programs**

A theory is a set of interrelated concepts, definitions, and propositions that present a systematic view or explanation of behaviors, events, or situations by specifying relations among multiple variables or factors. Theories are "abstractions," which mean they are not meant to explain specific and concrete content or topic areas such as specific behaviors of particular individuals. Instead they provide the shape and the boundaries for explaining a wide range of phenomena such as behavior patterns seen within groups of individuals. Theories are also generalizable, which means they can be used to explain a variety of similar situations among different populations and predict outcomes. Formal theories are those that are developed and tested within a scientific framework.

Theories can help us understand the nature of targeted health behaviors and suggest ways to achieve positive behavior change. They can explain the dynamics of the behavior, the processes for changing the behavior, and the effects of external influences on the behavior. Theories can also help, but should not be the only determinant, that health providers use to identify the most appropriate target populations for programs, the most effective methods for accomplishing positive behavior change, and the outcomes for evaluation. Some theories focus on individuals as the unit of change, while others focus on change in groups, communities, or organizations.

## **Theories and Approaches Relevant to HIV Prevention**

Because the HIV epidemic is driven by behavior, psychological and social theories of human behavior and behavior change have made significant contributions to the design, development, and evaluation of HIV prevention interventions. Programs that are most likely to be effective are guided by an ecological perspective, based not only on a clear understanding of targeted health behaviors, but also on their environmental context. Therefore one must approach HIV prevention, as well as other public health issues, at multiple levels of influence, stressing the interaction and integration of factors within and across levels. Key to this is the recognition that human behavior is affected by and is affecting these multiple levels of influence that are occurring within personal, social, and cultural environments. Therefore programs should combine behavioral and environmental components and be based on research and formative evaluation that assesses needs and influences at multiple levels. Below is a list of some of the principle theories that have been

used to guide HIV prevention interventions at individual and group levels and at the level of the target population or community. Brief summaries of these theories can be found in Appendix C.

- Health Belief Model
- Theory of Reasoned Action
- Social (Cognitive) Learning Theory
- Transtheoretical Model (Stages of Change)
- AIDS Risk Reduction Model
- Theory of Gender and Power
- Ecological Systems Theory

## **Discussion**

One of the greatest challenges is to learn to analyze the "fit" of a theory or model for issues one is working with, especially since the various theories used within the arena of HIV prevention share many elements. For instance, the four most prominent individually-based theories (the Health Belief Model, the Theory of Reasoned Action, Social Learning Theory, and the Transtheoretical Model) have the following in common: 1) perceptions of threat and susceptibility; 2) attitudes toward performing risk-reduction behaviors; 3) normative beliefs about one's peers and community members; 4) beliefs and attitudes about one's own ability to carry out preventive actions; 5) the acquisition of social and behavioral skills that result in risk reduction; and 6) motivational factors that bring a person to a state of readiness to act. What distinguishes these is what they emphasize. In designing a behavioral intervention, depending on the needs of the target population, one might use a combination of theories as the best fit to guide design, implementation, and evaluation.

The theories described above are not without their critics. The models of behavior change that focus on individuals are commonly critiqued for their lack of emphasis on context and the powerful influences on human behavior that are drawn from the sociocultural environment. Those that emphasize populations and communities are, in turn, critiqued, for their inability to accommodate the needs of individuals who may be disenfranchised from communities and/or who have special needs different from those of the general population. Others see a major limitation in the lack of specificity in all of these theories

concerning sexual desire, pleasure, affection, and sexual self-esteem. Relationships are at the core of HIV transmission, but the unique features of these relationships (love, affection, self-esteem, power, survival, intimacy, coercion, lust, and trust) are not directly addressed by existing models of behavior change.

## **Sources**

- Kalichman, Seth C., 1998, Preventing AIDS: A Source Book for Behavioral Interventions. Lawrence Erlbaum Associates, Inc.
- California STD/HIV Prevention Training Center, 1998, Participant Manual: Bridging Theory and Practice.
- National Cancer Institute, 1999, Theory at a Glance: A Guide for Health Promotion Practice. National Institutes of Health.
- Wingood, Gina M. and Ralph 3. DiClemente, 2000, Application of the Theory of Gender and Power to Examine HIV-Related Exposures, Risks Factors, and Effective Interventions for Women. Health Education and Behavior. (October).

## **Other Resources**

Compendium of HIV Prevention Interventions With Evidence of Effectiveness. Available on the Centers for Disease Control and Prevention (CDC) web site: <http://www.cdc.gov/hiv/topics/research/prs/evidence-based-interventions.htm>

Denver STD/HIV Prevention Training Center, Denver Public Health  
<http://www.denverptc.org/>





## Theories and Models

### **Appendix C**

(adapted from Colorado Department of Public Health and Environment)

#### **Health Belief Model**

The Health Belief Model is based on the premise that perceptions of personal threats are a necessary precursor to taking preventive action. The major factors that influence whether or not a person will adopt new behaviors to lower risk include:

- 1) characteristics of the individual that influence behavior;
- 2) perceived susceptibility on the part of the individual (i.e., to what extent do they think they can get HIV) and perceived severity of the health problem;
- 3) expectancies for taking action and making a particular behavior change (i.e., perceived benefits, barriers, and costs for taking action); and
- 4) cues in the environment that promote taking action.

Recently added to this model is the concept of self-efficacy, or one's confidence in the ability to successfully perform an action. Overall, one must believe that the benefits of performing a behavior outweigh the consequences of not performing it before behavior change will occur.

#### **Theory of Reasoned Action**

The Theory of Reasoned Action is based on the premise that attitudes about behaviors and perceived norms for practicing behaviors lead to intentions that are then a step away from engaging in a specific behavior. Behavioral intentions are determined by attitudes, beliefs, and perceptions that are all influenced by social contexts and individual experiences. Community attitudes and beliefs and norms are social forces that influence individuals' intentions and behavior. Behavior is a function of the processing of information available to a person in a given context at a given time. Behavior is therefore determined by intentions, attitudes, perceived normative pressures, beliefs about consequences, values placed on perceived norms, and values placed on potential outcomes. The Theory of Reasoned Action is also based on the premise that behaviors are under the direct

control of individuals. However, there are many instances when individuals lack direct control over their actions, and the theory is limited in explaining behaviors under these circumstances.

## **Social (Cognitive) Learning Theory**

The Social Learning Theory is also based on the premise that behaviors, environmental influences, and personal factors such as attitudes and beliefs are highly interactive and interdependent, meaning that they each influence the others. The environment shapes, maintains, and constrains behavior, but people are not passive in the process as they can create and change their environments. This theory emphasizes the roles of outcome expectancies (beliefs about positive or negative consequences) and reinforcement for adopting behavior changes. Central to the theory are self-efficacy beliefs that are tied to the ability to perform specific actions under specific circumstances. Acquisition of new skills is often required that are obtained through direct experience or by modeling others.

The Social Learning Theory assumes that individuals exist within environments where other people's thoughts, advice, examples, assistance, and emotional support affect their own feelings, behaviors, and health. Some of these influential people might include family members, coworkers, peers, health professionals, and others who are similar to them.

## **Transtheoretical Model (Stages of Change)**

The Transtheoretical Model proposes that behavior change is a process and not an event. People are at varying levels of motivation or readiness to change. The theory proposes that people move through a sequence of change processes that are ordered by degrees of motivation and behavior. These vary for different individuals and groups and for different behavioral changes. The theory emphasizes the primacy of cognitive processes (e.g., attitudes and beliefs).

The change process includes the following stages:

- 1) pre-contemplation;
- 2) contemplation;

- 3) preparation:
- 4) action; and
- 5) maintenance.

The process is not linear and often involves relapse as a normal part of one's attempt to change behaviors. A provider must determine people's status in the change process when designing an intervention. People at different points in the process of change can benefit from different interventions, matched to their stage at that time.

## **AIDS Risk Reduction Model**

Using constructs derived from the Health Belief Model, the Social Cognitive Theory, the Diffusion of Innovation Theory, and the Transtheoretical and other models, the AIDS Risk Reduction Model is crafted specifically for HIV prevention. It is also a stage model in which an individual must first recognize and label their vulnerability for HIV infection, make a commitment to changing their behavior (which involves changing attitudes and gaining self-efficacy), and, finally, enacting the change. This final stage includes "help seeking" which involves gaining support for changing behaviors, communicating with sex partners, and initiating change.

## **Theory of Gender and Power**

The Theory of Gender and Power grew from a realization that most of the theoretical models driving the field of HIV prevention had an individualistic orientation and did not consider the broader context of women's lives. It is a social structural theory based on premises of sexual inequality and gender and power imbalance. According to the theory, there are three major social structures that characterize the relationships between men and women: the sexual division of labor, the sexual division of power, and the structure of cathexis (including social norms and affective attachments). These three structures exist at two different levels: the societal and the institutional. They are rooted in society through numerous abstract, historical, and sociopolitical forces that consistently segregate power and ascribe social norms on the basis of gender-determined roles. They are evident in social institutions such as schools, work sites, families, religious institutions, and through images of women in the media. The presence of these and other social mechanisms

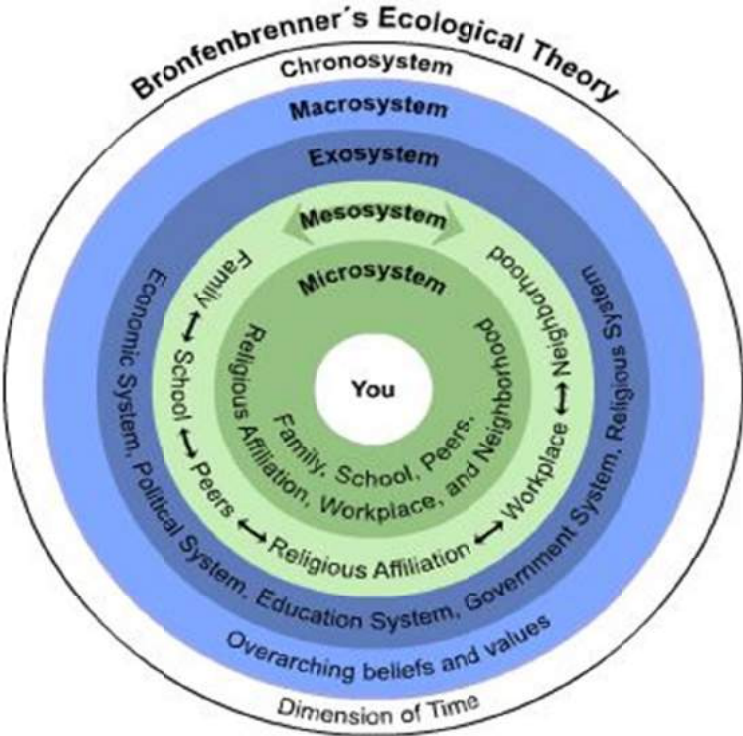
# Denver Linkage to Care



constrains women's behaviors by producing gender-based inequities in women's economic potential and control over resources as well as the expectations of women's roles in society. Such inequities and disparities in expectations generate exposures and risk factors that adversely influence women's risks for HIV.

## Ecological Systems Theory

The Ecological Systems Theory addresses the interaction between individuals and their environment and states that people are both products and creators of their own environments. The theory argues that each person uniquely possesses particular capacities, limitations, temperaments, preferences, values, norms, and experience and, that to understand the individual, one must understand the individual's ecological niche – the physical, social, and psychological environment in which the individual lives. This theory defines complex layers of environment that have effects on human development. Changes in one layer may have a ripple effect throughout the other layers. These environments can be thought of as nested within each other. The following diagram illustrates these layers.



Present the five ecological systems and note that each system contains roles, norms, and

rules that shape development:

- Microsystem – setting in which the individual lives and where the most direct interactions with social agents occurs; a person’s own biology may be considered part of the individual system.
- Mesosystem – relations between Microsystems or connections between contexts (e.g., between child and school).
- Exosystem – links between social settings where the individual has no active role and the individual’s immediate context (e.g., child’s home experience is influenced by the mother’s work experience).
- Macrosystem – culture in which the individual lives; includes socioeconomic status, poverty, ethnicity, etc. Also includes sociohistorical circumstances (e.g., influence of parents’ divorce in a person’s life or career opportunities for women).
- Chronosystem – (added later) patterning of environmental events and transitions over the course of a person’s life.

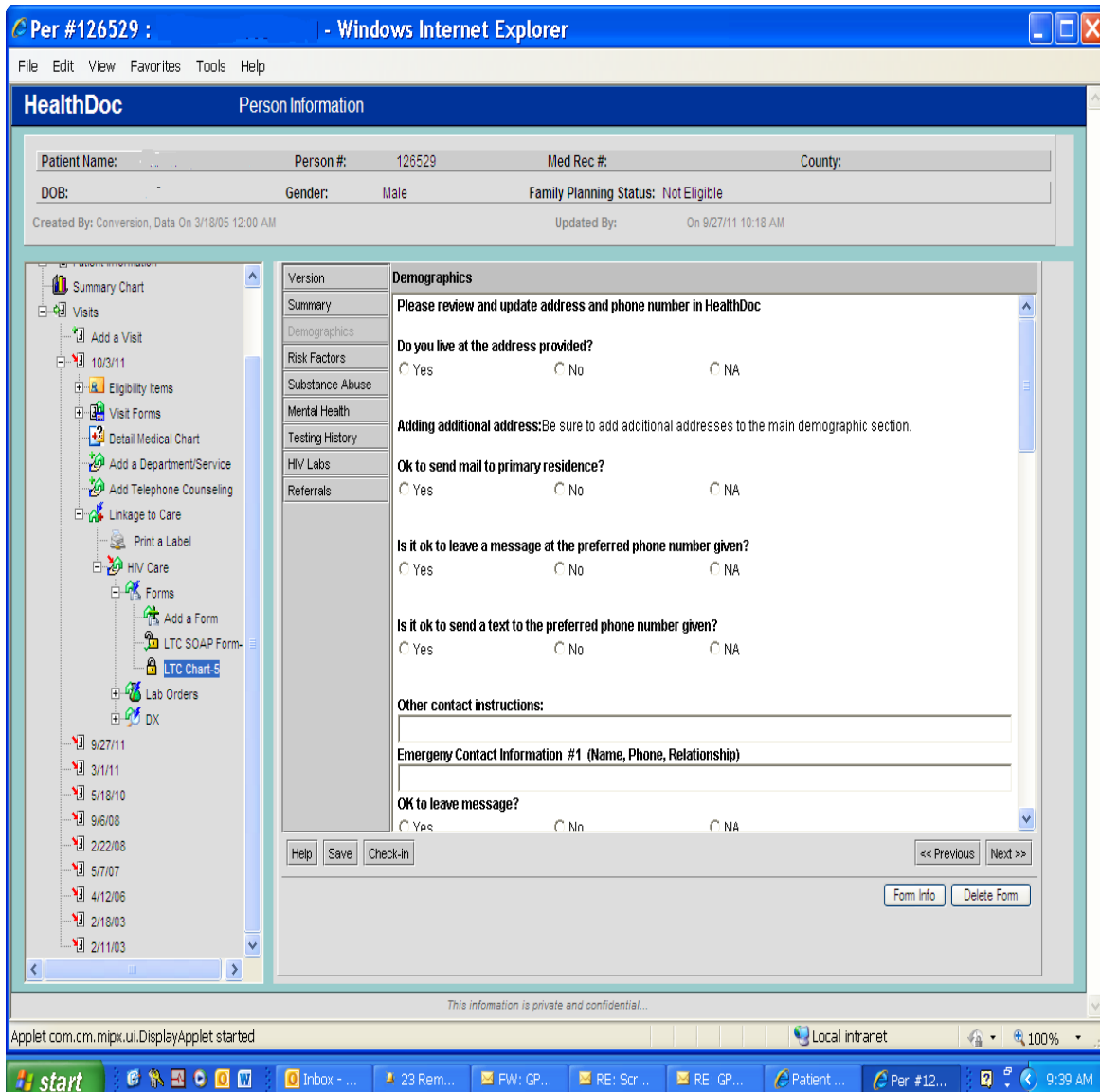
The value of using the Ecological Systems Theory approach:

- Shifts attention from the characteristics possessed by individuals or their environments to the interaction between systems (means no longer viewing the individual’s problems or disturbances as pathological)
- Presents individuals as having the ability to contribute to an environment, change it, or create a new one
- Develops understanding of open and closed systems and what these mean in terms of interventions
- Raises awareness of the impact of interventions, emphasizing that change in one part of a system can greatly affect the whole
- Helps determine where the point of intervention could or should be
- Provides a language that can cut across traditional disciplinary boundaries
- Explains cultural influences as dynamic



## LTC Chart in STD Electronic Records System

### A. Demographics



The screenshot shows a web browser window titled "Per #126529 : - Windows Internet Explorer". The main content area is titled "HealthDoc Person Information". At the top, there is a header bar with "HealthDoc" and "Person Information". Below this, a form displays patient details: Patient Name, Person # (126529), Med Rec #, County, DOB, Gender (Male), and Family Planning Status (Not Eligible). It also shows creation and update timestamps.

The main form area is titled "Demographics" and contains several sections:

- Summary:** A note: "Please review and update address and phone number in HealthDoc".
- Do you live at the address provided?:** Radio buttons for Yes, No, and NA.
- Adding additional address:** A text field with the instruction: "Be sure to add additional addresses to the main demographic section."
- Ok to send mail to primary residence?:** Radio buttons for Yes, No, and NA.
- Is it ok to leave a message at the preferred phone number given?:** Radio buttons for Yes, No, and NA.
- Is it ok to send a text to the preferred phone number given?:** Radio buttons for Yes, No, and NA.
- Other contact instructions:** A text input field.
- Emergency Contact Information #1 (Name, Phone, Relationship):** A text input field.
- OK to leave message?:** Radio buttons for Yes, No, and NA.

At the bottom of the form, there are buttons for "Help", "Save", "Check-in", "<< Previous", "Next >>", "Form Info", and "Delete Form". A footer note states "This information is private and confidential...". The browser's status bar shows "Applet.com.cm.mpx.ui.DisplayApplet started" and "Local intranet". The Windows taskbar at the bottom shows the start button, system tray, and several open applications including an email client and a patient management application.

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## B. Risk Factors

The screenshot shows a web browser window titled "Per #126529 : - Windows Internet Explorer" displaying the HealthDoc application. The page is titled "Person Information" and contains the following data:

Patient Name:	Person #:	126529	Med Rec #:	County:
DOB:	Gender:	Male	Family Planning Status:	Not Eligible

Created By: Conversion, Data On 3/18/05 12:00 AM Updated By: On 9/27/11 10:18 AM

The left sidebar shows a tree view with categories like "Summary Chart", "Visits", "Eligibility Items", "Visit Forms", "Detail Medical Chart", "Add a Department/Service", "Add Telephone Counseling", "Linkage to Care", "Print a Label", "HIV Care", "Forms", "Add a Form", "LTC SOAP Form", "LTC Chart-5", "Lab Orders", and "DX".

The main content area is titled "Risk Factors" and includes a list of checkboxes:

- Sex w/ MSM
- IDU
- High Risk Heterosexual
- Sex while intoxicated and/or high on drugs
- Gave money or drugs in exchange for sex
- Transfusion / Transplant
- Occupational Exposure (health care worker)
- Suspected perinatal infection
- Unknown
- Other:

At the bottom of the form, there are buttons for "Help", "Save", "Check-in", "<< Previous", "Next >>", "Form Info", and "Delete Form". A footer note states "This information is private and confidential...". The Windows taskbar at the bottom shows the start button, several open applications, and the system clock at 9:41 AM.



# Denver Linkage to Care



## C. Substance Abuse

The screenshot shows a web browser window titled "Per #126529 : - Windows Internet Explorer". The main content area is the "HealthDoc" interface, specifically the "Person Information" section. The patient's details are as follows:

- Patient Name: \_\_\_\_\_
- Person #: 126529
- Med Rec #: \_\_\_\_\_
- County: \_\_\_\_\_
- DOB: \_\_\_\_\_
- Gender: Male
- Family Planning Status: Not Eligible
- Created By: Conversion, Data On 3/18/05 12:00 AM
- Updated By: On 9/27/11 10:18 AM

The "Substance Abuse" form is displayed with the following questions and options:

- How often do you have a drink containing alcohol?**
  - Never
  - Monthly or less
  - 2-4 times a month
  - 2-3 times a week
  - 4+ times a week
  - NA
- How many drinks do you have on a typical day when you are drinking?**
  - 1 or 2
  - 3 or 4
  - 5 or 6
  - 7 to 9
  - 10 or more
  - NA
- How often do you have four or more drinks on one occasion?**
  - Never
  - Monthly or less
  - 2-4 times a month
  - 2-3 times a week
  - 4+ times a week
  - NA
- In the past year, how often did you use nonprescription drugs to get high?**
  - Never
  - Monthly or less
  - 2-4 times a month
  - 2-3 times a week
  - 4+ times a week
  - NA
- How often did you use prescription drugs to get high or change the way you feel?**
  - Never
  - Monthly or less
  - 2-4 times a month
  - 2-3 times a week
  - 4+ times a week
  - NA
- In the past year, how often did you drink or use drugs more than you meant to?**
  - Never
  - Monthly or less
  - 2-4 times a month
  - 2-3 times a week
  - 4+ times a week
  - NA
- In the past year how often did you want to cut drinking or drug use and not been able to?**
  - Never
  - Monthly or less
  - 2-4 times a month
  - 2-3 times a week

The form includes navigation buttons: "Help", "Save", "Check-in", "<< Previous", and "Next >>". There are also "Form Info" and "Delete Form" buttons at the bottom right. The Windows taskbar at the bottom shows the time as 9:42 AM and the date as 2/11/03.

# Denver Linkage to Care



## D. Mental Health

The screenshot shows a web browser window titled "Per #126529 : Windows Internet Explorer" displaying the HealthDoc "Person Information" page. The patient's details are as follows:

Patient Name:	Person #:	126529	Med Rec #:	County:
DOB:	Gender:	Male	Family Planning Status:	Not Eligible

Created By: Conversion, Data On 3/18/05 12:00 AM  
Updated By: Maciel, Renee On 9/27/11 10:18 AM

The main content area is titled "Mental Health" and contains the following questions and options:

**During the past 12 months:**

- Ever on medication/antidepressants for depression or nerve problems?  
 Yes  No  NA
- Ever a time when you felt sad, blue, or depressed for 2 weeks or more in a row?  
 Yes  No  NA
- Ever a time lasting 2+ weeks when you lost interest in most activities that usually give you pleasure?  
 Yes  No  NA
- Ever have a period lasting 1+ month when most of the time you felt worried and anxious?  
 Yes  No  NA
- Ever had an attack where you felt frightened, anxious, or uneasy when most people would not be?  
 Yes  No  NA
- Ever had a spell or an attack when for no reason your heart suddenly started to race.

At the bottom of the form, there are buttons for "Help", "Save", "Check-in", "<< Previous", "Next >>", "Form Info", and "Delete Form". A footer note states "This information is private and confidential...". The Windows taskbar at the bottom shows the Start button, system tray, and several open applications including Outlook and Internet Explorer.

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## E. Testing History

The screenshot shows a web browser window titled "Per #126529 : - Windows Internet Explorer". The main content area is the "HealthDoc" application, specifically the "Person Information" section for patient "Per #126529".

**Person Information:**

- Patient Name: [Redacted]
- Person #: 126529
- Med Rec #: [Redacted]
- County: [Redacted]
- DOB: [Redacted]
- Gender: Male
- Family Planning Status: Not Eligible
- Created By: Conversion, Data On 3/18/05 12:00 AM
- Updated By: On 9/27/11 10:18 AM

**Navigation Tree (Left):**

- Summary Chart
- Visits
  - Add a Visit
  - 10/3/11
  - Eligibility Items
  - Visit Forms
  - Detail Medical Chart
  - Add a Department/Service
  - Add Telephone Counseling
  - Linkage to Care
  - Print a Label
  - HIV Care
    - Forms
      - Add a Form
      - LTC SOAP Form
      - LTC Chart-S
    - Lab Orders
    - DX
  - 9/27/11
  - 3/1/11
  - 5/18/10
  - 9/6/08
  - 2/22/08
  - 5/7/07
  - 4/12/06
  - 2/18/03
  - 2/11/03

**Testing History Form (Right):**

- Version** (Dropdown)
- Summary** (Section Header)
- The month and year of the very first positive test for HIV: [Input field] [Reset] [Clear]
- When you first tested positive for HIV, did you test anonymously?  
 Yes  No  NA
- What was the name of the place where you got your first positive test?  
[Input field]
- State where you got your first positive test?  
[Input field]
- Did you get that test:  
Because you thought/were worried that you might have been exposed to HIV in the 6 months before your first positive test?  
 Yes  No  Refused  Don't Know  
 NA
- Because you got tested on a regular basis (1 or 2 times per year) and it was time for you to get tested again?  
 Yes  No  Refused  Don't Know  
 NA
- Because you were just checking to make sure you were HIV negative?

**Form Controls:** [Help] [Save] [Check-in] [Previous] [Next] [Form Info] [Delete Form]

This information is private and confidential...

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## F. HIV Labs

The screenshot displays the HealthDoc software interface within a Windows Internet Explorer browser window. The browser title bar shows "Per #126529 : - Windows Internet Explorer". The HealthDoc interface is titled "Person Information" and displays patient details for "Per #126529".

**Person Information:**

- Patient Name: [Blank]
- Person #: 126529
- Med Rec #: [Blank]
- County: [Blank]
- DOB: [Blank]
- Gender: Male
- Family Planning Status: Not Eligible
- Created By: Conversion, Data On 3/18/05 12:00 AM
- Updated By: [Blank] On 9/27/11 10:18 AM

**HIV Labs Form:**

- Confirmatory Lab Work Performed**
- CD4**  
 Yes  No  Refused  NA
- CD4 Absolute Value**  
[Text Input Field]
- CD4 Percent (%)**  
[Text Input Field]
- CD4/CD8 Ratio**  
[Text Input Field]
- Was CD4 value given to the client?**  
 Yes  No  NA
- Date CD4 value given:**  
[Text Input Field] [Reset] [Clear]
- Viral Load**  
 Yes  No  Refused  NA
- Viral Load Value**  
[Text Input Field]
- Was Viral Load value given to the client?**  
[Text Input Field]

Buttons at the bottom of the form include: Help, Save, Check-in, << Previous, Next >>, Form Info, and Delete Form.

The Windows taskbar at the bottom shows the Start button, several application icons, and the system tray with the time 9:43 AM and date 9/27/11.

# Denver Linkage to Care



## G. Referrals

The screenshot displays the HealthDoc software interface within a Windows Internet Explorer browser window. The browser title bar shows "Per #126529 : Windows Internet Explorer". The HealthDoc interface is titled "Person Information" and contains the following fields:

- Patient Name: \_\_\_\_\_
- Person #: 126529
- Med Rec #: \_\_\_\_\_
- County: \_\_\_\_\_
- DOB: \_\_\_\_\_
- Gender: Male
- Family Planning Status: Not Eligible
- Created By: Conversion, Data On 3/18/05 12:00 AM
- Updated By: I On 9/27/11 10:18 AM

The left navigation pane shows a tree structure with the following items:

- Summary Chart
- Visits
  - Add a Visit
  - 10/3/11
  - Eligibility Items
  - Visit Forms
  - Detail Medical Chart
  - Add a Department/Service
  - Add Telephone Counseling
  - Linkage to Care
    - Print a Label
    - HIV Care
      - Forms
        - Add a Form
        - LTC SOAP Form
        - LTC Chart-S
  - Lab Orders
  - DX
- 9/27/11
- 3/1/11
- 5/18/10
- 9/6/08
- 2/22/08
- 5/7/07
- 4/12/06
- 2/18/03
- 2/11/03

The main content area is titled "Referrals" and contains the following sections:

- Referred to HIV Care**
  - ID Clinic
  - PCC
  - Children's
  - Kaiser
  - Private Physician
  - University
  - Other
  - NA
- Attended HIV Care**
  - Yes
  - No
  - NA
- Date attended HIV Care**
  - \_\_\_\_\_
  - Reset
  - Clear
- Linked to HIV Care**
  - Yes
  - No
  - NA
- Name of Provider**
  - \_\_\_\_\_
- DIS / CDPHE / PCRS**
  - Yes
  - Refused
  - NA
- Name of DIS / CDPHE / PCRS worker:**
  - \_\_\_\_\_
- Client referred to the following services:**
  - \_\_\_\_\_
- Case Management**
  - \_\_\_\_\_

At the bottom of the form area, there are buttons for "Help", "Save", "Check-in", "<< Previous", and "Next >>". Below the form area, there are buttons for "Form Info" and "Delete Form".

The Windows taskbar at the bottom shows the Start button, several application icons, and the system tray with the time 9:44 AM and date 9/27/11.



**Need Linkage  
to HIV Care?**

**We Can Help!**

## **Linkage to Care**

Is a confidential, **FREE** service offered by Denver Public Health.

Linkage to Care offers access to medical care and other support services to people living with, or just recently diagnosed with HIV.

Linkage to Care is a simple start for all your HIV testing, care and medication needs.

# **Linkage to Care**

**Counseling and Referral  
Services for Connecting to HIV  
Medical Care and Resources**

**Support • Information • Referrals**



## **Recently learned you are living with HIV? We're here for you.**

When you learn that you are living with HIV, you may need additional support to understand and absorb this news. The Linkage to Care program provides expert, supportive assistance and guidance.

**Counseling is confidential and personalized.**

## **Haven't had an HIV test in a while? Can't afford HIV medical care?**

Your health is important to us. Contact us for:

- HIV testing;
- Assistance obtaining and understanding TCell and viral load tests if you test positive;
- Help applying to programs that pay for HIV medications; and
- Exploring and securing HIV care whether or not you have health insurance.

**Simple • Straightforward • Health**

## **Had HIV for a while but not in medical care, and need a doctor?**

Options are available. We provide assistance with financial screenings and insurance options. Linkage To Care works in cooperation with all Denver area HIV medical providers, so you can be referred based on your insurance status and personal preferences.

*"The Linkage counselor took the time to educate me on possible options. He spent a lot of time with me, getting to know me and my situation and, more importantly, educating me on HIV unlike anyone had before. He assisted me through financial screening, offered me words of encouragement and made this possibly nerve-racking experience a positive one."*

*~Randy*

**Denver Public Health  
Linkage to Care  
303-602-3652  
605 Bannock Street  
Denver, Colorado, 80204  
[www.denverhealth.org/ltc](http://www.denverhealth.org/ltc)**

All conversations and messages are kept confidential.



## ¿Necesita Linkage to Care para el VIH?

# ¡Podemos ayudarle!

# Linkage to Care

Servicios de asesoramiento y referencias para recibir atención médica y recursos para el VIH

Apoyo • Información • Referencias



## Linkage to Care

Es un servicio confidencial, **SIN COSTO**, ofrecido por Salud Pública de Denver.

Linkage to Care ofrece acceso a atención médica y otros servicios de apoyo para las personas que viven con el VIH o que han sido diagnosticadas recientemente con el VIH.

Linkage to Care es una forma simple de comenzar a llenar todas sus necesidades de exámenes, atención médica y medicamentos para el VIH.

### ¿Se enteró usted hace poco que tiene el VIH? Estamos aquí para ayudarle.

Cuando usted se entera de que tiene el VIH, es posible que necesite apoyo especial para entender y asimilar esta noticia. El programa Linkage to Care le proporciona asistencia, orientación y apoyo especializado.

El **asesoramiento es confidencial y personalizado.**

### ¿Hace tiempo que no se realiza un examen de VIH? ¿No puede pagar la atención médica para el VIH?

Su salud es importante para nosotros. Comuníquese con nosotros para:

- Exámenes de VIH;
- Asistencia para obtener y entender los exámenes de linfocitos T (TCell) y carga viral para personas con resultado positivo de VIH;
- Ayuda para solicitar programas de asistencia para pagar los medicamentos para el VIH; y
- Explorar y asegurar atención médica para el VIH ya sea que usted tenga seguro médico o no.

Salud • Simple • Directa

### ¿Tiene el VIH desde hace tiempo pero no recibe atención y necesita un médico?

Existen opciones. Proporcionamos asistencia para evaluaciones financieras y opciones de seguro. Linkage To Care trabaja en cooperación con todos los proveedores de atención médica para VIH del área de Denver, para que usted pueda ser referido según su situación con respecto al seguro médico y sus preferencias personales.

*"El consejero de Linkage se tomó el tiempo para educarme sobre las opciones posibles. Pasó mucho tiempo conmigo, conociéndome y entendiendo mi situación y, lo que es más importante, educándome sobre el VIH de una forma que nadie había hecho antes. Me ayudó con la evaluación financiera, me dio aliento e hizo que esta experiencia, que podría haber sido muy estresante, fuera positiva."*

~Randy

Denver Public Health  
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