



ARTAS

Linkage to Care

Antiretroviral Treatment and Access to Services (ARTAS)

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

Implementation Manual

July 2022

Important Information for Users

This strategy is intended to be used with persons who were recently diagnosed with HIV and who are voluntarily participating in this strategy, or who are attempting to re-enter care. The materials in this package are not intended for general audiences.

The package includes an implementation manual, training and technical assistance materials, and other items used in intervention delivery. You can find supplemental HIP training materials on the [Effective Interventions website](#).

Before conducting ARTAS in your community, all materials must be approved by your community HIV review panel for acceptability in your project area. Once approved for implementation, the materials are to be used by trained facilitators.



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TABLE OF CONTENTS

Acronyms	8
Section 1: Overview of the Implementation Manual	9
1.1 Purpose of the Manual.....	9
1.2 Description of the Manual Sections	9
Section 2: Introduction to ARTAS.....	11
2.1 The Importance of ARTAS.....	11
2.2 Overview of ARTAS.....	11
Implementing ARTAS	12
Goals of ARTAS	13
2.3 Why Integrate ARTAS into Your Agency?	13
Section 3: Background on ARTAS	15
3.1 History of ARTAS and the Original Research	15
3.2 Theoretical Basis for ARTAS	16
Strengths-Based Case Management.....	17
Social Cognitive Theory ¹⁵	18
3.3 Core Elements and Key Characteristics	19
Core Elements	19
Key Characteristics.....	20
Section 4: Getting Started at Your Agency (Pre-implementation)	21
4.1 What is Pre-implementation?.....	21
4.2 Pre-implementation Activities	21
1. Agency Assessment and Readiness Activities	21
2. Selecting Staff.....	27
3. Identifying and Preparing ARTAS Linkage Coordinators.....	28
4. Preparation for Work with Community Partners	37
5. Establishing Safety Guidelines and Protocols	45
6. Adapting the Intervention.....	50
7. Customizing an Evaluation Plan	52
Section 5: Conducting ARTAS at your Agency (Implementation).....	57

5.1 What is Implementation?	57
5.2 Implementation Activities	57
1. Preparing for Implementation	57
2. Implementing ARTAS	63
3. Maintaining Working Relationships with Community Partners.....	63
4. Supervising Linkage Coordinators.....	64
Section 6: Monitoring and Evaluating ARTAS (Maintenance)	66
1. Institutionalizing ARTAS	66
2. Quality Assurance.....	67
3. Monitoring and Evaluation (M&E)	68
Section 7: Linkage Coordinator Client Session Guide.....	70
Client Session Guide Overview	72
Session One: Building the Relationship.....	76
1A: Introduction	77
1B: Guided Discussion	78
1C: Linkage to Medical Care	79
1D: Client Assessment	82
1E: Review and Summarize the Session	84
1F: Schedule Medical Appointment and/or Next Session	84
Sessions Two, Three, and Four: Emphasizing Personal Strengths.....	88
2A: Review of Session One (and Two and Three, if appropriate)	89
2B: Client Assessment	90
2C: Linkage to Medical Care	91
2D: Review and Summarize the Session	94
2E: Schedule Medical Appointment and/or Next Session	94
Close-Out Session: Completing the Work	98
5A: Review the Transition Process: Linked Clients	99
5B: Review the Transition Process: Non-linked Clients	100
5C: Transition to Long-Term / Ryan White CM or Other Case Management Services	102
Session Forms.....	105
Strengths Assessment Instructions	106
ARTAS Session Plan Instructions	112

Overview of ARTAS Document	117
Appointment Cards	118
Email Reminder / Voice Message.....	118
Session Notes Instructions	119
Session Notes Summary Sheet Instructions	123
Case Review Form Instructions.....	125
Life Domains List	128
ARTAS Client Satisfaction Questionnaire.....	130
Client Session Guide Helpful Tips	131
Section 8: Linkage Coordinator Supervisor Guide	136
Linkage Coordinator Supervisor Guide Overview.....	137
1. Implementing a Strengths-Based Approach to Supervision.....	138
2. Case Review	139
3. Staff Meetings.....	141
4. Supervisor’s Meetings with Clients	141
5. Shadowing/Coaching Exercises	142
Linkage Coordinator Strengths Assessment	144
Shadowing Exercise Assessment.....	149
References.....	154
Appendices	157
Appendix A: Research Articles and Resources	157
Appendix B: Pre-implementation Forms	158
B.1 Agency Readiness Checklist.....	158
B.2 Identifying Barriers and Solutions Example Form	160
B.3 Community Partner’s Buy-in Worksheets.....	162
B.4 Cost Categories for the Implementation of ARTAS.....	168
B.5 ARTAS Behavior Change Logic Model	171
B.6 ARTAS Implementation Summary	172
B.7 ARTAS Work Plan.....	174
B.8 Effective Communication Skills	175
B.9 Agency/Clinic Need-to-Know Information Form	181
B.10 ARTAS Client Referral Flowchart.....	183

B.11 Memorandum of Agreement Template.....	184
B.12 Suggested Client Enrollment Flow Process	187
B.13 Community Mapping	188
Appendix C: Monitoring and Evaluation Forms.....	189
C.1 ARTAS Fidelity Assessment Quarterly Report Template.....	189
C.2 ARTAS Performance Process Indicator Form	190
C.3 ARTAS Partner Tracking and Recruitment Process Indicator Form	193

Acronyms

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

ADAP	AIDS Drugs Assistance Program
ARTAS	Antiretroviral Treatment and Access to Services (formerly Antiretroviral Treatment Access Study)
ART	Antiretroviral therapy
ASO	AIDS service organization
CBA	Capacity building assistance
CBO	Community-based organization
CDC	Centers for Disease Control and Prevention
CITAR	Center for Interventions, Treatment and Addictions Research
CLAS	National Standards on Culturally and Linguistically Appropriate Services
CM	Case manager
EHE	Ending the HIV Epidemic in the U.S.
HIP	High-impact prevention
IRB	Institutional review board
LC	Linkage coordinator
M&E	Monitoring and evaluation
MOA	Memoranda of agreement
PWH	Person(s) with HIV
PWID	Person(s) who inject(s) drugs
SMART	Specific, measurable, achievable, relevant, and time-bound
STD	Sexually transmitted disease

Section 1: Overview of the Implementation Manual

Congratulations! You are about to implement Antiretroviral Treatment and Access to Services (ARTAS) at your organization.

1.1 Purpose of the Manual

Antiretroviral Treatment and Access to Services (ARTAS) is intended to be implemented by agencies that either conduct case management services for persons with HIV (PWH) or are engaged in linking persons with recently diagnosed HIV to care providers and/or auxiliary support services. This manual can be used by agencies such as health departments, HIV testing sites, Ryan White case management programs, drug treatment programs, or community-based organizations involved in HIV prevention.

1.2 Description of the Manual Sections

The manual is divided into the following eight sections and the appendices.

Section 1: Overview of the Implementation Manual: This section introduces the intervention and provides an overview of the manual.

Section 2: Introduction to ARTAS: This section includes a description of the intervention as well as the goals and objectives. It describes the themes that make this intervention unique. The section concludes with a discussion of the benefits of implementing this intervention at your agency.

Section 3: Background on ARTAS: This section includes a description of the original research study and the theoretical framework that guides the intervention. It also describes the intervention's core elements and key characteristics.

Section 4: Getting Started at Your Agency (Pre-implementation Phase): This section describes the planning phase, including staffing suggestions, specific staff skills needed to implement ARTAS, establishing relationships with community partners, safety guidelines and protocols, ways to adapt ARTAS, examples of successful adaptations, and recommendations for setting up intervention evaluation plans.

Section 5: Conducting ARTAS at Your Agency (Implementation): This section provides information about how to conduct ARTAS. It includes instructions for preparing for implementation, implementing the intervention, maintaining working relationships with community partners, and supervising linkage coordinators.

Section 6: Monitoring and Evaluating ARTAS (Maintenance Phase): This section discusses the evaluation phase of the program and what type of evaluation is needed for your site (formative, process, and outcome). These sets of data will assist in adapting the intervention to meet the needs of your program's priority populations and in measuring success.

Section 7: ARTAS Client Session Guide: This section is the ARTAS Client Session Guide, which is the instructional tool that the linkage coordinators use to facilitate the five client sessions and the session-related forms need for ARTAS.

Section 8: Supervisor Guide: This section is the ARTAS Supervisor Guide, which provides the linkage coordinator supervisor with guidance for the implementation of ARTAS and supervision of linkage coordinators.

Appendices: The final section consists of three appendices that include a variety of supplemental materials and information (links to research articles, pre-implementation, and M&E forms).

Section 2: Introduction to ARTAS

2.1 The Importance of ARTAS

Antiretroviral Treatment and Access to Services (ARTAS) is an individual-level, multi-session, time-limited intervention to link individuals with recently diagnosed HIV to medical care. CDC estimates that approximately 38,000 Americans become infected with HIV annually. As a result, the number of people living with HIV in the U.S., now at nearly 1.1 million, continues to grow, thereby creating opportunities for HIV transmission and the need to intensify HIV prevention efforts. The HIV epidemic is an important public health issue, and the Ending the HIV Epidemic in the U.S. (EHE) initiative seeks to reduce new HIV infections in the U.S. by 75% by 2025 and then by at least 90% by 2030.¹

Despite the well-documented benefits of early entry into medical care, preliminary data for 2020 shows that nearly 18% of people diagnosed with HIV in the U.S. have not received care for their HIV diagnosis within one month of diagnosis.² Many individuals are interested in linking to care immediately after receiving an HIV diagnosis, but others do not link to medical care for various reasons, including but not limited to personal barriers such as unemployment, lack of health insurance, fear, stigma, substance use, mental health issues, lack of transportation, homelessness, and/or not having the required forms of identification to receive services. People also might not seek medical care because of system-level barriers such as a lack of personnel, healthcare providers, and culturally appropriate services. Other system-level barriers include wait lists for services and/or medications and complex, confusing administrative processes. Rarely do people face only one barrier to accessing medical care.

The ARTAS intervention supports access to HIV medical care and helps clients make changes by emphasizing the client's *abilities* to address barriers rather than *inabilities*. The setting of objectives is driven by the client who must implement these changes, not dictated by a third party such as a case manager or healthcare provider. Finally, the mutually respectful and cooperative relationship between the client and linkage coordinator supports the client in their efforts to implement changes and overcome barriers.

2.2 Overview of ARTAS

ARTAS is based on the strengths-based case management model, which is rooted in social cognitive theory (especially the concept of self-efficacy) and humanistic psychology. Strengths-based case management is a case management model that encourages the client to identify and use personal strengths; create goals and objectives for themselves; and establish an effective working relationship with the linkage coordinator. The three defining features of the intervention are (1) building effective working relationships between the client and linkage coordinator and between the linkage coordinator and community partners, (2) focusing on the client's strengths rather than weaknesses, and (3)

maintaining a client-driven approach.

The strengths-based approach used in ARTAS helps the client do the following:

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

Implementing ARTAS

The population that ARTAS serves includes *any* individual with recently diagnosed HIV (typically defined as within the past 6–12 months) and willing to participate in ARTAS. During the research stage, the criteria for clients to participate were:

- 18 years of age or older
- HIV diagnosis within the past 6–12 months
- not on antiretroviral treatment
- not receiving case management or social work services for HIV-related needs
- interested in participating in ARTAS
- not previously seen by an HIV care provider more than once

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

The ARTAS intervention consists of up to five client sessions conducted over a 90-day period or until the client links to medical care. In accordance with EHE goals, rapid linkage to care as soon as possible should be prioritized, and the intervention should also be tailored to persons who may need more time, not exceeding the 90 days or five sessions. During the client sessions, the linkage coordinator (LC) assesses the client's readiness for HIV care and builds a relationship with the client. The client, focusing on their self-identified strengths, creates an action plan (known as the ARTAS Session Plan) with objectives that will help them achieve the goal of linking to medical care. Not every client will follow the same sequence of steps in their sessions, nor will every client complete all five sessions.

For those who complete all five, the sessions will be structured as follows:

- The purpose of Client Session One is to assess the client's general knowledge about HIV, their readiness to link to care, and their understanding of the benefits of linking to care early. The linkage coordinator will ensure the client understands the goals of ARTAS and will start to build a relationship with the client. Rapid linkage can be achieved if the client is able to link after the first session, though some clients may need additional sessions of ARTAS to link to care.
- The purpose of Sessions Two, Three, and Four is (a) to support the client in overcoming barriers to linking to care by identifying personal strengths and (b) to

clarify and address any questions or areas of confusion the client may have from the previous session(s).

- The purpose of the Close-Out Session is to review the progress the client has made during ARTAS and, if applicable, discuss the client's visit with their medical provider.

Following the final session with the linkage coordinator, the client may be linked to a long-term case manager and/or another service delivery system to address their longer-term needs (e.g., substance use treatment or mental health services).

If at any point the client successfully links to medical care, the linkage coordinator does not need to continue with the remaining sessions. However, implementing agencies may find it useful to hold a close-out session to help the client transition to long-term care and, if necessary, introduce their new case manager.

Goals of ARTAS

- I. ARTAS helps clients overcome barriers to successfully linking to medical care.
- II. ARTAS aims to create a trusting, effective relationship between client and linkage coordinator.
- III. ARTAS facilitates a client's ability to create an action plan for linking to medical care.

2.3 Why Integrate ARTAS into Your Agency?

Interventions that link people to medical care soon after receiving a positive HIV test result are important because delays in seeking care can result in a negative treatment prognosis and contribute to the spread of HIV.³ Early treatment has many benefits for PWH, including the following:

- PWH receiving medical care are able to benefit from antiretroviral therapy (ART), which improves disease progression and health outcomes.^{4,5} If taken as prescribed, HIV medicine reduces the amount of HIV in the body (viral load) to a very low level, which keeps the immune system working and prevents illness. This is called viral suppression, defined as having less than 200 copies of HIV per milliliter of blood. HIV medicine can even make the viral load so low that a test cannot detect it. This is called an undetectable viral load.
- People with HIV who take HIV medicine as prescribed and who achieve and keep an undetectable viral load (or stay virally suppressed) have effectively no risk of transmitting HIV to HIV-negative sexual partners. This is sometimes referred to as "treatment as prevention."

- Medical care provides an opportunity to address the overall health needs of the client. One of which is counseling on behaviors and risk-reduction.⁶ Healthcare providers can educate patients about appropriate behaviors as they provide medical treatment, possibly decreasing risk behaviors and transmission. Medical providers can also provide referrals for individuals to other social services.⁷
- Early linkage to care results in cost savings to individuals and the healthcare system. Direct care costs in the year following HIV diagnosis can be more than 200 percent lower for patients who receive treatment early.⁵

Section 3: Background on ARTAS

This section reviews the history of and original research on ARTAS and considerations for adaptations to the intervention. This section also describes the theoretical framework that guides the intervention, the core elements, and key characteristics.

3.1 History of ARTAS and the Original Research

ARTAS was developed by the Center for Interventions, Treatment, and Addictions Research (CITAR) in the Department of Community Health at the Wright State University Boonshoft School of Medicine in Dayton, Ohio. The strengths-based case management model on which ARTAS is based was created at the University of Kansas's School of Social Welfare in 1982.⁸

In conjunction with the Centers for Disease Control and Prevention (CDC) and CITAR, four sites implemented and evaluated a randomized controlled trial known as the Antiretroviral Treatment Access Study (ARTAS-I). In the original study, 316 participants were randomly assigned to either the ARTAS linkage case management group (n=136) or the standard of care group (n=137). The standard of care group received only HIV information and a paper referral to a local HIV healthcare provider. The results showed a higher proportion of successful linkage to medical care among the ARTAS participants (78%) than the standard of care participants (60%). Successful linkage was defined as attending at least one appointment with an HIV healthcare provider within a six-month period. A higher percentage of ARTAS participants than the standard of care group attended at least two appointments within 12 months (64% versus 49%). Individuals over the age of 40, Hispanic participants, individuals enrolled within 6 months of an HIV-positive test result, and participants without recent crack cocaine use were all significantly more likely to have gone to at least two medical visits.³

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

The following is a list of characteristics of ARTAS participants who were statistically more likely ($p < 0.05$) to be linked to medical care:

- Attended two or more sessions with the linkage coordinator
- Male⁹
- 26 years of age or older

- Hispanic (compared with Black and non-Hispanic)
- Had three or more HIV-related symptoms⁹
- Had health insurance⁹
- Had stable housing
- Had not recently used injection drugs
- Was not experiencing depressive symptoms¹⁰
- Had a higher education⁵
- Recruited at a site where the case management services and HIV medical care were co-located¹¹

Other studies have had similar findings on characteristics that support linkage to care, but it is important to note that some clients may need more support to successfully link to care.

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

Additional analysis of ARTAS-II data was later supplemented by information from site visits and director reports from participating organizations to identify the following best practices for successful linkage to care programs:

- Selecting appropriate organizations with strong, established working relationships with high-volume HIV testing sites to implement the linkage programs
- Establishing and strengthening essential community partnerships, including for HIV testing, HIV care, and long-term case management services
- Differentiating between ARTAS and long-term case management
- Communicating the benefits of ARTAS when marketing the program to potential referral partners, including long-term case managers
- Maintaining ongoing communication and frequent contact with supervisory and frontline staff at partner agencies to obtain and sustain strong relationships with partner agencies
- Supporting linkage coordinators to travel to meet clients, when needed
- Seamlessly transitioning clients from ARTAS linkage case management to long-term case management
- Providing ongoing support and supervision to linkage coordinators
- Securing ongoing resources to support a sustainable linkage program¹²

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

3.2 Theoretical Basis for ARTAS

ARTAS is a theory-based intervention guided by the strengths-based case management

model and social cognitive theory.

Strengths-Based Case Management

Strengths-based case management incorporates a strengths-based approach in the primary functions of case management:

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

The strengths-based approach is commonly used in social work and has a strong theoretical foundation as an effective strategy to build an individual's success.

The strengths-based approach emphasizes the client's self-determination and the strengths they bring to a problem or crisis. The strengths-based approach is client-led, with a focus on future outcomes.

The strengths-based approach is based on the belief that individuals have abilities and inner capacities to successfully cope with their own challenges and overcome perceived and existing barriers to meeting their goals and objectives.¹³ The strengths-based approach uses asset identification rather than a deficit approach. Instead of focusing on what is going wrong with the client, the counselor helps the client reframe their thinking to consider what is right.

The strengths-based approach has four basic assumptions:

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

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

- Encourage clients to identify and use their strengths, abilities, and assets to

- accomplish goals and objectives.
- Recognize and support client control over goal-setting and searching for needed resources.
- Establish an effective working relationship with the client.
- View the community as a resource and identify sources of support.
- Conduct case management as an active, community-based activity.¹⁴

Social Cognitive Theory¹⁵

Behavior change is not simple, and many factors affect a person's ability to change. Social cognitive theory considers that behavior is a continuous, reciprocal interaction between personal (related to attitudes and beliefs), behavioral, and environmental influences¹⁶ (figure 1).¹⁷

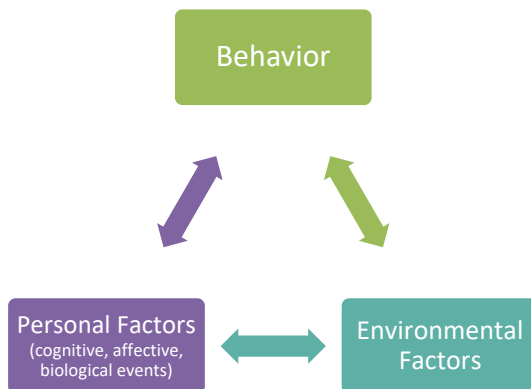


Figure 1: Social Cognitive Theory

Behavior change is influenced by:¹⁸

- **Information:** awareness of risk and knowledge of techniques for coping with the environment.
- **Self-efficacy:** belief in one's ability to control their motivations, thoughts, emotions, and specific behaviors.
- **Outcome expectations:** belief that good, valuable, important things will result from the new behavior.
- **Social skills within interpersonal relationships:** ability to communicate effectively, negotiate with others, and resist pressures from others.
- **Self-regulating skills:** ability to motivate, guide, and encourage oneself and solve one's problems.
- **Reinforcement value:** emphasizing the benefits (rewards) produced by adopting a new behavior instead of focusing on what is being given up (costs) by adopting a new behavior. Reinforcements are the responses to a person's behavior that increase or decrease the likelihood of reoccurrence.

According to social cognitive theory, successful behavior change can be achieved by:

- Learning new information from others.
- Discussing strategies with others.
- Guided practice or rehearsal of new behaviors and skills.
- Receiving corrective feedback on one's performance of the new behaviors or skills.
- Acquiring personal experience with new behaviors and skills.
- Receiving social support for the new behaviors.
- Hearing the positive outcomes of other people who adapted the new behaviors.
- Observing new behaviors being modeled.
- Observing other people's behaviors and experiences.

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

3.3 Core Elements and Key Characteristics

Core Elements

Core elements are the central features of an intervention's intent and design and are thought to be responsible for its effectiveness. The core elements are derived from components of behavioral theories and/or the experience of implementing the intervention. ARTAS has four core elements based on the principles of strengths-based case management.

The core elements are as follows:

1. Build an effective working relationship between the LC and each client.
2. Focus on the client's strengths by:
 - a. Conducting a strengths-based assessment.
 - b. Encouraging each client to identify and use their strengths, abilities, and skills to link to medical care and accomplish other objectives that will facilitate linkage to care.
3. Facilitate the client's ability to:
 - a. Identify and pursue their own objectives.
 - b. Develop a step-by-step plan to accomplish those objectives using the ARTAS Session Plan.
4. Maintain a client-driven approach by:
 - a. Conducting between one and five structured sessions with each client.
 - b. Conducting active, community-based case management by meeting each client in their environment and outside the office, whenever possible.
 - c. Coordinating and linking each client to available community resources, both formal (e.g., housing agencies, food banks) and informal (e.g., friends, support groups, spiritual groups) based on the client's needs.
 - d. Advocating on each client's behalf, as needed, to link them to medical care

and/or other needed services.

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

Key Characteristics

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

The key characteristics identified from the original research and during the implementation of ARTAS are as follows:

- Build and maintain effective relationships with community partners and, whenever possible, sign a memorandum of agreement (MOA, [Appendix B.11](#)) between the implementing agency and community partners to facilitate the referral process.
- Conduct a client session with two LCs if the LC is uncomfortable with the client-selected location. The client should agree to this arrangement in advance.
- Implement a strengths-based approach to supervision. This will allow the supervisor to model a “strengths attitude” for their employees.
- Provide transportation to and from the client sessions or medical appointments. This can be in the form of taxi or public transportation reimbursement or transportation in the LC's personal vehicle.
- Ensure access to same-day ART initiation through partnering with clinics that are able to support same-day ART, including through use of telemedicine or provision of medication starter packs.
- Provide incentives, such as gift cards or food vouchers, to support linkage.
- Attend medical and other appointments with the client, if requested.

Section 4: Getting Started at Your Agency (Pre-implementation)

Implementing ARTAS at your site consists of three phases: (1) pre-implementation, (2) implementation, and (3) maintenance and evaluation. This section will explore the pre-implementation phase, including various tools, checklists, and helpful reminders for the agency to use.

4.1 What is Pre-implementation?

Pre-implementation prepares the implementing agency to perform the intervention. During this period, your agency can make any necessary organizational changes, assess resource needs, and develop evaluation plans. Pre-implementation is also the time to explore adapting ARTAS to the needs of your specific agency.

4.2 Pre-implementation Activities

Pre-implementation activities may include the following:

1. Agency assessment and readiness activities
2. Selecting staff
3. Identifying and preparing ARTAS linkage coordinators
4. Preparation work with community partners
5. Establishing safety guidelines and protocols
6. Adapting the intervention
7. Customizing an evaluation plan

1. Agency Assessment and Readiness Activities

When deciding whether ARTAS is a good fit for an agency and community, it is important to examine the agency's readiness and capacity to implement ARTAS, identify potential barriers to implementation and solutions to these barriers, obtain internal and external buy-in for ARTAS, and develop a budget. These are the four activities that will help an agency decide whether to implement the intervention. It is important to note that these activities do not necessarily happen in the order in which they appear below, and some may occur simultaneously. The specifics of each activity should be adjusted to meet the agency's needs, unless the activity is linked to a core element of ARTAS. For example, the staff positions are suggestions to assist in the planning process. They should not be viewed as required staff positions or levels of effort.

Examine Agency Capacity and Readiness

The first activity is to examine the agency's capacity and readiness to implement ARTAS to assess whether the ARTAS intervention is right for the agency. Although not required, this activity was identified by the demonstration sites as beneficial to making the implementation of ARTAS easier and more efficient. Examining the agency's capacity will

help in developing a budget (e.g., to determine whether additional resources are needed for training and staffing).

Recommended agency capacities:

- **Experience providing case management services:** ARTAS will be implemented most successfully by an agency with experience providing case management services, or by contracting with an agency with strong case management capacity. Agencies with this capacity already have in place the structures that are necessary to implement ARTAS, such as staff who are able to oversee case management services, experienced staff trained in case management, related policies on confidentiality, and protocols for setting professional boundaries and safety guidelines.
- **Strong existing relationships with community partners:** It is incredibly valuable to have existing relationships with key community partners before implementing ARTAS. If a community partner has a strong existing relationship with the agency, then the community partner will likely be more receptive to learning about and participating in the intervention. In addition, where networks are already established, ARTAS can simply be folded into the existing system of referrals to get clients into the ARTAS intervention and to link them to medical care and other needed services. Successful linkage to care relies on a strong relationship between ARTAS programs and medical providers in the community.
- **Technological capacity:** Agencies should have the technological capacity to maintain data collection and management systems for monitoring and evaluation (M&E) purposes, particularly if the funding agency requires evaluation activities. Staff should be proficient in the use of common computer software. The funding agency may have specific requirements, but software to consider includes Microsoft Excel, Microsoft Access, and/or SPSS.
- **Staffing:** Agencies should assess existing personnel capacity to oversee and implement ARTAS. Staffing suggestions are provided in [section 4.2.2](#).

Next, the agency should assess its readiness to implement ARTAS. The [Agency Readiness Checklist in Appendix B.1](#) contains information on recommended agency capacities to possess before implementing ARTAS.

Identify Potential Barriers and Solutions

It is also important to review potential barriers to the successful implementation of ARTAS. Although the agency may not be able to eliminate all potential barriers, being aware of them will allow the agency to plan accordingly. The [Identifying Barriers and Solutions Form in Appendix B.2](#) provides common barriers identified by the researchers and demonstration sites.

Obtain Internal and External Buy-in from Community partners

Gaining support or buy-in from both internal community partners (agency staff) and external community partners (community partners) is a critical pre-implementation activity.

This activity guides the agency through the recommended steps for (1) identifying community partners within the agency and the community, (2) involving these community partners in ARTAS, and (3) gaining their buy-in for ARTAS.

The implementing agency should use this activity as a guide to consider which organizations to reach out to within the community and how to engage them in the implementation of ARTAS. Since the implementation of ARTAS varies slightly by setting (health department versus CBO/other), two different worksheets are provided in [Appendix B.3](#). Whichever works best for the implementing agency should be used.

Develop a Budget

The agency should also develop a budget. (Note: These figures will vary by agency and are meant only as guidance. These budget figures should be adjusted according to the agency's implementation plan and to meet the needs of the population being served.)

Personnel

Staff levels of effort to consider are as follows:

- One 25-percent full-time equivalent (FTE) paid program director/manager to oversee implementation activities. If the program director/manager will serve as the evaluator, then increase the FTE to 40 percent.
- One 25-percent FTE paid contracts manager (if the agency is a health department contracting out the implementation of ARTAS). The program director/manager may also serve as the contracts manager, in which case the FTE should be increased to 40 percent.
- One 15-percent FTE paid evaluator to design and conduct monitoring activities. (One 7-percent FTE paid supervisor to provide clinical supervision to the LC. (Due to the low level of effort for the supervisor, the agency will likely want to use current staffing capacity for this position. This work could be absorbed into an existing supervisor's role.)
- As many paid LCs as needed to serve the population. The percentage of time allocated for each FTE LC will be determined by the agency's caseload.

Travel and Transportation

The agency should plan to send each LC to a CDC-approved ARTAS training and, if it is an in-person training, cover associated travel costs. In some instances, virtual instructor led ARTAS trainings may be available. Attending a virtual training will require staff to have their schedules completely free during training hours. Due to staff turnover, it is recommended that implementing agencies budget for travel for one staff person per year to attend the training during the implementation phase.

The agency should plan to reimburse the LC for work-related travel—attending the client sessions, going to medical appointments, and meeting with community partners. Additionally, transportation is frequently a barrier to accessing medical care for clients. To support linkage to care, it is useful to provide clients with subsidies to facilitate

transportation to a medical appointment directly from an ARTAS session.

Equipment

Each LC will likely need access to a laptop or desktop computer to use for attending virtual instructor-led trainings, entering data, and writing reports. LCs attending a virtual instructor-led training will need to have access to reliable Internet, video, and audio capabilities (webcam, external microphone, and/or headset). When implementing ARTAS, the agency should provide each LC with a cell phone so they can be available to clients and can be reached immediately when a person receives an HIV diagnosis.

Marketing and Recruitment

It is important to conduct initial outreach to community partners to introduce them to ARTAS and gain their support. Expenses related to outreach include producing and printing brochures and other marketing materials as well as room rentals and other costs associated with informational meetings. These costs will vary based on the number of resources that the implementing agency deems necessary to devote to marketing. Some agencies will not need to market the intervention extensively because the services are co-located or because referral processes are already in place with testing and medical sites. The implementing agency may also choose to provide small incentives to clients for attending client sessions or completing the intervention.

Cost Sheet

As noted above, an agency may need a 25- to 40-percent FTE program director/manager, 25-percent contracts manager, 15-percent FTE evaluator, 7-percent FTE supervisor, and LC(s). The **cost sheet** located in [Appendix B.4](#) may be used as a guide to prepare a budget.

Intervention Logic Model

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

While the visual scheme of a logic model may vary, it will contain the following core components: inputs, activities, outputs, outcomes, and effect. The **ARTAS Behavior Change Logic Model** in [Appendix B.5](#) summarizes *what* change is intended when an agency implements the intervention. The **ARTAS Implementation Summary** in [Appendix B.6](#) summarizes *how* the behavior change logic model is intended to be implemented or the central requirements to be put into practice.

The **ARTAS Work Plan** in [Appendix B.7](#) depicts the phase in which each activity listed on the ARTAS Implementation Summary should be conducted. (Note: Several activities are

conducted during one or more phases (Pre-implementation, Implementation, Maintenance, and Adaptation)).

During pre-implementation, the agency should look at internal and external factors that may support or hinder the success of the intervention. These include client-, agency-, and system-level factors. Although the agency may be able to do little more than plan around the client- or system-level issues, it should be able to address agency-level issues.

Agency-level issues can be addressed by adapting agency policies, practices, and staffing allocations and/or by adapting the intervention.

When examining the following pre-implementation activities, agency staff will need to assess whether the agency will require internal changes to implement ARTAS. Adapting ARTAS will be discussed later, in the adaptation section ([4.2.6](#)).

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

- **Assess the agency using a strengths-based approach:** It is important to review the agency capacity and readiness assessments discussed earlier and articulate the strengths and abilities that have served the agency well in the past. Staff should consider using a modified version of the strengths assessment and goal-setting exercise used during the client sessions. This will allow the implementing agency to practice working within a strengths-based approach. The agency should use the strengths and abilities identified to resolve any potential barriers to implementation.
- **Create a supportive environment for a strengths-based approach within the agency:** Institutionalizing a new, strengths-based approach or mindset will not occur overnight. ARTAS staff members and other key agency personnel may wish to change the culture of the agency slowly throughout the implementation of ARTAS. The agency can achieve this gradual change by introducing the strengths-based approach at many levels within the agency—for example, training the receptionist to focus on clients' positive attributes (e.g., showing up for an appointment), using a strengths-focused approach to supervision, and revising agency paperwork to highlight a client's strengths and abilities rather than inabilities. Incorporating a strengths-based approach within the implementing agency can provide a greater understanding of and demonstrate support for the ARTAS core elements.

ARTAS requires a strengths assessment and client-driven goal setting. However, the agency may have existing intake forms or case management forms that focus on the person's *inabilities* or *previous failed attempts* to link to medical care. Because the implementing agency *must* revise the paperwork used for ARTAS, the agency may want to consider revising the existing paperwork used for other services within the agency, to avoid confusion among the clients. The agency

should seek capacity building assistance (CBA) services if needed in this area.

- **Compare current linkage processes with the proposed ARTAS linkage processes:** The agency should detail the processes it currently uses to link clients to support services or treatment, compare them with the proposed ARTAS linkage processes, and then answer these questions:
 - Are the processes consistent with one another? If not, how do they differ?
 - Do the existing processes contradict the core elements of ARTAS?

If the two processes are consistent, then it may be possible to integrate the ARTAS linkage process into preexisting protocols without major alterations.

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

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

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

During pre-implementation, the implementing agency should review its current non-ARTAS policies, procedures, and safety guidelines for any discrepancies with the core elements of the intervention. Additional information on safety guidelines and protocols can be found in [section 4.2.5](#).

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

2. Selecting Staff

The following are staffing suggestions for a CBO to consider when deciding to implement ARTAS (Note: Except for the LC, these are not full-time positions.). Many of the recommended qualifications for each staff position discussed below were identified by some of the demonstration sites in the research study.

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

The staff positions to consider when implementing ARTAS are a program director/manager, an LC supervisor, an evaluator, and as many LCs as needed to serve the population (based on a small caseload of 25 to 30 clients at any given time).

The **program director/manager** should have experience with program management, including budgeting, staffing, marketing, and reporting. If desired, the program director/manager may also serve as the evaluator, as long as they have evaluation experience. They are responsible for the overall implementation of the intervention, including:

- Providing leadership both internally and externally.
- Assessing and building the agency's capacity to implement ARTAS.
- Providing fiscal management, which includes identifying and securing the necessary resources.
- Managing and monitoring the intervention, including ensuring fidelity.
- Obtaining internal support for the intervention.
- Obtaining external support and participation from community partners and HIV care providers, as needed.

The **LC supervisor** should, ideally, have strong clinical skills, experience with case management and supervising CMs, and familiarity with program management principles. The LC supervisor plays a crucial role in supporting the LC in the day-to-day implementation of ARTAS as well as activities to support the core elements. The LC supervisor is responsible for:

- Coordinating activities with the program director/manager and evaluator to monitor quality assurance and fidelity to implementation.
- Reaching out to community partners and HIV medical care providers, as needed.
- Facilitating communication between the ARTAS staff and other agency staff—especially with non-ARTAS CMs—to minimize conflict.
- Using a strengths-based approach to supervision to model and reinforce behaviors for the LC.
- Conducting regular staff meetings and supervision for each LC.
- Monitoring the activities, accomplishments, and barriers faced by each LC.

The LC supervisor should have an excellent understanding of boundaries; knowledge of

community, regional, and state resources available (e.g., Ryan White services, AIDS Drug Assistance Program (ADAP), resources to cover the costs of care services); and knowledge of HIV prevention, care, treatment, and counseling. Previous experience with motivational interviewing techniques, specifically responsive listening, is useful but not required. The supervisor should be knowledgeable about strengths-based case management and must be supportive of a strengths-based approach to linking people to medical care and supervision.

The **LC** is responsible for the actual implementation of the intervention (i.e., meeting with clients, attending the first medical appointment). Due to the intensive nature of ARTAS, the LC's caseload should be between 25 and 30 clients at any given time. The LC is also responsible for:

- Screening recently diagnosed, or out-of-care, individuals for eligibility to participate in ARTAS.
- Conducting active, community-based, strengths-based case management.
- Developing and implementing a marketing plan for ARTAS.
- Creating marketing materials to educate potential community partners.
- Building and maintaining effective working relationships with community partners.
- Working closely with CMs and social workers in both a medical and community setting to coordinate medical care.
- Conducting data collection and entry.
- Maintaining careful and accurate documentation for all contact with ARTAS clients.
- Carrying out other ARTAS duties as required.

The LC supervisor and LC should be located at the same agency.

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

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

3. Identifying and Preparing ARTAS Linkage Coordinators

LC Identification

To a significant degree, successful implementation of ARTAS depends on careful selection of the LC(s) who will deliver the intervention. Certain qualifications, such as previous experience and specific skill sets, are important, and other characteristics and personality traits will also help the LC better facilitate the implementation of ARTAS.

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

It is recommended that an LC:

- Have at least a bachelor's degree in social work or a similar field along with 3–5 years' experience, or a master's degree along with 1 year of experience working with the healthcare delivery system and assisting marginalized populations.
- Have experience providing case management to clients and willingness to learn and use a *new and modified approach* to case management—the strengths-based approach.
- Have a familiarity with motivational interviewing techniques and other effective communication skills. The LC can seek training to gain these skills and/or strengthen existing skills.
- Have experience with commonly used computer software systems, such as Microsoft Excel, Microsoft Access, SPSS, or any software required by the funding agency and other computer systems used to track clients.

Because of the core elements of ARTAS, an LC *must* have knowledge of and experience with:

- Existing cost covering resources such as Medicare, Medicaid, Ryan White, and ADAP.
- Regional/state care delivery systems.
- Services, skills, and reputations of HIV care providers and clinics.

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

Important characteristics and personality traits for the LC to possess:

- Creative problem-solving ability.
- Flexibility, especially to adjust to clients' needs, conduct sessions outside the agency, and attend the first medical appointment with a client.
- Appreciation of the role that CMs have in helping clients.
- Genuine compassion for and interest in clients' wellbeing.
- Persistence, particularly to follow up with clients multiple times, which includes calling, visiting, and attending appointments with clients.
- Patience, especially to provide education, support, and encouragement.
- Detail-oriented organizational skills, particularly to maintain session notes, follow up with clients, and know where and when to meet a client.

- Friendly disposition.
- Comfort with diverse populations and lifestyles.
- Openness to learning new approaches to working with clients.

LC Preparation

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

Prior to Working with Clients

In addition to the LC qualifications listed above under "LC Identification" on page 29, before meeting with the first client the LC should become proficient in:

1. The core elements and practical application of ARTAS.
2. The *latest* information about HIV prevention, care, and treatment and how to explain these concepts in easy-to-understand language. Suggested sources of information and training include the [CDC website](#) or the state or local health department; capacity building assistance (CBA) services; and an HIV course offered through a state or local health department, if available.
3. The community resources available and other service delivery systems such as HIV care providers, clinics, and treatment centers.
4. Other common coexisting conditions, such as depression, post-traumatic stress disorder, and anxiety disorders, and community resources for these conditions.

The core elements of ARTAS emphasize the components of a strengths-based approach and perspective, which are discussed below:

- Since ARTAS is client-driven, the LC should learn to focus on helping clients identify their own objectives and barriers to linkage to best help them achieve the goal of linking to medical care.
- An LC does not simply link a client to medical care where the LC thinks the client should go. Therefore, the LC should learn to help clients assess the advantages and disadvantages of connecting with a particular health care provider and/or any resource or system for assistance.
- The LC should learn to not automatically assume *anything* about a client. This includes assuming that every client benefits from long-term case management services. Rather, the LC should be able to actively solicit a wide range of formal and informal resources to help clients overcome personal barriers.
- The LC should be culturally competent and not judge or challenge clients on any aspect of their lifestyles, motivations, or decisions, including the decision not to change a particular behavior or not to link to medical care.

- The LC does not simply provide solutions to problems. The LC must help clients *learn and practice* specific skills by helping the client create the ARTAS Session Plan.
- The LC should strive for engagement with their clients rather than control over them.

Training for new LCs may include shadowing and coaching activities. During the shadowing exercise, the new LC will observe mock or real client sessions and use a tool to track and identify the key components they see modeled by an experienced LC and the client. For quality assurance, all LCs should expect to be assessed by their supervisor using these same activities. These activities are fully described in the [LC Supervisor Guide \(Section 8\)](#).

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

Communication Skills

Effective communication skills support successful implementation of ARTAS. The LC should be able to engage in a meaningful dialogue and exchange with the client throughout the five client sessions, leading to the outcome of linkage to medical care. This intervention recognizes that the client is ultimately responsible for their own behavior change. As such, it can be useful for the LC to be familiar with motivational interviewing techniques, such as responsive listening, prior to seeing the first client. Responsive listening is a counseling method that focuses on building an understanding between the LC and client.¹⁹ The following are a few specific communication skills that may be helpful to effectively and efficiently implement ARTAS:

- **Self-Awareness:** Good communication requires a high level of self-awareness and knowledge of one's own personal communication style. Being self-aware means considering the tone and body language that the LC typically communicates to others when speaking. It also means being aware of personal judgments, beliefs, and assumptions that can distort what the client hears in the conversation.
- An LC should be able to make the **necessary adjustments** to have a successful conversation with the client and/or community partners. It is also important that the LC know their personal attitudes and/or triggers that may preclude working effectively with particular clients. When possible, the supervisor or intake

coordinator should assign clients accordingly.

- **Setting the Tone:** It is important to set the tone in the first client encounter—whether on the phone or in person—by being welcoming, making an immediate connection, and building trust. A key factor in building a trusting relationship with the client is to be respectful and nonjudgmental. Also, the LC should ensure there are no distractions such as noise, ringing phones, or interruptions by coworkers when meeting with a client. To minimize the possibility of distractions, turn off all phones and put a “Do not disturb” sign on the door.
- **Responsive Listening:** Communication is a two-way process: speaking and listening. Responsive listening says to a client, “You are being heard and understood.” At least half of the time spent communicating involves listening. How well the LC listens will affect their relationship with the client. In responsive listening, the LC does not simply hear the client’s *words*; they hear the client’s *thoughts, beliefs, and feelings*. Listening is a communication skill that improves with practice.
- **Affirming:** Affirmations can include statements or questions that verbally support or validate the client’s thoughts, emotions, actions, views, and perceptions.
- **Reflecting:** This is the act of making a statement that clarifies, amplifies, or guesses at the meaning of the client’s statement. All verbal communication involves encoding and vocalizing by the speaker and hearing and decoding by the listener. Reflecting is a way of giving voice to a decoded interpretation of the client’s message.
- **Summarizing:** This is the practice of restating or reframing what the client said, usually in a condensed form.
- **Asking open-ended questions:** Such questions prompt the client to provide an answer beyond a simple “yes,” “no,” or “maybe” and do not lead the client to a specific or desired answer.
- **Nonverbal communication:** Body language and facial expressions are good ways to “read” the client, whether or not the client is speaking.
- **Managing silence:** An important communication tool, silence can be used as a powerful stimulus for conversation that leads the client to an important expression of a thought or emotion. However, it is important to know *when* and *how* to use silence. Managing silence also means knowing *how to end silence*. The four techniques listed immediately above are effective ways to end silence.

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

For full descriptions and sample dialogues of each technique, refer to [Appendix B.8](#).

It is especially important to keep in mind the primary goal of ARTAS: linking clients to medical care.

- **Affirm any commitment to linking to medical care or taking other steps in that direction.** Examples are (1) looking at medical care in a new light, (2) being willing to talk to others about visiting a clinic, or (3) being able to discuss fears, concerns, and barriers to linkage. At some point in every session, the LC should ask the client to describe their ideas, thoughts, feelings, or concerns about linking to medical care.
- **Affirm self-motivating statements.** This provides the client with an opportunity to hear someone else's observation about a self-motivating statement that highlights a critical strength. Respond to any situations that relate to seeking medical care.
- **Normalize any ambivalence the client is feeling about linking to medical care with affirmations.** When the LC normalizes clients' feelings of reluctance, fear, or opposition, they reduce clients' need to defend their reluctance to seek medical care. When someone says, "There's nothing to be afraid of," the normal response is to defend one's reason for being afraid. A less defensive response is elicited when someone says, "I don't blame you for being scared." Affirm the reasons for the client's reluctance and help them understand those feelings as a normal response. This will help the LC avoid the role of trying to convince a client to do something they do not want to do and help the LC and client move the discussion toward the advantages and disadvantages of seeking medical care.
- **Put down the pen!** During the ARTAS-II study, one of the most consistent themes in the client feedback was that the LC was different—and more effective—because they looked at the client while listening. If the LC looks at the client while they speak, the LC cannot write at the same time. It is okay to jot down a quick note or write out responses on the ARTAS Session Plan, since the client will receive a copy. However, in general, the LC should keep the writing to a minimum.
- **Do not jump too quickly to problem-solving.** ARTAS involves giving advice when asked, suggesting alternatives, and providing direction. While the LC can assume an expert role, they do not want to become yet another person in the client's life telling the client what to do. It is also important to maintain professional boundaries and remain client-focused.
- **Remember that ARTAS is not about ordering or coercing a client into medical care.** It is about helping a client decide whether obtaining medical care is right for them. When the client is in charge, they gain the ability to overcome the many obstacles presented. It is the LC's job to take advantage of the opportunity to build the important asset of self-reliance within the client.

Cultural Humility

Cultural humility is both a complex challenge and an opportunity to meet the health needs of persons with HIV. Cultural humility is an ongoing process of developing the awareness, behavior, structures, and practices that allow an organization, its programs, and its staff to

serve diverse groups and communities. When the LC is embodying cultural humility, they have awareness of and sensitivity to clients' attitudes, behaviors, and cultural mores. Key behaviors that demonstrate cultural humility include, but are not limited to:

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

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

- Attitudes, behaviors, belief systems, and family structures specific to the populations served.
- Potentially destructive psychosocial effects of cultural beliefs—stigma, guilt, and shame of HIV-positive status—that present in many populations.
- Effect that cultural mores, environment, values, and beliefs have on a client's ability to seek and access healthcare services.
- Different communication styles, both verbal and nonverbal.

Although it is not required for implementing ARTAS, there is great value in the LC taking a cultural humility course or engaging in diversity awareness activities to enhance their ability to relate well to clients from diverse backgrounds.

The U.S. Department of Health and Human Services developed a set of 14 standards to help healthcare providers engage in culturally humble practices. These are referred to as the [National Standards on Culturally and Linguistically Appropriate Services](#). Some of the standards are federal requirements for organizations receiving U.S. government funds, while others are only guidelines or recommendations. Each LC should review the set of standards for relevance to implementing ARTAS in a culturally humble way.

Marketing ARTAS to Potential Partners

People who are recently diagnosed with HIV face challenges that will require referrals to a host of service providers, including but not limited to health clinics, food banks, employment agencies, social services providers, physicians, mental health services, and faith-based organizations. Because the LC is the primary marketer of the intervention to community partners, it is important to learn how to “sell” the intervention to others.

When preparing to work with potential community partners, HIV care providers, and other service delivery systems, the LC should focus on being able to explain the intervention and facilitate meetings with partners. Understanding the goals of these agencies and how they accomplish those goals are important facets of each LC's preparation.

The following is a detailed description of how to summarize ARTAS and use facilitation skills:

A. Summarizing ARTAS:

Learning to clearly, succinctly summarize the intervention to potential community partners is the first partner-related pre-implementation activity for the LC. In addition to knowing how to briefly and easily explain ARTAS, the LC must be able to “sell” the intervention. Therefore, it is important to know and articulate each agency’s role and the benefits of ARTAS to clients, to each agency, and to the overall healthcare system.

Below are the basic points to summarize about the intervention. Other key points should be added to tailor the discussion to each potential partner. If the LC has to reach out to a large number of potential partners, then the points below, along with the tailored messages, can be turned into marketing materials for mass distribution. Developing a marketing plan is discussed on [page 41](#) of this section.

- ARTAS links persons with HIV to medical care and improves clients’ willingness and ability to successfully link to care.
- ARTAS is a short-term, individual-level, evidence-based intervention. ARTAS study participants linked to medical care at a rate of 78% (compared with 60% in the control group).
- A specially trained LC conducts up to five structured client sessions over a 90-day period or until the client attends their first clinical appointment with an HIV care provider, whichever comes first.
- Once either of the above events occurs, ARTAS ends, and the client is systematically transferred to a long-term / Ryan White CM and any other needed services the client identifies.
- The benefits to partnering agencies/clinics include (1) having clients who are more likely to follow through on a referral, (2) having an additional staff person to work with clients at no cost, and (3) clients entering the system with more knowledge about the purpose of case management.
- If the client is transferred to a long-term / Ryan White CM, the LC can ease the burden on the CM by completing required documentation before transferring the client.

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

B. Facilitation Skills

In addition to the client-centered skills and techniques listed above, ARTAS staff—particularly the LC—may find it helpful to have good facilitation skills. These skills can be

useful during meetings with community partners and colleagues and in training new staff. Facilitation refers to the process of designing and running a successful meeting or training.

Role of the Facilitator

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

The facilitator's role is as follows:

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

Process and Content

In ARTAS, the LC will need to have sufficient facilitation skills to manage the process and content of a meeting. "Process" refers to the actions and techniques the facilitator uses to manage the group and the flow of the meeting. "Content" refers to the meeting objectives, agenda, discussion topics, and expected outcomes.

Tips on Preparing for the Meeting

The following are helpful tips for the LC to prepare for meetings to inform community partners about ARTAS and/or give training sessions for new ARTAS staff:

- Ensure that meeting/training attendees have a clear understanding of the meeting purpose in advance.
- Know the audience and keep their potential concerns in mind.
- Develop an agenda ahead of time and consider whether it should be sent in advance of the meeting.
- Decide how to record the information from the meeting.
- Take care of all the meeting logistics (e.g., location, room setup, equipment, supplies, and refreshments). In considering the meeting location, one implementing agency incorporated the discussion of ARTAS into an existing monthly HIV provider network meeting. This eliminated the need for providers to come to an extra meeting and provided a venue to share information with others.

Tips on Facilitating the Meeting

The following are helpful tips for the LC to facilitate meetings to inform community partners

about ARTAS and/or give training sessions for new ARTAS staff:

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

Some of these tips may be helpful for the LC as they are preparing for and conducting client sessions as well.

4. Preparation for Work with Community Partners

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

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

It is especially important to distinguish ARTAS from Ryan White case

management. While linkage to medical care is a component of these other services, the process of making this link varies among agencies and can consist of simply a paper referral. Other services also have a broader focus and assist clients in addressing many issues. It should be noted that ARTAS is a short-term, intensive intervention with the specific goal of linking clients to medical care and creating a mindset that they will continue with care. ARTAS serves as a complement to Ryan White case management by getting clients into medical care and allowing other CMs to focus their limited time and resources on helping clients obtain other needed services.

- It is imperative to clearly explain the goals of ARTAS and explicitly discuss how the LC relies on collaboration with other agencies. A useful tool to promote collaboration and decrease misunderstandings is a simple flowchart that outlines the basic steps of the ARTAS linkage to medical care process and indicates where partner agencies fit into that process. Incoming referrals can come from a variety of sources, including sexually transmitted disease (STD) clinics, counseling and testing sites, CBOs, or another program within the implementing agency. Outgoing referrals are ARTAS clients who are referred out of the program to numerous community resources, including medical providers, substance abuse / mental health treatment, long-term / Ryan White case management, and other social services that address basic client needs. Many of these agencies may also have referred clients into the program. See **ARTAS Client Referral Flow Chart** in [Appendix B.10](#).
- People at all levels of the partner and implementing agencies should be made aware of ARTAS and its implications for their particular roles and responsibilities. The implementing agency should provide print materials that describe ARTAS with an emphasis on *how the intervention can benefit the staff at the implementing and partner agencies*.
- It is important to develop a memorandum of agreement (MOA) between the implementing and partner agencies to guide the agencies' interactions at all levels. Developing an MOA allows the implementing agency to address potential problem areas, save time, and avoid misunderstandings. For an MOA template, see [Appendix B.11](#).

A. Identifying Community Partners

Successful partnerships have a clear purpose, add value to the work of the partners, and are carefully developed to ensure the partnership is valuable and sustainable.²⁰

When identifying community partners, agencies should consider the following questions:²¹

- What type of organization is the most beneficial to pursue (i.e., HIV services organizations, health department clinics, faith-based organizations)?

- Who would be most helpful to people recently diagnosed with HIV?
- How is the organization/clinic regarded in the community?
- Is there a pre-established relationship with the organization/clinic? What kind of relationship is it, and will it be helpful in helping clients link to care?

B. Becoming Familiar with Community Partners

A significant pre-implementation activity for the LC involves developing a thorough knowledge of existing services, partner agencies (whether referral agencies, HIV care providers, or other services), and their staff and processes. It is crucial that each LC become familiar with both the *formal and informal* practices and characteristics of partner agencies and their services.

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

Summary of Activities for Building a Strong Knowledge Base of Community Resources

To develop a solid knowledge base of resources and services available in the community, the LC might:

1. Complete the **Agency/Clinic Need-to-Know Information Form** in [Appendix B.9](#) (one per agency/clinic). This information will be used for step 2.
2. Create or refer to an existing directory of resources (i.e., HIV services organizations, health department clinics, faith-based organizations) based on step 1. Organize the agencies by categories that will be most useful to the LC and clients. Ideas for potential categories include general health care, mental health treatment, substance abuse treatment, HIV-related medical care, housing, dental services, transportation, and interpreter services.
Tip: Create an electronic database to store this information. With an electronic database, the LC can easily update information and quickly sort by important fields relevant to the client's needs, such as "Language" or "Housing Services."
3. Personally contact individuals at the agency/clinic and schedule a meeting with the key staff who are likely to serve as advocates for ARTAS. These may include healthcare providers, CMs, counseling and testing staff, and others.
4. Ask the staff member(s) to walk the LC through the typical application and screening processes. This may include a step-by-step explanation of the

processes or a “mock” client intake, where the staff member simulates the process with the LC acting as the client.

5. Ask the staff member(s) for permission to shadow them as they conduct intake processes with a client.
6. Make a notation of any differences in the processes/procedures between step 4 and step 5. Also, make a notation of any differences in the processes/procedures in these steps and *formal* requirements listed by the agency/clinic. Make note of any *informal* requirements or characteristics of the agency/clinic or of key staff who will facilitate the referral process.
7. Cultivate personal and professional relationships with the staff members who will facilitate the ARTAS referral process.
8. Create an inviting and easy-to-use referral directory for clients. The directory should include both the *formal* requirements (photo identification required) and the *informal* hints that are helpful for the client.

LC’s Preparation to Work with Healthcare Providers

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

To prepare in advance, the LC should discuss and get answers (preferably in a written agreement) to the following questions:

1. If a waitlist exists for receiving treatment at the clinic, will the client’s name be added to it, or will they be given preferential treatment for participating in ARTAS and seen before others on the waitlist?
2. Will the clinic staff allow the LC to accompany the client, with the client’s approval, to all aspects of the appointment—administrative, psychosocial, and medical?
3. When transferring the client from ARTAS to long-term / Ryan White case management services:
 - a. Can the LC attend the first case management session or a pre-session to introduce the two parties?
 - b. Will the LC complete some or all of the intake and enrollment paperwork prior to the client’s first session?

- c. What information does the clinic/agency expect to receive from the LC?
- d. What follow-up information will the clinic/agency provide the LC post-linkage? For example, how can the LC verify the client attended the appointment, if they did not accompany the client? Will there be a formal or informal process to keep the LC updated on the client?

C. Marketing Strategies

During the pre-implementation phase, it may be necessary for the LC or program director/manager to develop specific marketing strategies (or consult with an agency staff person with marketing experience) that encourage community agencies in a partnership to either refer clients to ARTAS or receive ARTAS clients being linked to medical care and other services. Such a partnership depends on, among other factors, whether the agency has testing, medical, and case management services co-located and whether the agency has existing, formal relationships with partner agencies that are conducive to the implementation of ARTAS. The following steps will help in developing a marketing strategy:

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

Step 2: Identify the available resources for the implementing agency to develop print and electronic materials describing the intervention. Some agencies have a communications department or access to consultants who can create an ARTAS brochure and/or information package. A key principle to remember is to keep the messages clear and simple. For main points to include in these brochures, see the brief summary of ARTAS under “Preparing Your ARTAS Overview” on page 37 of this section.

Step 3: Schedule meetings with potential community partners to provide information about ARTAS. The aim of these meetings is to educate agencies and providers about ARTAS and encourage them to enter into an MOA that clearly and formally spells out the relationship with the implementing agency.

Step 4: Develop low-cost, creative strategies to inform other key community partners within the community about ARTAS. The aim is to help increase referrals to the intervention. A few marketing strategies to consider include:

- Inform clergy, physicians, college counselors, and community outreach workers about the intervention. Provide them with printed materials and encourage them to refer recently diagnosed, or out-of-care, individuals to the intervention.
- Attend regularly scheduled meetings of groups such as HIV consortia, referral networks, and community planning groups, and use these venues to market the

ARTAS intervention to a wide range of health care providers.

D. Referral Strategies

The implementing agency will want to develop two types of referral processes: incoming referrals, for clients who are referred into the ARTAS intervention, and outgoing referrals, for clients linking to medical care and other long-term services. The steps necessary to implement the two processes are outlined below:

- To obtain **incoming referrals** of clients to ARTAS, the agency and LCs should:
 - Meet with community partners and market ARTAS to raise awareness of the program and gain buy-in among referral sources. Agencies must ensure that all partners understand their roles and responsibilities as part of the program.
 - Establish and maintain formal referral relationships through MOAs with community partners that agree to refer clients (e.g., health department clinics, HIV testing sites, STD clinics, social services agencies).
 - Establish informal relationships with people in the community who may have direct contact and influence with recently diagnosed, or out-of-care, clients (e.g., outreach workers, drug counselors, clergy, high school and college counselors).
 - Agencies should establish and make partners aware of specific procedures such as the method of receiving referrals (e.g., referral source calls agency directly, agency information is given to client) and the agency's process for engaging the client in ARTAS upon receipt of referral.
 - ARTAS staff should create a system to update incoming referral sources on the status of clients they have referred to the intervention. Staff may choose to inform the referral site of the client's progress in linking to medical care by phone, email, or letter. This contact is important because it shows that the referral sites are an integral part of the intervention and demonstrates that ARTAS is providing the services it has advertised. If the referral is coming from another program within the implementing agency, it is still important to follow this process.
- To make **outgoing referrals** linking clients to medical care within 90 days, the agency and LC should:
 - Establish formal relationships, through MOAs, with medical care providers to receive clients.
 - Establish formal relationships, through MOAs, with agencies that will receive ARTAS clients into their long-term case management and/or other immediate service delivery systems such as food banks, shelters, housing agencies, and employment training programs.
 - Ensure all partners for outgoing referrals understand their roles and responsibilities as part of the program.

- Make sure that the identification of outgoing referrals is consistent with the client-driven nature of ARTAS: the LC should work with the client to identify potential referrals instead of choosing them for the client. Since the client may have many possible referrals, the LC should help the client define their priorities. It is important that referrals reflect the client's priorities. After clients have identified possible referrals, the LC can discuss them with the client and offer any additional suggestions that they have not listed.
- When giving the referral to the client, the LC should acknowledge that there may be stigma attached to seeking certain services and should normalize the referral by talking about it generally in the third person, explaining that clients are routinely recommended to these services. The LC should make an effort to refer to services they are familiar with and offer the client any firsthand knowledge of the services and providers.
- If the client does not agree with the referral, it is less likely that they will show up for the appointment. The LC should assess the client's reaction to all referrals, since client buy-in is essential in making successful outgoing referrals. If the client is not agreeable to the initial referral, offer other options.
- The LC must facilitate active referrals and should make this expectation clear to partners to which clients will be referred after ARTAS. The LC should assist the client in handling logistics such as arranging the first appointment, obtaining transportation, and finding someone to accompany the client to the meeting, if the client so desires. It can be helpful for the LC to participate in the client's first meeting with the referral, especially if it is a long-term / Ryan White CM, to facilitate consistency during the transition and ensure that all follow-up issues are addressed. The LC should develop a plan for the client to follow up and report back about the appointment after accessing the referral.¹⁵

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

E. Finalizing Referral Processes

Before the agency begins to implement ARTAS, it should ensure that the MOA and other necessary documents have been signed by all relevant agencies, including referral sites for individuals who are interested in and ready for rapid linkage to HIV care within seven days. It is important to document the ARTAS referral protocol in writing, listing the specific actions to be taken, and, where applicable, to make sure the protocol lists the specific person responsible for each task and when it is to be completed. It may be useful to visually depict the referral process by using a flowchart or other graphic.

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

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

ARTAS Referral Processes	Standard Referral Processes
<ul style="list-style-type: none"> • Immediate follow-up on incoming referrals; LC may be available when diagnosis is given. 	<ul style="list-style-type: none"> • Client is referred to agency post-diagnosis; referral follow-up time will vary by agency.
<ul style="list-style-type: none"> • The same LC conducts intake and works with client for the duration of the program. 	<ul style="list-style-type: none"> • Initial intake may be performed by intake counselor or non-case management staff at agency.
<ul style="list-style-type: none"> • LC facilitates active referrals to medical care and other services, including rapid linkage, if applicable. LC may attend the first medical appointment with the client. LC works with client to determine client's needs for outgoing referrals and to set up appointments. 	<ul style="list-style-type: none"> • Referral to medical care and other services may be passive (client is given agency information but must follow up on their own).

If necessary, the agency should hold a final meeting with ARTAS staff and the community partners to ensure that everyone understands the goal of ARTAS, comprehends the referral protocol for the program, and has copies of this protocol to refer to and distribute at their agency before the intervention begins. Answer any remaining questions and explain that LCs will remain in contact with the agencies throughout the ARTAS intervention. At

this point, it is also important to solve any remaining logistical issues, such as finding space at each referral site for the LC to meet privately with the client and ensuring that the referral sites have the names and cell phone numbers of each LC.

F. Client Enrollment

All incoming referrals should be directed to one of the LCs in the implementing agency or someone else who is trained to conduct the ARTAS intake. Upon receiving an incoming referral, the LC should determine whether the client is eligible to participate in the intervention based on the eligibility criteria set by the implementing agency. The agency may want to consider using the same criteria used in the research studies. The original research criteria state that the client must:

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

However, it is important to note that the implementing agencies should *choose eligibility criteria that best suit the needs of their priority population and agency*, unless the eligibility criteria are determined by the funding agency. As an example, some agencies use ARTAS for reengaging out-of-care clients. While the LC screens the client for ARTAS, they should obtain the initial intake information from the referral source. If the client meets the eligibility criteria and agrees to participate in the intervention, then the LC should enroll the client into ARTAS.

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

If the client is not eligible or does not wish to participate in ARTAS, they should be referred to long-term / Ryan White case management or other support services. For a diagram of the ARTAS **Client Enrollment Flow Process**, see [Appendix B.12](#).

5. Establishing Safety Guidelines and Protocols

Assess policies and/or procedures

During pre-implementation, the implementing agency should review its current non-ARTAS policies and procedures for any discrepancies with the core elements of the intervention. If there are inconsistencies, then the agency should consider revising agency policies, if possible, to facilitate successful implementation. While the policies do not need to be

completely rewritten to accommodate ARTAS, the value of making some of these changes, for both the intervention and the agency overall, should be considered.

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

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

The two main safety considerations related to ARTAS and guidance for handling them are as follows:

Conducting client sessions in the community: ARTAS is a client-driven intervention, and one of the core elements requires that the LC conduct case management as an active, community-based activity. This core element is important because it gets the LC out into the client's community and gives them a better understanding of the environment in which the client is living and barriers they are facing. By engaging with the client at this level, the LC will have a better understanding of possible solutions to recommend.

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

However, the client may agree to attend client sessions at the agency, at a mutually agreed-upon location, virtually, and/or with a second LC present.

The implementing agency may want to train the LC on the agency's safety guidelines and stress the importance of being cautious when conducting sessions in the community.

Recommendations for safety guidelines and procedures for the LC to follow during client sessions occurring outside the agency include, but are not limited to:

- Meet in a public place that also maintains the client's privacy.
- Keep a calendar at the agency of the LC's whereabouts, including the meeting location and time, when they are expected back in the office, and the client with whom the LC is meeting.
- Check in with the LC supervisor or designated agency employee before and after

each client session.

- If the LC is uncomfortable with a meeting place or meeting with a client at night, then they may bring a colleague, if approved by the client, or change the meeting time or location while still ensuring the client is comfortable.
- Do not divulge personal information, such as home address, to clients.
- Immediately leave any location or situation that feels uncomfortable, unsafe, or threatening, and go to a secure site.
- Always travel with a fully charged cell phone.
- Pre-program local emergency numbers into the LC's cell phone.
- Determine in advance the safest driving route to the destination and safest place to park.
- If meeting in a client's home or a private location, be the last person to enter a room and ensure the door remains unlocked.

Transporting clients: Providing transportation is a key characteristic of ARTAS. If the implementing agency decides not to allow the LC to transport a client in their personal vehicle, then the agency should make other arrangements to assist the client with transportation via an agency-owned vehicle. If transportation policies cannot be changed, then the agency can think about other strategies such as providing subsidies for taxi cabs or public transit.

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

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

Boundaries

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

important for the LC to have an excellent understanding of boundaries, which always need to be respected and observed in the client–LC relationship.

One approach to viewing boundaries is to consider four categories:

- Category 1: Absolute boundaries
- Category 2: Agency-derived boundaries
- Category 3: LC-derived boundaries
- Category 4: Client-derived boundaries

Absolute boundaries are the most obvious. Examples include:

- **Do not** have sex or engage in intimate relationships of any kind with clients.
- **Do not** loan money to or borrow money from clients.
- **Do not** hire clients to do work for the individual LC.

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

LC-derived boundaries include personal boundaries set by the LC regarding their relationships with clients. For example, the LC must decide whether to give out home or personal cell phone numbers and how available they will be outside of the agency’s normal business hours. If the implementing agency purchases a cell phone for the expressed purpose of giving the number to ARTAS clients, the LC must decide at what time of day they will turn it on and off. Because of the short-term, intensive nature of the LC/client relationship, the LC will need to be very careful to maintain boundaries with their ARTAS clients. On the one hand, the short-term, intensive design of the intervention may provide useful parameters to the client–LC relationship (i.e., knowing there will be only a few client sessions may serve as encouragement for the client to act promptly). On the other hand, it may blur the client–LC boundaries.

Because the client sessions are held at a client-identified location and the LC accompanies the client to medical appointments, the LC gets a firsthand view of their clients’ struggles and obstacles and the environment in which they live. This may lead to a stronger bond between the client and LC. That strong bond may lead to the LC doing more for their ARTAS client than they would normally do for other clients.

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

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

Tips for the LC in setting boundaries with clients:

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

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

The crucial questions about agency, LC, and client boundaries are whether they protect clients and staff, facilitate the goal of ARTAS, and adhere to the core elements.

Regardless of the boundary “category,” the implementing agency must have a system in place to create personal and professional boundaries and resolve any related issues that may occur. Every professional certifying and licensing body for social workers and CMs— as well as most employers—has rules on acceptable and unacceptable relationships between professionals and clients. Every intervention staff person must be familiar with boundary-related policies and the procedures to report a violation. The LC should receive a written copy, training, and an annual reminder of the agency’s policies and procedures. Clients should receive a copy of the policies and procedures as well.

Confidentiality

All CMs, including the LC, are bound by codes of ethics to respect a client’s confidentiality and right to privacy. In the course of conducting the five client sessions, the LC should only solicit private information that is essential to linking clients to medical care or completing the paperwork. The following are critical points about confidentiality to observe in a client—

LC relationship:

- The LC should adhere to an appropriate code of ethics that governs their interactions with clients. National bodies like the National Association of Social Workers or state certifying agencies normally have a code of ethics for social work professionals. Following such a code of ethics not only protects the client but also the LC and agency.
- Once the client shares private information, the code of ethics immediately applies. The information obtained from clients in the sessions is deemed confidential, and the LC is expected to protect its confidentiality. However, the LC may disclose confidential information with written consent from the client, when appropriate. For example, if a client is linked to medical care and would like to have their records transferred to another agency, then the client must give written consent.
- The LC should never discuss confidential information *about* clients in public or semi-public areas such as hallways, waiting rooms, elevators, and restaurants. Because client sessions may be held outside the agency and in public or semi-public places such as libraries or restaurants, the LC must take precautions to protect the client's confidentiality.
- The general expectations regarding confidentiality do not apply when disclosure is necessary to prevent serious or imminent harm to a client or another person.
- The client's right to privacy should also be respected and the LC should ensure that the space used to conduct the five client sessions allows for privacy.
- When phone calls are made or letters are mailed to the client, this must be done in a manner that maintains privacy and confidentiality. It is likely that some clients may not have disclosed their HIV status to anyone, or only to very few people, and may not want letters with the name of the agency mailed to their home address.
- The LC should protect the confidentiality of clients' written and electronic records and other sensitive information. Reasonable steps must be taken to ensure that client records are stored in a secure location and are not available to unauthorized persons. Client records should be transferred or disposed of in a manner that protects confidentiality and aligns with state or local laws governing patient records. Considerations for client records include but are not limited to: transferring records and information through computers, electronic mail, or facsimile machines; using telephones and answering machines (leaving voicemail messages); maintaining double-locked file cabinets; maintaining password-protected files; having fax machines for ARTAS purposes; using plain envelopes without the agency name or address; and following all client-derived boundaries regarding contact and communication.

6. Adapting the Intervention

Adapting ARTAS involves customizing its delivery to ensure the strategies and activities meet the needs of the implementing agency and of the population(s) being served **without**

altering, deleting, or adding to the core elements. In other words, adaptation refers to the “who,” “what,” “when,” “where,” and “how” of the intervention. Before an implementing agency adapts ARTAS, it is important to first:

- Implement the intervention as designed.
- Carefully consider how and why the intervention is being adapted.
- Obtain adaptation-related capacity building assistance (CBA) services that are available for qualified agencies. You may access additional information on CBA services at [CDC’s Effective Interventions website](#) or by contacting the implementing agency’s CDC and/or health department project officer to access these services.

Below are several examples of past adaptations to ARTAS. This is not intended to be a comprehensive list, nor is it a guide on how to adapt the intervention.

One adaptation example has been a shift at some organizations from in-person client sessions to virtual client sessions using a secure web conferencing platform or, in some cases, telephone calls. Many agencies began implementing a virtual adaptation of ARTAS in response to COVID-19 physical-distancing mandates when in-person client sessions became unfeasible. Since then, as these mandates have been lifted, some organizations have chosen to continue offering virtual client sessions as they can reduce the impact of client barriers to accessing services such as not having a reliable source of transportation to attend in-person sessions.

Another example of an adaptation is expanding the population being served to include more people not currently engaged in medical care, including those in need of re-engagement in care. In the original research (ARTAS-I), the priority population included people within 6 months of diagnosis. In the implementation research study (ARTAS-II), the priority population was expanded to 6–12 months from diagnosis. (Note: Nearly 96 percent of the participants were within 6 months of diagnosis.)

It is important to note that this expansion of the priority population may affect the results of the intervention slightly, since these populations are typically more difficult to reach and to link to medical care. Individuals who are further out from an HIV diagnosis, especially people who are asymptomatic, may still not be ready to link to medical care and may even be more resistant. On the other hand, they may have accepted their HIV-positive status and may now be ready to link to medical care but still have barriers.

For this reason, some ARTAS implementers have chosen to expand their eligibility criteria to include any persons with HIV who are not currently linked to HIV care, regardless of the time of diagnosis. For instance, 6 months into recruitment for the Modified Antiretroviral Treatment Access Study ([MARTAS](#))²⁵, yet another adaptation of ARTAS, the researchers expanded eligibility criteria to include all persons with HIV attending the study sites who had never been linked to HIV care. Other adaptations employed in MARTAS include the use of trained nurses as the linkage coordinator, the use of up to six sessions with the

linkage coordinator (three in-person and three by phone), and the use of text message appointment reminders.

During ARTAS-II, some demonstration sites decided to have clients talk on the phone or meet in person with the LC upon receiving their test results. Within minutes of receiving the diagnosis, the client could speak with the LC to begin building the relationship. On the other hand, some demonstration sites chose to collect the client's contact information and ask the LC to follow up with the client after they left the testing site. In both scenarios, the testing site discussed the intervention with the clients and obtained their permission to release their test results and contact information to the LC.

Another adaptation took place at a health department. The health department staff *required* the STD clinic staff to refer *all* recently diagnosed patients to the LC.

In all of these scenarios, the LC pre-screened the clients for eligibility for and interest in participating in ARTAS before enrolling them in the intervention.

When adapting ARTAS, it is important to think of the *effect* of adaptation on the clients, community partners, and outcomes of the intervention. *Adaptation does not and should not affect the core elements of the intervention.* Adaptation should:

- Enhance the delivery of the intervention.
- Make the information more accessible to clients.
- Give the agency a chance to be creative with the intervention.

There are numerous ways to adapt ARTAS. Before the agency adapts ARTAS, it should consider the needs of the population, the resources and capabilities of the implementing agency and partners, and the core elements of the intervention and it should obtain CBA services. Also, it is important to document all adaptations and evaluate them to determine their effectiveness. Once an adaptation occurs, it is always possible that the efficacy of the intervention could change. Whether the change is positive or negative, it is important to have clear documentation of the process.

7. Customizing an Evaluation Plan

During pre-implementation, the implementing agency is encouraged to develop a monitoring and evaluation (M&E) plan. This plan should be implemented throughout the delivery of ARTAS. **It is important to review any M&E requirements (activities and/or indicators) with the funding agency before designing a plan.** The implementing agency should review the sample monitoring forms referenced in the [Maintenance section](#) of this manual, and the agency may adapt the forms to fit its implementation plan and monitoring activities. For qualifying agencies, CBA services for M&E are available through CDC.

(Note: This section discusses developing an M&E plan. However, implementing and/or

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

A. Reasons to Monitor and Evaluate

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

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

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

Monitoring also helps agencies compare actual outcomes with target outcomes. Examples may include:

- Number of people enrolled
- Number of sessions conducted
- Number of clients referred to medical care

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

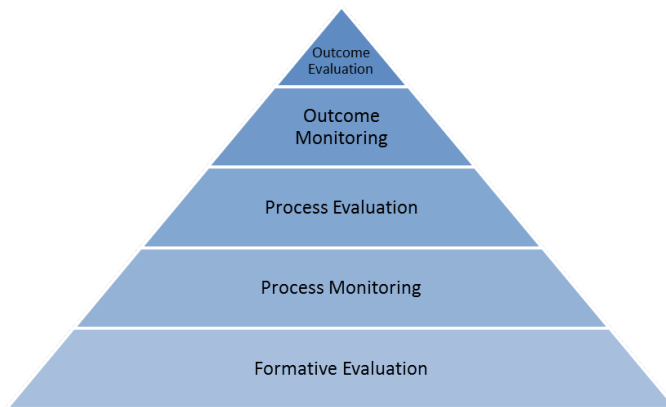
The information gathered through M&E activities should be used to help the implementing agency fine-tune the intervention delivery by addressing areas where problems arose in the implementation plan. Below is a basic description of different types of M&E: formative evaluation, process monitoring, process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

B. The Logic Model and Types of M&E

The Behavior Change Logic Model ([Appendix B.5](#)), discussed on page 24 is the basic structure of the intervention and is related to M&E. The components include a problem statement, the behavioral determinants or barriers that prevent the client from linking to care, the intervention activities to address those barriers, and the client outcomes.

In addition to the logic model, the CDC evaluation pyramid, shown in **Figure 4** below, is helpful for framing M&E.

Figure 4: CDC Evaluation Pyramid



The different types of M&E activities and their relation to the logic model are described below:

Formative evaluation, the first type of evaluation an agency may wish to conduct, is defined as a process of gathering information that is used to develop an evaluation plan. In the case of ARTAS, formative evaluation refers to the process of collecting data that describe the types of HIV care services to which clients can be linked in a given community. Through the formative evaluation process, agencies should gather data on such factors as the location of HIV services, hours of operation, eligibility requirements, and fees. In addition, agencies can use a Community Mapping Tool to identify medical care providers that clients can be linked to for care. See [Appendix B.13](#) for a sample **Community Mapping Tool**.

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

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

On the logic model, this relates to the second column, "Activities to address behavioral determinants." Process monitoring takes place here (e.g., documenting client goal-setting and strengths assessment information).

Questions to ask include:

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

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

Process evaluation involves comparing the process monitoring data with what was planned. The results of this comparison can inform future program planning as well as demonstrate areas of success. Questions include:

- Was each core element addressed?
- Were any of the ARTAS key characteristics changed?
- Which key characteristics were changed?
- Was the intended priority population recruited/enrolled?
- What recruitment sites were most productive?
- Were the intended numbers of clients enrolled?
- Were sessions held in a convenient place for the clients?
- What challenges were faced in recruiting clients?
- What challenges were faced during the sessions?
- What was the feedback from the participating clients?

In the logic model, process evaluation also takes place in the middle “Activities” column. Once the activities progress over the course of ARTAS sessions, more information can be captured on how activities were implemented and whether they were performed as planned.

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

participation.

Outcome monitoring indicates how clients have changed after participating in ARTAS. It may measure the changes in clients' behaviors, intentions, and attitudes *before* the intervention compared with *after* the intervention.

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

There are also immediate outcomes:

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

In the logic model, outcome monitoring relates to the third column, "Outcomes," including immediate and intermediate outcomes.

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

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

This section provided an overview of pre-implementation activities such as how to build relationships with community partners, develop a marketing plan, and develop an M&E plan. The next section provides an overview of implementation-related activities.

Section 5: Conducting ARTAS at your Agency (Implementation)

5.1 What is Implementation?

The implementation phase involves LCs delivering the intervention to clients with confidence, skills, proficiency, and fidelity.

5.2 Implementation Activities

Implementation activities are focused on the following:

1. Preparing for implementation
2. Implementing ARTAS
3. Maintaining community partners
4. Supervising LCs

1. Preparing for Implementation

On days when the LC is scheduled to deliver the intervention, they are responsible for making sure they have access to a private space and the materials needed to conduct the intervention. The following LC skills (relationship building, strengths assessment, and setting objectives) are core elements of ARTAS and thus essential to implementation.

Building Effective Relationships

This skill relates to both the LC/client relationship and the relationships between ARTAS staff and community partners. To implement ARTAS with fidelity to the core elements, the LC must build effective working relationships with their clients. In focus groups with clients who participated in other applications of strengths-based case management, the clients identified key ways in which their relationships with a strengths-based CM became a trusting relationship. These included the strengths-based CM doing the following:²²

- Making time for the client
- Being persistent in following up with the client
- Treating the client as a person
- Being a good listener
- Being nonjudgmental
- Being there for the client
- Going at the client's pace
- Focusing on strengths
- Being understanding

Moreover, the LC will have to build positive relationships with healthcare providers, HIV testing centers, and other community partners that will be the primary sources for referring and receiving clients. Without a strong referral network and a positive working relationship

between the implementing and partner agencies, it will be difficult to implement ARTAS. This is why an emphasis is placed on pre-implementation activities with partners; regular communication with them throughout the Implementation phase is strongly encouraged.

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

Conducting a Strengths Assessment

Another essential skill for the LC is the ability to conduct a strengths assessment. The purpose of the ARTAS strengths assessment is to help the client identify personal strengths, abilities, and skills that they can use to access medical care and accomplish their objectives to successfully reach the goal of linkage to care.

Focusing on strengths during the assessment helps the LC to do the following:

1. Avoid engaging in a conversation based in skepticism and hopelessness, which may be common for persons confronting numerous life challenges.
2. Encourage a positive, trusting relationship.
3. Promote confidence in the client to follow through with accessing medical care.

The strengths assessment was originally created to be a comprehensive summary of a client's life across multiple domains, such as general life skills, relationships, and personal attributes.²³ The ARTAS strengths assessment has a narrower focus and covers experiences identified by the client. The strengths assessment gives the client an opportunity to identify specific life situation(s) when the client achieved success based on their actions and abilities. The client and LC will use these successful situation(s) to identify resources for accomplishing future goals, such as linking to medical care.

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

The [Life Domains List](#) (see [page 132](#) in the Client Session Guide forms section) can be a helpful tool to use *only as a reference* for the LC. It lists questions that can be used as refreshers about various life domains and ways that clients show strengths in those domains. (Please note: *Using the Life Domains List while the client is present and writing down the "answers" to the Life Domains List is not appropriate.* The exercise should not become a catalog of deficits and past failures.)

STRENGTHS ASSESSMENT FORM

Client's Copy

Date: April 13, 2018

Session Number: Four

New Assessment or **Updated Assessment** (Circle one)

1. My strengths, skills, or abilities identified:

- a. Strengths: I keep my family organized.
- b. Skills: I make the kids' lunches, get them to school on time, and pick them up every day.
- c. Abilities: I can plan ahead if I think something will interfere with my kids' school schedule. If I can't pick them up one day, I make sure my mom or sister can.
- d. Ms. Angie, my LC, helped me see that an everyday thing like getting the kids to school is a strength.

2. Examples I gave about a time(s) that I successfully faced barrier(s) in my life: I had a job at the corner market, and I paid most of my own bills.

- a. Examples of barrier(s): I never had a job before, so I didn't think anyone would hire me.
- b. Things I did to overcome the barrier(s): I talked to the manager and explained why I did not have a job before. I told him I could work every morning at 8 because my kids go to school at 7:30. I worked hard to make him believe he could rely on me.

3. Things I am good at: Cooking, cleaning, counting money, organizing my family.

4. Example(s) of when I felt like most things in my life were going well: When I got my job.

- a. Things I did to make them go well: I knew I needed a job to take care of my kids when my boyfriend went to jail. I got a job. I asked my mom to watch the kids. I got up early every morning, so the kids didn't miss school and I didn't miss work.

Setting Objectives

The third essential skill for the LC is goal setting. The LC helps the client plan and set SMART objectives to overcome barriers to linking to medical care. This section defines key terms from the ARTAS Session Plan form and discusses how to develop SMART objectives. The terms are defined as follows:

- **Goal:** A goal is an endpoint that the client intends to reach, which in ARTAS is linking to medical care.
- **Objective:** An objective is a measurable milestone or significant step that must be accomplished on the way to meeting a goal. It is typical to have multiple objectives to meet one single goal. A client may identify objectives that they wish to pursue and that will help meet the ARTAS goal of linking to medical care.
- **Activities:** Activities are the smaller actions that lead to achieving an objective.

Using the SMART objective principles allows the LC and client to make clear objectives.

SMART stands for: Specific, Measurable, Achievable, Relevant, and Time-bound.

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

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

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

Measurable: Objectives need to be measurable. Here the focus is on “how much” change is expected. Objectives should quantify the amount of change the LC or client hopes to achieve. For example, in “the client will identify three barriers to seeking medical care by the next session,” “three” represents the “how much” of the objective.

Achievable: Objectives should be achievable given the client’s resources and needs. For example, if the LC reads, “The client will follow 100% of the doctor’s recommendations,” they realize that this is not achievable. Without knowing the doctor’s recommendations, the client cannot say with certainty that they will follow 100% of them. The recommendations may be against the client’s cultural beliefs or impractical because of financial concerns.

Relevant: Objectives are relevant when they relate directly to the client’s goals and

together represent reasonable steps that can be achieved within a specific time frame. For instance, if an LC's goal is to get MOAs signed before seeing their first client, a relevant objective may be: "Execute two signed MOAs from community partners by November 6."

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

The ARTAS Session Plan

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

ARTAS SESSION PLAN

Date: April 13, 2018

Name: Jane Smith

Client ID: 80-215jb

Linkage Coordinator: Ms. Angie

Goal 1: Link with Medical Services

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

Activity	Related Strengths	Potential Barriers	Target Date	Person(s) Responsible
1. Write a list of three things I'm looking for in a doctor.	I treat others with respect.	Little experience with doctors.	Before our second session.	Jane
2. Write a list of at least four doctors or clinics in the city.	I know how to get around the city.	Don't know many doctors.	Before our second session.	Ms. Angie
3. Compare my list with Ms. Angie's list.	Good at thinking about pros and cons.	N/A	At our second session.	Jane and Ms. Angie

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

Activity	Related Strengths	Potential Barriers	Target Date	Person(s) Responsible
1. Write down all forms needed for the doctor/clinic I choose.	Participating in ARTAS.	Don't know what forms to use.	Before our second session.	Ms. Angie
2. Get a copy of my Social Security card so I can fill out the forms.	Had a Social Security card before.	Getting time off to go for my card.	Before our fourth session.	Jane
3. Fill out all forms needed for the doctor/clinic I choose.	Participating in ARTAS.	N/A	At our fourth session.	Jane, with Ms. Angie's help

2. Implementing ARTAS

The Client Session Guide step-by-step instructions to facilitate each of the five client sessions, helpful tips, and the forms and documents needed to conduct and track each client session. This guide is written for the LC implementing ARTAS.

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

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

Some forms in the Client Session Guide will be completed with the client, and others will be completed after the client session. This information will be provided in the step-by-step instructions.

See the [ARTAS Client Session Flow Process on page 79](#) of the **Client Session Guide** for a visual representation of the client sessions. It also shows how ARTAS complements long-term / Ryan White case management: A client can be referred from long-term / Ryan White case management into ARTAS to provide more intensive, individualized work to link them to medical care. Or a client can be referred to these programs if they are not interested in or eligible for ARTAS, or if they have already completed ARTAS.

3. Maintaining Working Relationships with Community Partners

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

Keeping in contact with these sites serves as a reminder of the intervention, encourages referrals, and contributes to the successful implementation of ARTAS.

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

To maintain effective working relationships with community partners, the LC should engage in regular face-to-face, telephone, or e-mail contact with them. The LC should also

plan to participate in regular meetings with other HIV providers in groups such as community-wide referral networks, community planning groups, regional advisory groups, and CM meetings and use these opportunities to continually market ARTAS to new community partners and medical care providers.

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

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

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

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

4. Supervising Linkage Coordinators

With a strengths-based approach to supervision, the LC supervisor conducts one-on-one supervisory meetings with an emphasis on *strengths and abilities*, not deficiencies and inabilities. Using this intervention allows the supervisor to (1) assess an LC's understanding of the strengths approach, (2) model strengths-based practices for them on

a regular basis, and (3) reinforce what the LC should be doing with their clients. The LC supervisors should also closely monitor the LC's caseloads. Due to the intensive nature of ARTAS, the recommended caseload is 25–30 clients per LC at a given time. For further information on the LC supervisor's role in the implementation of ARTAS, refer to [Section 8, the Supervisor Guide](#).

Section 6: Monitoring and Evaluating ARTAS (Maintenance)

The Maintenance section contains guidance for integrating ARTAS into the implementing agency's existing services. Institutionalization—or embedding the intervention into the implementing agency's mission, hierarchy, standard operations, and budget—is a potential goal at this phase. Maintenance begins after the first client completes ARTAS and continues as long as the agency implements the intervention. During this phase, process and outcome monitoring data are entered into a database and analyzed. These sets of data may be submitted to appropriate community partners. This information, along with quality assurance documentation, will assist the agency in adapting the intervention to meet the needs of the priority populations. Below is a list of topics covered in this section:

1. Institutionalizing ARTAS
2. Quality Assurance
3. Monitoring

1. Institutionalizing ARTAS

It is very important that the implementing agency take ownership of ARTAS and incorporate it into existing client services. Institutionalization of ARTAS may include the following:

Incorporating ARTAS and/or a Strengths-based Approach into the Agency's Mission

To make ARTAS and/or a strengths-based approach a component of the agency's services to link clients to medical care, agency managers, CMs, and/or intervention staff need to discuss the benefits of ARTAS to the agency. This discussion could take place in a regularly scheduled staff meeting, during a brown-bag ARTAS presentation, or during in-service education training. ARTAS staff can make a presentation on the ARTAS intervention and provide handouts that detail the intervention's history, purpose, core elements, key characteristics, and potential benefits.

Clearly understanding how ARTAS can complement the agency's current programs can lead to buy-in from and ownership by agency staff and can assist with institutionalization by integrating the intervention within the agency's overall mission. It may be helpful to obtain feedback from other agencies that have effectively institutionalized the intervention into existing services.

Securing Continued Funding for ARTAS

A barrier to continuing the ARTAS intervention could be a lack of long-term funding. To identify sources of continued funding for ARTAS, the implementing agency may want to consult with existing HIV prevention organizations, care funding agencies, local health departments, or capacity building assistance providers to determine what public and/or private funding sources may be available.

Integrating ARTAS Activities into Job Descriptions

Once an agency has decided to incorporate ARTAS into existing client services, it should develop a matrix outlining all of the job duties related to ARTAS. This matrix can then be used to decide how to integrate ARTAS into the job descriptions of existing staff and/or create job descriptions for new staff. When ARTAS activities are integrated into agency job descriptions, all intervention staff members should participate in planning, training, and intervention improvement. This process further enhances the institutionalization of ARTAS and the transfer of evidence-based interventions to client services.

2. Quality Assurance

Quality assurance is defined as the steps taken to ensure that an intervention or services are of high quality and meet specified requirements. With respect to ARTAS, it is the process by which a person familiar with the intervention observes its implementation, provides feedback, documents any issues, and makes recommendations for improvements. The aim of the quality assurance assessment is to determine whether fidelity to the intervention is maintained and clients are being linked to medical care. The agency will know its intervention is working when clients are being referred to the intervention and then linked into care within five ARTAS sessions.

Key questions in the quality assurance assessment are:

- Did the agency leadership introduce ARTAS to the agency in a way that resulted in staff buy-in?
- Did the LC build strong referral relationships within the community to attract clients to ARTAS? Why or why not?
- Were the client session objectives achieved? Why or why not?
- Did the LC practice good relationship-building and communication skills with the client?
- Were the client sessions conducted with fidelity to ARTAS's core elements?
- Were clients linked to medical care within the five sessions? If so, what factors led to the linkage taking place? If not, what factors prohibited the linkage from taking place?

The responsibility of quality assurance falls to the program director/manager and/or evaluator. The paperwork required to conduct the quality assurance assessment includes an assessment tool with questions such as those identified above. However, it is very likely that the supervisor will conduct the quality assurance assessment as part of the shadowing exercise. Periodically, they need to shadow each LC during client sessions (as discussed in the [Shadowing Exercise Assessment](#) on [page 155](#) of the [LC Supervisor Guide in Section 8](#)).

The information obtained from the assessments conducted by the program

director/manager, evaluator, and/or supervisor should be used to strengthen staff skills in building strong referral networks, conducting ARTAS, and identifying strategies to help clients address barriers to linkage to medical care.

3. Monitoring and Evaluation (M&E)

During the pre-implementation phase, the implementing agency is encouraged to develop an M&E plan. This plan should be implemented throughout the delivery of ARTAS. The M&E plan consists of formative evaluation, process monitoring, process evaluation, and outcome monitoring. For definitions and sample questions, see “Developing an M&E Plan” in section 4.2.7.

The implementation of the M&E plan will result in several sets of data that can then be reviewed and analyzed. These data will help the agency adjust the implementation by addressing the areas where the implementation plan encountered problems. Two specific types of data collected are process monitoring data and outcome monitoring data.

Process and outcome monitoring data are best collected in a spreadsheet or database format (e.g., Microsoft Excel, Microsoft Access, SPSS) since they are primarily numerical and are reviewed over time. These sets of data should be reviewed by the program director/manager on a regular basis—at least quarterly.

The following are three examples of the types of monitoring tools to use—either verbatim or a modified version—to document results.

A. Fidelity Assessment

Fidelity means conducting and continuing an intervention by following the core elements, protocols, procedures, and content set by the research study that determined its effectiveness. Although the core elements cannot be altered, changed, deleted, or added to, implementing agencies can adapt key characteristics. The fidelity assessment should be completed by the supervisor and/or LCs and reviewed by the program director/manager or evaluator on a quarterly basis. The [Fidelity Assessment Quarterly Report Template in Appendix C.1](#) is a useful tool to assess the fidelity with which the intervention is being implemented. This template also helps the implementing agency track adherence to each core element.

Fidelity assessments are essential to ensure that the implementing agency continues to implement ARTAS as designed for the best results and to avoid intervention drift. Intervention drift is the tendency to revert to practices established prior to the implementation of ARTAS. The greatest risk for intervention drift to occur is when:

- Intervention staff members do not receive adequate training.
- There is a lack of internal and external buy-in achieved.
- Agency policies and procedures do not support the core elements of ARTAS.

- There is a lack of support and supervision for the LC.
- The LC is asked to complete assignments outside the purview of ARTAS.

B. Session Notes and Session Note Summary Sheet

As discussed in the Implementation section of this manual, the **Session Notes** (on page 126 of the Client Session Guide) and the **Session Notes Summary Sheet** (on page 128 of the Client Session Guide) can be used as process monitoring tools for the intervention. The LC must track the number of client sessions and telephone conversations with each client, the length of each client session and call, a summary of each session, and other process measures determined by the agency's M&E plan.

Other process monitoring tools implementing agencies may want to use for monitoring are the [ARTAS Performance Process Indicator Form in Appendix C.2](#) and the [ARTAS Partner Tracking and Recruitment Process Indicator Form in Appendix C.3](#). These performance process indicators will help agencies track their contact with partners and the LC's interactions with clients. These forms should be modified to meet the needs of the implementing agency. For example, if the agency has sufficient relationships with all medical and service providers in the community, the agency does not have to add Performance Objective 3 (on the ARTAS Partner Tracking and Recruitment Process Indicator Form) to the M&E plan.

C. Client Feedback

While it is not required, the agency may choose to institute follow-up with clients, regardless of whether they link to medical care, to get their input on the ARTAS process. The [Client Satisfaction Questionnaire, on page 130](#) of the Client Session Guide, is a tool the agency may choose to use. Clients should fill it out immediately after completing the last client session to assess their satisfaction with the intervention, their experience, and relationship with the LC. The client can complete this questionnaire directly or in an exit interview with the supervisor, if appropriate.

Section 7: Linkage Coordinator Client Session Guide

Antiretroviral Treatment and Access to Services (ARTAS)

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

Client Session Guide

July 2022

Table of Contents

Client Session Guide Overview	72
Session One: Building the Relationship.....	76
1A: Introduction	77
1B: Guided Discussion	78
1C: Linkage to Medical Care	79
1D: Client Assessment	82
1E: Review and Summarize the Session	84
1F: Schedule Medical Appointment and/or Next Session	84
Sessions Two, Three, and Four: Emphasizing Personal Strengths.....	88
2A: Review of Session One (and Two and Three, if appropriate)	89
2B: Client Assessment	90
2C: Linkage to Medical Care	91
2D: Review and Summarize the Session	94
2E: Schedule Medical Appointment and/or Next Session	94
Close-Out Session: Completing the Work	98
5A: Review the Transition Process: Linked Clients	99
5B: Review the Transition Process: Non-linked Clients	100
5C: Transition to Long-Term / Ryan White CM or Other Case Management Services	102
Session Forms.....	105
Strengths Assessment Instructions	106
ARTAS Session Plan Instructions	112
Overview of ARTAS Document	117
Appointment Cards.....	118
Email Reminder / Voice Message	118
Session Notes Instructions	119
Session Notes Summary Sheet Instructions	123
Case Review Form Instructions.....	125
Life Domains List.....	128
ARTAS Client Satisfaction Questionnaire	130
Client Session Guide Helpful Tips	131

Client Session Guide Overview

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

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

In addition, many clients identify system-level barriers, such as restrictive service application hours, biases against persons with HIV (PWH), and a lack of childcare. Addressing these barriers will facilitate linkage to medical care. Therefore, you should be skilled in finding solutions to common system-level barriers.

How to Use the Client Session Guide

ARTAS is an individual-level intervention. As such, the content, timing, and structure of each client session will differ greatly depending on the client and their needs, barriers, and strengths. You should be prepared to adjust the session content, timing, and structure depending on the client. The Client Session Guide provides a basic structure for each client session.

The five client sessions are:

Session One: Building the Relationship

Session Two: Emphasizing Personal Strengths

Session Three: Learning to Make Contact

Session Four: Reviewing Progress

Close-Out Session (Session Five): Completing the Work

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

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

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

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

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

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

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

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

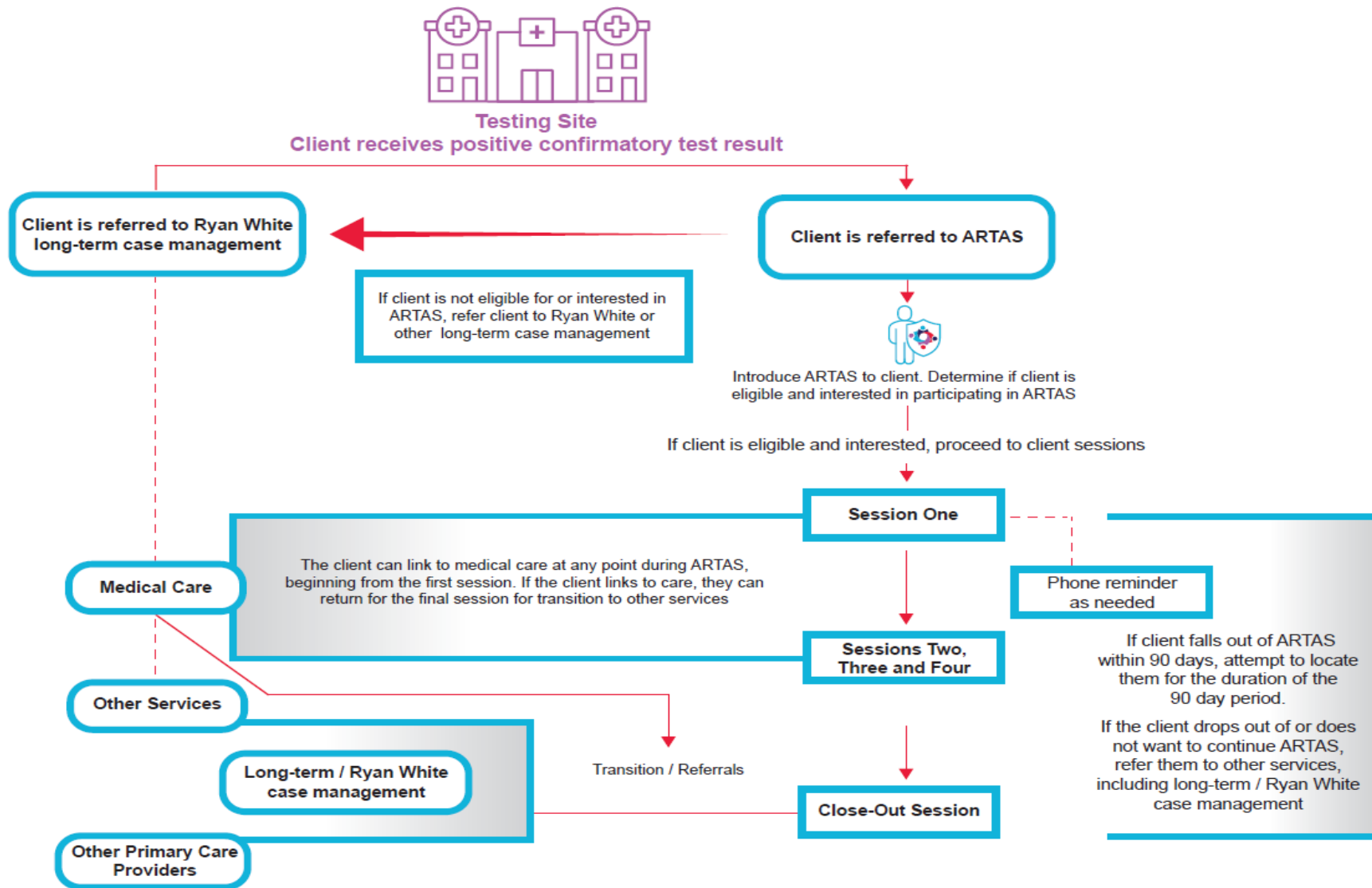
Finally, it is important to note that the content within each of the five sessions is intentionally redundant in places. Because a client may be under a great deal of stress and/or at different stages of decision-making from one session to the next, repeating information and key points is important to ensure they understand and retain the information. As you progress from one session to the next with the client, you will also note subtle differences in the step-by-step procedures and key considerations. These differences are reminders for you to check in with the client on unresolved barriers and further explore why they are not ready to link to medical care. The differences are noted throughout the Client Session Guide.

Some forms in the Client Session Guide will be completed with the client, and others will be completed after the client session. This information will be provided as part of the step-by-step instructions. Finally, the guide provides an overview of helpful tips to consider when implementing ARTAS, such as how to integrate an assessment of client readiness for rapid linkage to HIV care within the ARTAS model.

See **Figure 1: ARTAS Client Session Flow Process** on the next page for a visual representation of the client sessions. The figure depicts how a client flows into ARTAS and through the client sessions, linkage to medical care, and referral to other programs upon

completion of ARTAS. It also shows how ARTAS complements long-term / Ryan White case management. A client can be referred from long-term / Ryan White case management into ARTAS to provide more intensive, individualized work to link them to medical care. Or a client can be referred to these programs if they are not interested in or eligible for ARTAS, or if they have already completed ARTAS.

Figure 1: ARTAS Client Session Flow Process



Session One: Building the Relationship

Approximately: 1.5–2 hours

Session One Activities:

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

Session One Guide Agenda

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

Forms and Documents Needed for Session One:

- *Overview of ARTAS Document*
- *Educational material about living with HIV*
- *Strengths Assessment Form*
- *ARTAS Session Plan*
- *Resource directory*
 - *A listing of medical and psychiatric service providers and local social service providers (e.g., housing, food, insurance)*
- *Fact sheet on current treatment options and their side effects*
- *Appointment cards*
- *Incentives, if provided*
- *Session Notes*
- *Session Notes Summary Sheet*
- *Case Review Form*
- *Life Domains List*

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

1A: Introduction

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

Forms and Documents: *Overview of ARTAS Document*

Advanced Preparation:

- Review the Overview of ARTAS Document.
- Familiarize yourself with HIV care clinics in the area, including hours, average new patient wait times, and availability of treatment.
- Be familiar with insurance and benefits navigation in your state or jurisdiction.
- Be prepared to talk about the benefits of linkage to care and starting treatment.

Key Considerations:

Remember that:

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

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

Procedure:

For all clients:

1. Introduce yourself to the client. Describe your professional background, especially as it applies to working with persons with HIV (PWH). Emphasize your training, interest in assisting PWH, and/or knowledge of HIV- specific healthcare services.
2. Give the client an overview of ARTAS and information on the importance of linkage. (Note: During the pre-implementation phase, you should have created a brief ARTAS summary for reaching out to community partners., you can access information on linkage on [CDC's Effective Interventions website](#)). Either read the overview or paraphrase its key points. It is important that you confidently convey the key points to the client. The key points for the **Overview of ARTAS Document** can be found on [page 117](#) in the Session Forms section.
3. Next step, continue to 1B: Guided Discussion.

1B: Guided Discussion

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

Forms and Documents: Review information on current treatment options and their side effects: [HIV.gov's HIV Treatment Overview](#) and/or [HIV Info's HIV Treatment webpage](#).

Advanced Preparation:

- Review the fact sheet on current treatment options and their side effects.

Key Considerations:

You should:

- Possess comprehensive and in-depth knowledge about HIV and AIDS (the medical, psychological, and social aspects) and be able to answer the client's detailed questions.
- Refer to current resources to answer the client's questions.
- Promote the personal and partner benefits of risk reduction and detail the value of seeking medical care early, medication adherence, viral suppression, [undetectable=untransmittable \(U=U\)](#), and treatment as prevention (TasP).
- Diminish fears or concerns the client might have about treatment, visiting a doctor, their sex life, and/or personal relationships.
- Be realistic about the limitations of treatment: there is no cure for HIV; but persons should remain on medications to achieve healthy outcomes.
- Help the client explore personal resources to help them to be successful.
- Be careful to neither directly confront nor reinforce the client's statements at this time.

Procedure:

For all clients:

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

Possible open-ended follow-up questions include:

- *"What resources did the health department tell you about when you received your test results?"*
 - *"What were your biggest worries when you received your positive test results?"*
2. Ask the client what materials about HIV the testing site gave them, if any. Possible open-ended follow-up questions include:
 - *"What did you think about the material you received?"*

- “What additional questions do you have about HIV?”
3. Clarify any questions the client has about HIV (specifically about symptoms, care and treatment options, support services, and counseling). Possible open-ended follow-up questions include:
 - “What other questions do you have?”
 - “Have you discussed your HIV status with a doctor or nurse since you received your test results? If so, what did you talk about? Do you have additional questions?”
 - “What are your concerns about seeking treatment or medical care?”
 4. Next step, continue to 1C: Linkage to Medical Care.

1C: Linkage to Medical Care

Purpose: Encourage the client to seek immediate medical care, and, if interested, assist them with same-day linkage.

Forms and Documents: *ARTAS Session Plan*
Resource directory
Session Notes
Session Notes Summary Sheet
Case Review Form

Advanced Preparation:

- Review any specific requirements, characteristics/traits, agency policies, and required paperwork of the health care providers.
- Review any local, state, or federal policies such as eligibility requirements for services, Medicaid, AIDS Drug Assistance Programs (ADAP), Ryan White services, waitlists, mandatory disclosure laws.

Key Considerations:

Inform the client about the following:

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

Procedure:

For all clients:

1. Ask the client about their expectations and concerns about seeking medical care and treatment for HIV, including their interest and readiness for rapid linkage. Be sensitive to the client's stated and unstated reasons for not wanting to seek medical treatment. Begin the discussion with these questions:
 1. *“What are your thoughts about linking to medical care?”*
 2. *“What barriers or problems might get in the way of your going to a doctor or medical clinic?”*
2. Discuss the benefits of linkage, early HIV treatment, and medication adherence with the client. If the client expresses interest and readiness for rapid linkage, implement your organization's rapid linkage protocol. If not, continue to #3.
3. Assess the client's tangible and perceived barriers. The client may have a multitude of personal barriers that impede their ability to seek services. Check in with the client about the following:
 1. What is their housing situation? Will homelessness or insecure housing pose a barrier to linking to care?
 2. How will they get to their medical appointment? Do they anticipate any transportation issues?
 3. What financial considerations may pose a barrier to linkage to care?
 4. Will active drug or alcohol addiction pose a barrier to linkage to care?

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

4. Engage the client in a discussion about medical options, provide information, and help them clarify concerns, issues, and barriers. **Remember, it is not your role to make the decision to link to medical care for the client.**
5. Demonstrate your thorough knowledge of the medical care environment and requirements and provide information based on available resources. This includes:
 1. Providers and their specialties and personalities.
 2. How to navigate the system to apply for and access Ryan White, Medicaid, or other services.
 3. All the background research you did in the pre-implementation section to become familiar with community partners.

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

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

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

the Session.

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

For clients who wish to link to medical care at this point, but are either not willing or not able to follow your organization's rapid linkage protocols:

6. Introduce the ARTAS Session Plan:

“Our goal is to help you get connected to a doctor. As you may recall, we will have up to five sessions in 90 days to help you link to care by identifying your strengths and overcoming barriers.

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

7. Follow the **ARTAS Session Plan** instructions on [page 112](#) of the Session Forms section. The ARTAS Session Plan helps the client identify objectives and possible barriers, activities to accomplish the objective(s), the person responsible, target dates to complete each activity, and related strength(s). It is recommended that the plan be committed to in writing to allow you and the client to easily track progress and pinpoint activities that may need to be adjusted over time.
 8. Next step, continue to 1E: Review and Summarize the Session.
-

For clients who want to drop out of ARTAS or do not want to link to medical care now or in the near future:

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

(Note: If at any point the client decides to link to medical care and/or not drop out of ARTAS, continue to 1E: Review and Summarize the Session.)

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

1D: Client Assessment

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

Forms and Documents: *Strengths Assessment Form*

Advanced Preparation:

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

Key Considerations:

You should:

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

Procedure:

For all clients:

1. Identify and explore reasons why the client may be hesitant to link to medical care. Provide information that may help alleviate client concerns and/or address any misinformation.
2. Explain how identifying the client's strengths, abilities, and skills relates to their ability to stay healthy and link to medical care. For example:
" Oftentimes, when you see ways that you've been successful in the past, it helps you to be successful again. Knowing how you've been successful helps you plan how to deal with barriers or problems you may have getting the medical care you need or achieving other goals."
3. Ask the client to talk about their personal experiences. Guide the client to speak

from a strengths perspective and about their abilities, rather than putting themselves down. While the strengths assessment is formally introduced in Session Two, it is important to start talking about strengths from the very beginning and recording them in the Strengths Assessment Form.

4. Cite examples of the client's strengths and abilities that have already become apparent in your conversation or during this session. This will help the client think about personal strengths, resources, and skills. Some common examples include:
 - The courage to get tested for HIV.
 - The wisdom to come to Session One of ARTAS.
 - The ability or desire to live independently.
 - Being punctual, if they arrived on time.
5. Help the client assess the role others have in supporting or impeding their access to medical care. Ask the client:
 - *“Who do you think could support or help you get to the doctor? Think about friends, family, neighbors, significant others, anyone. These are people you feel can take you to appointments, let you borrow their car, provide financial assistance, watch your kids, give emotional support, and help with other things you might need.”*
6. Discuss the advantages or disadvantages of telling a significant other or sexual partner(s) about testing positive.

If the client is currently involved in a sexual relationship(s), ask them:

- *“Does your significant other/sexual partner(s) know you've been diagnosed with HIV?”*

If yes, follow up with:

- *“How do you think [insert name of significant other/partner] could help you get into medical care?”*

If no, follow up with:

- *“What do you think are some of the advantages to telling [insert name of significant other/partner]?”*
- *“What are some of the disadvantages?”*

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

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

1E: Review and Summarize the Session

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

Forms and Documents: *ARTAS Session Plan*

Advanced Preparation: *None.*

Key Considerations:

You should:

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

Procedure:

For clients who wish to link to medical care at this point, or clients who are not ready to make this decision:

1. Provide a summary of the session or ask the client to summarize the session and the client's strengths. During the first session, the client may be very emotional and upset, particularly if they have been recently diagnosed. Therefore, summarizing the session is extremely important to help the client remember the key points.
2. Review the ARTAS Session Plan activities, person responsible, and target date to complete the items with the client, if a plan was developed. Remember, some of these are activities you are committing to complete prior to the session.
3. Next step, continue to 1F: Schedule Medical Appointment and/or Next Session.

1F: Schedule Medical Appointment and/or Next Session

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

Forms and Documents: *ARTAS Session Plan*
Resource directory
Appointment cards
Incentive, if provided
Session Notes
Session Notes Summary Sheet
Case Review Form

Advanced Preparation:

- Review your availability for the next session and/or medical appointment.

- Review the resource directory for medical providers, clinics, and other services as needed.
- Bring the transportation vouchers/tokens/schedules.

Key Considerations:

You should:

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

Procedure:

For clients who wish to link to medical care at this point:

1. Clarify whether the client would like you to accompany them to the medical appointment.
2. If the initial appointment is a telehealth appointment, make sure the client has the technology needed to attend the appointment.
3. Discuss the best time and date to schedule the appointment.
 - If the ARTAS Session Plan has activities that must be completed before the medical appointment that may take some time, schedule the appointment further out or wait until the next session to schedule the medical appointment. Examples of activities that might take more time to complete are arranging for transportation and processing Medicaid enrollment forms.
4. Call the clinic or community partner (or have the client call) to schedule an appointment.
 - If the next time you see the client will be at the medical visit:
 - Give them information about the staff and doctor and required documents.
 - Discuss in detail what the client should expect at each stage of the appointment.
 - Help the client write down questions they would like to ask the healthcare provider and/or other clinic staff. Depending on the

client, practice asking and answering questions with them, so they feel comfortable with the list of prepared questions.

- Ask the client if they would like for you to call them before the medical appointment, as a reminder.

For all clients:

5. Schedule and/or make arrangements for the client to access needed social services, such as temporary housing and food banks.
6. Schedule a day, time, and meeting location for the next ARTAS session. Make sure accommodations are compatible with agency safety guidelines.
 - If the next session is **before the medical appointment or the client is not linking to medical care at this point**, offer to write down these details and to call the client before your next session as a reminder. The topics covered will follow the format for Session Two.
 - If the next session is scheduled for **after the medical appointment**, the next session will be the Close-Out Session (completing the work with the client).
7. Offer the client an **appointment card** (see samples on [page 118](#) of the Session Forms section) to document the time, location, and agency name.
8. Give the client transportation tokens or vouchers to get home and/or to the next session or appointment. Offer to pick the client up, if that is an allowable activity at your agency.
9. Gather any contact and/or locator information from the client before they leave. Locator information will allow you to locate the client through family, friends, or other individuals who know how to reach them if the client's address changes, phone is disconnected, or the client is not reachable through the means provided in the initial intake (conducted within the agreed-upon rules for communicating with the client). Remind the client that you will attempt to contact them through these means only after a missed appointment.
 - To gather this information, discuss how the locator information will be used and be sure to inform the client that none of their personal information will be shared with the contacts provided. Information collected from the contact persons includes the following: usual place of residence, telephone number or address of someone who usually knows where the client can be found, places where they pick up mail or messages.
 - Ask the client if the contacts are aware of their HIV status and assure the client that their contacts will not be told the reason for the call. You can say

you are a friend trying to reach the client.

10. End the session by thanking the client for coming and congratulate them for a productive session. Remind the client that linking to medical care is important to their overall health, and that you are there to help them attain services needed so that they are ready to access medical care and treatment.

11. Next step, complete paperwork:

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

Sessions Two, Three, and Four: Emphasizing Personal Strengths

Approximately: 1.5–2 hours

Sessions Two, Three, and Four Activities:

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

Sessions Two, Three, and Four Guide Agenda

- 2A. Review of Session One
- 2B. Client Assessment
- 2C. Linkage to Medical Care
- 2D. Review and Summarize the Session
- 2E. Schedule Medical Appointment and/or Next Session

Forms and Documents Needed for Sessions Two, Three, and Four:

- *ARTAS Session Plan*
- *Strengths Assessment Form*
- *Resource directory*
- *Appointment cards*
- *Incentive, if provided*
- *Session Notes*
- *Session Notes Summary Sheet*
- *Case Review Form*
- *Life Domains List*

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

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

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

Forms and Documents: *ARTAS Session Plan*

Advanced Preparation:

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

Key Considerations:

Remember that the client:

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

Procedure:

For all clients:

1. Welcome the client back for Session Two (or Three or Four) and congratulate them on following up successfully with today's session. Recognize the many demands the client has and state how much you appreciate their taking time to meet with you.
2. Ask the client what questions, concerns, or new insights they have as a result of the previous session. You may also want to ask about their thoughts about linking to medical care since your last session and any reactions they have to the focus on strengths, which will help you to assess whether they are starting to adopt the approach.
3. Summarize any additional points made during the discussion.

For clients who have not decided to link to medical care:

4. Next step, continue to 2B: Client Assessment.

For clients who have decided to link to medical care but have not yet attended their appointment:

5. Review the outcomes of all activities listed on the ARTAS Session Plan for both you and the client. If necessary, revise the plan.

6. Ask the client about any new barriers and/or strengths discovered as a result of completing the ARTAS Session Plan activities. If necessary, revise the plan.
7. Next step, skip to section 2D: Review and Summarize the Session.

2B: Client Assessment

Purpose: Assess readiness to link to medical care and to help the client self-identify personal strengths, abilities, and skills.

Forms and Documents: *Resource directory*
Strengths Assessment Form

Advanced Preparation:

- Review the state/local legal requirements regarding HIV disclosure.
- Review the client's strengths assessment, if one was started in the previous session.

Key Considerations:

You should:

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

Procedure:

For clients who have not yet decided to link to medical care:

1. Remind the client about the benefits of linkage, early HIV treatment, and medication adherence.
2. Identify and explore reasons why the client may be hesitant to link to medical care. Provide information that may help alleviate client concerns and/or address any misinformation.
3. Remind the client how identifying strengths, abilities, and skills relates to their ability to stay healthy and link to medical care. For example:
“Often times, when you see ways that you’ve been successful in the past, it helps you to be successful again. Knowing how you’ve been successful helps you plan how to deal with barriers or problems you may have getting the medical care you need or achieving other goals.”
4. Remind the client of examples of their strengths and abilities that have already become apparent in the previous session. This will help the client think about

personal strengths, resources, and skills. Some common examples include:

- The courage to get tested for HIV
 - The wisdom to come to ARTAS
 - The ability or desire to live independently
 - Being punctual, if they arrived on time
5. **This is a new activity started in Session Two.** Conduct the strengths assessment by following the instructions and introduction script starting on [page 106](#) of the Session Forms section.
6. Next step, continue to 2C: Linkage to Medical Care.

2C: Linkage to Medical Care

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

Forms and Documents: *ARTAS Session Plan*
 Resource directory
 Session Notes
 Session Notes Summary Sheet
 Case Review Form

Advanced Preparation:

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

Key Considerations:

Inform the client about the following:

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

Procedure:**For clients who have not decided to link to medical care:**

1. Ask the client about their expectations and concerns about seeking medical care and treatment for HIV. Be sensitive to the client's stated and unstated reasons for not wanting to seek medical treatment. Begin the discussion with these questions:
 - *“What are your thoughts about linking to medical care?”*
 - *“What barriers or problems might get in the way of your going to a doctor or medical clinic?”*
2. Assess the client's tangible and perceived barriers. The client may have a multitude of personal barriers that impede their ability to seek services. Check in with the client about the following:
 - What is their housing situation? Will homelessness or insecure housing pose a barrier to linking to care?
 - How will they get to their medical appointment? Do they anticipate any transportation issues?
 - What financial considerations may pose a barrier to linkage to care?
 - Will active drug or alcohol addiction pose a barrier to linkage to care (if applicable)?

Some of the perceived barriers could be fears about family, friends, and community members discovering their HIV status or healthcare needs.

3. Engage the client in a discussion about medical options, provide information, and help them clarify concerns, issues, and barriers. **Remember, it is not your role to make the decision to link to medical care for the client.**
4. Demonstrate your thorough knowledge of the medical care environment and requirements and provide information based on available resources. This includes:
 - Providers and their specialties and personalities
 - How to navigate the system to apply for and access Ryan White, Medicaid, or other services
 - In other words, all the background research you did in the pre-implementation section to become familiar with community partners

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

If the client decides to link to medical care at this point, continue to the Close-Out Session.

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

the Session.

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

For clients who wish to link to medical care at this point:

5. Introduce the ARTAS Session Plan:
“Our goal is to help you get connected to a doctor. As you may recall, we will have up to five sessions in 90 days to help you achieve this and other objectives by identifying your strengths and overcoming barriers.”

“The ARTAS Session Plan is one of the activities that can guide us to accomplish your goal(s). This plan will help us organize our work together and make sure that we identify everything we need to work on. We’ll write down the goals to remind us of what we’re doing, and you will always have a copy of your most recent ARTAS Session Plan, if you want it.”
 6. Follow the **ARTAS Session Plan** instructions on [page 112](#) of the Session Forms section. The ARTAS Session Plan helps the client identify objectives and possible barriers, activities to accomplish the objective(s), the person responsible, target dates to complete each activity, and related strength(s). It is recommended to commit to the plan in writing, allowing you and the client to easily track progress and pinpoint activities that may need to be adjusted over time.
 7. Next step, continue to 2D: Review and Summarize the Session.
-

For clients who want to drop out of ARTAS or do not want to link to medical care now or in the near future:

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

(Note: If at any point the client decides to link to medical care and/or not drop out of ARTAS, continue to 2E: Review and Summarize the Session.)

9. Next step, end the session and complete paperwork:

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

2D: Review and Summarize the Session

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

Forms and Documents: *ARTAS Session Plan*

Advanced Preparation: *None.*

Key Considerations:

You should:

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

Procedure:

For clients who wish to link to medical care at this point or clients who are not ready to make this decision:

1. Provide a summary of the session or ask the client to summarize the session and the client's strengths. During the session, the client may be very emotional and upset, particularly if they have been recently diagnosed. Therefore, summarizing the session and the client's strengths is extremely important to help the client remember the key points.
2. Review the ARTAS Session Plan activities, person responsible, and target date to complete the items with the client, if a plan was developed. Remember, some of these are activities you are committing to complete prior to the session.
3. Next step, continue to 2E: Schedule Medical Appointment and/or Next Session.

2E: Schedule Medical Appointment and/or Next Session

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

Forms and Documents: *ARTAS Session Plan*
Resource directory
Appointment cards
Incentive, if provided
Session Notes
Session Notes Summary Sheet
Case Review Form

Advanced Preparation:

- Review your availability for the next session and/or medical appointment.
- Review the resource directory for medical providers, clinics, and other services as needed.
- Bring the transportation vouchers/tokens/schedules.

Key Considerations:

You should:

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

Procedure:

For clients who wish to link to medical care at this point:

1. Clarify whether the client would like you to accompany them to the medical appointment.
2. Discuss the best time and date to schedule the appointment.
 - If the ARTAS Session Plan has activities that must be completed before the medical appointment that may take some time, schedule the appointment further out or wait until the next session to schedule the medical appointment. Examples of activities that might take more time to complete are arranging for transportation and processing Medicaid enrollment forms.
3. Call the clinic or community partner (or have the client call) to schedule an appointment.
 - **If the next time you see the client will be at the medical visit:**

- Give them information about the staff and doctor and any required documents.
 - Discuss in detail what the client should expect at each stage of the appointment.
 - Help the client write down questions they would like to ask the health care provider and/or other clinic staff. Depending on the client, practice asking and answering questions with them so they feel comfortable with the list of prepared questions.
 - Ask the client if they would like for you to call them before the medical appointment, as a reminder.
-

For all clients:

4. Schedule and/or make arrangements for the client to access needed social services, such as temporary housing and food banks.
5. Schedule a day, time, and meeting location for the next ARTAS session. Make sure accommodations are compatible with agency safety guidelines.
 - If the next session is **before the medical appointment or the client is not linking to medical care at this point**, offer to write down these details and to call the client before your next session as a reminder. The topics covered will follow the format for Session Three.
 - If the next session is scheduled for **after the medical appointment**, the next session will be the Close-Out Session (completing the work with the client).
6. Offer the client an **appointment card** (see samples on [page 118](#) of the Session Forms section) to document the time, location, and agency name.
7. Give the client transportation tokens or vouchers to get home and/or to the next session or appointment. Offer to pick the client up, if that is an allowable activity at your agency.
8. Gather any contact and/or locator information from the client before they leave. Locator information will allow you to locate the client through family, friends, or other individuals who know how to reach them if the client's address changes, phone is disconnected, or the client is not reachable through the means provided in the initial intake (conducted within the agreed-upon rules for communicating with the client). Remind the client that you will attempt to contact them through these means only after a missed appointment.
 - To gather this information, discuss how the locator information will be used and be sure to inform the client that none of their personal information will be shared with the contacts provided. Information collected from the

contact persons includes the following: usual place of residence, telephone number or address of someone who usually knows where the client can be found, places where they pick up mail or messages.

- Ask the client if the contacts are aware of their HIV status and assure the client that their contacts will not be told the reason for the call. You can say you are a friend trying to reach the client.
9. End the session by thanking the client for coming and congratulate them for a productive session. Remind the client that linking to medical care is important to their overall health and that you are there to help them attain services needed so that they are ready to access medical care and treatment.
10. Next step, complete paperwork:
- Depending on your agency's procedures and/or schedule for the day, you may want to take a few minutes to complete all the required paperwork before moving on to the next client and/or task. Recommended paperwork to complete includes:
 - Session Notes
 - Session Notes Summary Sheet (if the client dropped out)
 - Case Review Form

Close-Out Session: Completing the Work

Approximately: 1.5–2 hours

Session Five Activities:

- A. Review the transition process for clients linked to medical care.
- B. Review the transition process for clients not yet linked to medical care.
- C. Transition to long-term / Ryan White case manager or other providers.

Close-Out Session Guide Agenda

5A. Review the Transition Process: Linked Clients

5B. Review the Transition Process: Non-Linked Clients

5C. Transition to Long-Term / Ryan White Case Manager (CM) or Other Case Management Services

Forms and Documents Needed for Close-Out Session:

- *ARTAS Session Plan*
- *Resource directory*
- *Contact information for long-term / Ryan White CM and agency*
- *Paperwork for long-term / Ryan White CM*
- *Session Notes*
- *Session Notes Summary Sheet*
- *Case Review Form*
- *Client Satisfaction Questionnaire*

(Note: For the Close-Out Session, you do not conduct all three agenda items for each client.)

For clients linked to medical care, conduct agenda items 5A and 5C.

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

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

5A: Review the Transition Process: Linked Clients

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

Forms and Documents: *ARTAS Session Plan*
Resource directory

- *List of medical providers*
- *List of community service providers (e.g., substance abuse, mental health, housing, food, and insurance)*

Advanced Preparation:

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

Key Considerations:

Remember that the client:

- May not be ready to transition from ARTAS and/or end your relationship.

Procedure:

For all clients:

1. Welcome the client back for the last session and congratulate them on following up successfully with today's session. Recognize the many demands the client has and state how much you appreciate them taking time to meet with you.
2. Ask the client what questions, concerns, or new insights they have as a result of the previous session(s).
3. Summarize any additional points made during the discussion.

For clients who have decided to link to medical care but have not yet attended their appointment:

4. Review the outcomes of all activities listed on the ARTAS Session Plan for both you and the client. If necessary, revise the plan.
5. Ask the client about any new barriers and/or strengths discovered as a result of completing the ARTAS Session Plan activities. If necessary, revise the plan.
6. **This is a new step added to the Close-Out Session.** Discuss how the client can continue to use this plan to achieve their goals and objectives after ARTAS.
7. **This is a new step added to the Close-Out Session.** Complete the steps listed under 4F: Schedule Medical Appointment and/or Next Session. Then, skip to step 9 in this section.

For clients who attended a medical appointment:

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

For all clients:

- a. Discuss the barriers that the client identified and overcame during ARTAS. Review strategies that they identified as successful. Point out any additional strategies that you noticed that they may not have noted.
- b. Discuss any remaining barriers that could interfere with the client attending their next medical appointment or linking to other support services. Strategize with the client to identify ways that they can overcome these. If there are items in the ARTAS Session Plan that the client has yet to complete, obtain a commitment from them that they will continue to work on these.
- c. Ask the client what questions, concerns, or insights they have now that they have completed the intervention. Address any additional issues that arise.
- d. Encourage self-help through HIV support groups and linkage to long-term social services. Review the community resources discussed during earlier sessions. Also review the important role the client's family, friends, social groups, and other informal networks can play in supporting their continued use of medical care and other services. Provide verbal and written information regarding community services available.
- e. Next step, skip to 5C: Transition to Long-Term / Ryan White CM or Other Providers.

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

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

Forms and Documents: *ARTAS Session Plan*
Resource directory

- *List of medical providers*
- *List of community service providers (e.g., substance abuse, mental health, housing, food, and insurance)*
- *Paperwork for long-term / Ryan White case management*

Advanced Preparation:

- Review the client's ARTAS Session Plan, if one was developed in the previous

session.

Key Considerations:

Remember that the client:

- May not be ready to transition from ARTAS and/or end your relationship.
- May feel discouraged or that they have failed by not linking to medical care during ARTAS.

Procedure:**For all non-linked clients:**

1. Welcome the client back for the last session and congratulate them on following up successfully with today's session. Recognize the many demands the client has and state how much you appreciate them taking time to meet with you.
2. Ask the client what questions, concerns, or new insights they have as a result of the previous session(s). You may also want to ask about how the client's thoughts about linking to medical care may have evolved since your last session. In addition, you may ask about any reactions they have to ARTAS's focus on strengths.
3. Summarize any additional points made during the discussion.
4. Using the ARTAS Session Plan, review the client's progress over the course of the intervention. Discuss the client's strengths and how they used these to complete the tasks listed in their plan. Emphasize the client's accomplishments during ARTAS.
5. Discuss the barriers that the client identified and overcame during ARTAS. Review strategies that they identify as being successful. Point out any additional strategies that you have noticed they may not have noted.
6. Discuss the client's hesitance to link to medical care. Review the psychological and/or physical barriers that are preventing the client from accessing medical care. Discuss with the client how they can overcome these barriers. If the client desires, revise the ARTAS Session Plan to reflect concrete steps they can take, post-ARTAS, to link to medical care.
7. Remind the client about the benefits of early entry into medical care. Provide them with contact information for community medical providers and promote the client's independent contact with the clinic. Offer them the opportunity to call you one additional time following their independent clinic visit.
8. Ask the client what questions, concerns, or insights they have now that they have completed the intervention. Address any additional issues that arise.

9. Encourage self-help and linkage to medical and long-term social services. Review the community resources discussed during earlier sessions. Also review the important role the client's family, friends, social groups, and other informal networks can play in supporting their linkage to medical care and other services. Provide verbal and written information regarding other community services available.
10. Next step, continue to 5C: Transition to Long-Term / Ryan White CM or Other Providers.

5C: Transition to Long-Term / Ryan White CM or Other Case Management Services

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

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

Advanced Preparation:

- Ask the new long-term / Ryan White CM to be available during the client session so they can meet the client.
- Bring the name and contact information of the long-term / Ryan White CM.

Key Considerations:

Remember:

- The client may be unsure about what to expect from long-term / Ryan White case management.
- The client may be hesitant to connect with a new CM.
- Ask the long-term / Ryan White CM to join the session, if the client agrees.

Procedure:

For all clients:

1. Explain what the client can and cannot expect from long-term / Ryan White case management and how it differs from ARTAS, as follows:
 - While ARTAS focuses mainly on overcoming short-term barriers to linking to medical care, the long-term / Ryan White CM can work with the client on more general issues such as housing, employment, and other treatment needs.
 - The relationship with the long-term / Ryan White CM will not be as intensive as their relationship with you. As a result, the CM may not be able to accompany the client to appointments.

- The relationship between the client and long-term / Ryan White CM will not be restricted to 90 days or five sessions.
 - The client will still be expected to actively participate in their care.
2. Emphasize how the client can use the strengths identified during their participation in ARTAS to overcome barriers to services provided by the new CM. Validate the client's concerns by saying, *"This kind of case management is different and you won't be working with me. But you can have a similar working relationship with your new CM."*
 3. Answer any questions and address any concerns the client has about this new form of case management.
 4. Ask the client if they would be open to having the long-term / Ryan White CM join the session, if they are available. (Note: Plan in advance with the new CM and ensure they are available.)
 - a. **If the client would like to meet the new CM**, then bring them into the session and introduce them to each other. Ask the client to tell their story and share the work they have done in ARTAS and the strengths they have identified. Ask the client to discuss the barriers that they identified through ARTAS and what they have done to overcome them. Review any other barriers to accessing medical care or support services that will need to be addressed. Discuss any other issues that have arisen during ARTAS that the client will need to address during long-term / Ryan White case management.
 - b. **If the client is not comfortable having the long-term / Ryan White CM join the session**, then discuss their reluctance. Discuss how the client will access case management on their own and how they can overcome barriers or discomfort associated with doing so. Review the benefits of case management and what the client can gain from participating. Provide the client with the contact information for their long-term / Ryan White CM, and ask their permission to give their contact information to the new CM.
 5. Complete all paperwork necessary to transfer the client to another agency and/or CM, if this is in the memorandum of agreement between your agency and community partner. This could include discharge forms for your agency, intake/referral forms for the partner agency, and updates on client progress/status.
 6. Thank the client for coming and congratulate them on completing the intervention and working with you. Remind the client that linking to medical care is important to their overall health, and that you hope they use the skills you talked about to obtain services needed so they can access medical care and treatment.
 7. End the session by asking the client to complete the **Client Satisfaction**

Questionnaire on [page 130](#) in the Session Forms section.

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

Session Forms

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

Table of Contents

Strengths Assessment	Page 106
ARTAS Session Plan	Page 112
Overview of ARTAS Document	Page 117
Appointment Cards	Page 118
Session Notes	Page 119
Session Notes Summary Sheet	Page 123
Case Review Form	Page 125
Life Domains List	Page 128
ARTAS Client Satisfaction Questionnaire	Page 130
Client Session Guide Helpful Tips	Page 131

Strengths Assessment Instructions

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

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

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

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

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

OR

Option 2: Start the conversation about strengths using very general, but direct questions, such as:

- *What strengths do you think you have?*

- *What are your abilities?*
 - *When have you successfully faced barriers, and what did you do to overcome them?*
 - *What are you good at?*
 - *Tell me about a time when you felt like most things were going well. What were you doing to make them go well?*
3. During the conversation (regardless of which option you choose), listen for examples where the client identifies their strengths. Focus on what the client says, and remember these examples by using reflection, summarizing, and affirmations to reinforce the ideas for you and the client (if necessary, jot down a *quick* note). This is important because many of the ideas and examples will apply to the client's goals.
 4. Make a list of the strengths, abilities, and skills identified by the client in their stories during the conversation. Use the client's own words. What is most important is giving the client an opportunity to see, in writing, a list of their personal, positive attributes. Therefore, you can choose a format for the assessment that suits your agency. A suggested format for the strengths assessment is on page 110.
 5. Copy the list for the client, if they would like to take it home.

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

Collecting information that is not strengths-based: While the emphasis of ARTAS is on identifying strengths and abilities, it is always appropriate and necessary to incorporate sound clinical practice into each session. Therefore, it is also essential to collect information that is not strengths-based. Examples of non-strengths information that must be collected include:

- Suicidal ideation or attempts
- Risk to do harm to others
- Physical problems associated with substance abuse, including overdose risk, delirium tremens, or drug withdrawal
- Inherent limitations, such as not being able to read, having a learning disability, or

having physical impairments that may affect the client's ability to link to medical care

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

When collecting this non-strengths information, you should remember to treat the client as an individual and to not make assumptions.

Additional key points to remember when conducting the strengths assessment are listed below:

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

- Avoid acting as an investigator. It is better to assume a facilitator role in the search for abilities.
- Keep the goal of linkage to care as an honest part of the strengths assessment and all discussions. Do not try to covertly or overtly steer the client in a desired direction.

STRENGTHS ASSESSMENT FORM

Linkage Coordinator's

Copy

Client ID: _____

LC's Name: _____

Date: _____ Session Number: _____

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

1. What strengths, skills, or abilities did the client identify (either directly or indirectly)?

a. Strengths:

b. Skills:

c. Abilities:

d. Which items from the Life Domains List, if needed, prompted the client?

2. What examples did the client give about a time when they successfully faced barriers?

a. What did they do to overcome the barrier(s)?

3. What did the client explicitly say they were good at?

4. What did the client implicitly say they were good at, i.e., what did you hear them say?

a. Did the client agree with what you heard as something they are good at once you repeated it back?

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

STRENGTHS ASSESSMENT FORM

Client's Copy

Date: _____ Session Number _____

New Assessment or Updated Assessment? (Circle one)

1. My strengths, skills, or abilities identified:

a. Strengths:

b. Skills:

c. Abilities:

2. Examples I gave about a time(s) that I successfully faced barrier(s) in my life:

d. Example of barrier(s):

e. Things I did to overcome the barrier(s):

3. Things I am good at:

4. Example(s) of when I felt like most things in my life were going well:

f. Things I did to make them go well:

ARTAS Session Plan Instructions

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

While the format is less important than the content captured, a sample form to use as a guide for the **ARTAS Session Plan** is on **page 115**. It is useful for the plan to be organized by objectives, activities, related strengths, potential barriers, person responsible, and target dates for each objective and activity.

- **Identifying Goals:** In keeping with a strengths-based perspective, all goals should reflect the client's wishes, not your or the agency's wishes. Take great care not to impose your own goals on a client. Even the goal of linking to medical care should not be imposed on the client.

Throughout the ARTAS sessions, the LC will advocate for linking to medical care, while being careful not to force this goal or any others onto the client. LCs must consider the objectives identified by the client during the intervention and ensure that the efforts put toward these objectives do not restrict the client's ability to reach the ultimate goal of linkage to care.

Goals are written as broad statements and **always in the client's exact words**. Using a client's own words decreases the distance between the client and the goal and places the responsibility for accomplishing the goal squarely on the client. Further, it eliminates the possibility that you inadvertently alter the goal to something you believe is more important. In the end, the client must embrace their goals if they are to be successful.

- **Creating Objectives and Activities:** Objectives will be appropriate and effective if you follow the SMART technique for writing objectives. The components of a SMART objective are Specific, Measurable, Achievable, Relevant, and Time-bound. For more details on writing SMART objectives, please see "[Setting Objectives](#)" on [page 60](#) in the Implementation section.

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

GOAL: Find a job I enjoy.

OBJECTIVE 1: Take the General Equivalency Diploma (GED) exam by the end of the year.

ACTIVITIES: (1) Obtain a GED application by April 1; (2) study a GED work guide 10 hours each week from April 1 to June 30; and (3) schedule an appointment to take the GED exam in July.

OBJECTIVE 2: Complete a course on identifying job interests at Smith Vocational School by August 1.

ACTIVITIES: (1) Identify courses available, the dates, and the cost; (2) save \$10 a month until I've saved enough money; and (3) sign up and attend the course.

Creating objectives and activities requires detailed attention and must be taken seriously. Goal-setting is important because it helps the client to:

1. Learn a problem-solving approach that is transferable to other areas of life.
2. Evaluate progress in very personal and specific terms.

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

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

- **Your Role in Developing the ARTAS Session Plan:** You have multiple responsibilities in developing the ARTAS Session Plan with each client and helping them accomplish the plan successfully. These responsibilities include helping the client to:
 - Create SMART objectives.
 - Identify activities for each objective.
 - Prioritize objectives.
 - Identify alternative activities to accomplish objectives.
 - Weigh the advantages and disadvantages of different actions.
 - Connect the client's strengths and assets to the objectives and activities created.
 - Become knowledgeable about existing resources to help the client achieve

their objectives.

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

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

General points about the ARTAS Session Plan are listed below:

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

Check in with clients to ask if they see particular actions, thoughts, or feelings as strengths. Do not impose your view but assist clients in making those linkages.

Ultimately, the client's perception of something as a positive in their life will mobilize them to solve current problems.

ARTAS SESSION PLAN

Date: _____ Name: _____ Client ID: _____ Linkage Coordinator: _____

Goal 1: Link to Medical Care

Objective 1: _____

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

Objective 2: _____

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

Objective 3: _____

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

Objective 4: _____

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

Overview of ARTAS Document

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

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

Appointment Cards

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

Appointment
<i>Your appointment is on</i>
_____ at _____ a.m./p.m.
(Date) (Time)
<i>with</i>

(Name)

(Agency address)

Email Reminder / Voice Message

Hello---

This is ----. This message is to remind you of your upcoming appointment on -----.

Please let me know if you need to reschedule or if you have any questions before our next appointment.

Looking forward to seeing you again soon. Take care.

Session Notes Instructions

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

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

Section I

Session number: Fill in the session number, 1–5. If this is a telephone communication, use numbers starting with “6” for the first phone communication and then increase the numbering from there. For example, the first phone communication is 6, the second is 7, and so on. If the phone communication is with someone other than the client (e.g., you are contacting a person on the client’s locator form), do not complete a session form for this communication.

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

- | | |
|--------------------------------------|--|
| (1) Client | (5) Friend |
| (2) LC | (6) Medical care staff |
| (3) Family member, such as a sibling | (7) Other clinical staff (non-medical) |
| (4) Significant other—partner/spouse | (8) Other agency personnel |

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

- | | |
|--|----------------------------------|
| (1) Agency office | (5) Community partner agency |
| (2) Client’s residence | (6) Telephone |
| (3) Medical care clinic or hospital | (7) Car/vehicle |
| (4) Public location _____ (please specify) | (8) Virtual meeting |
| | (9) Other _____ (please specify) |

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

- | | |
|--------------------|---------------------------|
| (1) Client vehicle | (2) Public transportation |
|--------------------|---------------------------|

- (3) LC or agency's vehicle
- (4) Friend or family
- (5) Walked
- (6) Taxi

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

Section II

Narrative: This section should cover, at a minimum, the following areas:

- Objectives and activities for the session that were or were not accomplished, and why.
- Notable client reactions to completing or not completing the objectives and activities.
- Client's threats to self or others or pressing medical/psychological problems to be followed up on immediately.

Record what parts of the ARTAS Session Plan were discussed.

Section III

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

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

In the "Method of Referral" field, use the following code(s) to record how the referral was handled:

- 1: LC provided the client with the name and contact information for a referral site(s) and left it up to the client to make the connection.
- 2: LC called the resource and asked questions on the client's behalf. When appropriate, the LC advocated for the client's involvement with the referral site.
- 3: LC accompanied the client to the referral site.

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

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

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

Session Notes

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

LC Name: _____

Session Start Time: ____ : ____ AM/PM (circle one) End Time: ____ : ____ AM/PM (circle one)
 Total Time: _____ (in minutes)

Session Number (1–5): _____

Persons Involved in Session: _____ (From code list above)

Primary Session Location(s): _____ (From code list above)

Client Transportation to/from Session: _____ (From code list above)

Narrative: _____

Non-Clinic Referrals

Was a referral(s) made to a community partner (whether another agency, resource, or service provider) during this session? Yes (1) or No (2) If yes, where was referral made and how assertive was the referral?

Referred to:						
Method of Referral:						

Linkage Coordinator Signature: _____

Session Notes Summary Sheet Instructions

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

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

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

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

Session Notes Summary Sheet

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

Contacts		General Information				Referrals		
	Date	Total Time	Persons Involved	Session Location	Transportation (if required, what type was provided)	Referral Made (Yes or No)?	To?	Method of Referral
Session 1								
Session 2								
Session 3								
Session 4								
Session 5								
Phone contact								
Phone contact								
Mail contact								
E-mail contact								

Total number of scheduled sessions the client missed: No show _____ Canceled _____

Did the client link with a medical care provider? Yes (1) No (2) Don't Know (3)

If yes (1), where did the client link? _____

General comments (NOT required for data entry): _____

Case Review Form Instructions

The Case Review Form is designed to encourage you, your supervisor, and your colleagues to adhere to a strengths-based approach during the case review. Moreover, the form serves as a reminder to **always** view your clients from a strengths-based perspective, not only when the client is present.

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

Question 3 asks about the client’s strengths. This is not just an exercise to be undertaken. It also serves as a reminder to always view the client from a strengths-based perspective—regardless of whether or not the client is present. Furthermore, the discussion will help you understand the client’s past or current abilities that will serve the client in their attempt to achieve the goal of linkage to medical care.

Question 4 should include a discussion of the client’s barriers—both personal and structural—that they see as interfering with linkage to care. It is important to cast a potential deficit or short-coming simply as a “barrier,” or something that interferes with attaining a goal. The discussion of barriers—rather than problems or pathology—assumes that the client is responsible for and capable of solving them. An emphasis on problems or pathology may create resistance. It is important to check the language you use when speaking to and about your clients, as that may contribute to problems. This Case Review Form is designed to help you get to the source of problems and assist the client in achieving their goal of linkage to care, among other goals.

Case Review Form

Client ID: _____

Referred to ARTAS by: _____

Date Assigned to ARTAS (month/date/year): _____

LC Name: _____

LC Referred Client to: _____

Method of Referral: _____

Date Referred (month/date/year): _____

- Describe your early attempts to make contact with the client:

- Why did the client decide to participate in ARTAS?

- Describe at least three of the client's most significant strengths:

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

- What are the client's objectives that will help them link to medical care?

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

Life Domains List

Introduction: The linkage coordinator can use the Life Domains List questions as a refresher about various life domains and ways that clients show strengths in those areas. Use these questions only as a reference or stimulus to help the client when they may be having difficulties identifying strengths. You do not want the exercise to become a catalog of past failures. (Please note: **Using this list while the client is present and writing down the “answers” is not appropriate.**)

General Life Skills

Do you:

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

Relationships

Do you:

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

Living Arrangements

Do you:

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

Health

Do you:

- Generally get enough sleep?
- Exercise regularly? If so, what do you like to do?
- Go for regular medical/dental check-ups? Have you in the past?
- Generally address any health problems as they arise?
- Generally feel comfortable asking questions of your doctor or other health providers?
- Generally take your medicine on time and as prescribed?
- Practice safe sex with your partner(s)?
- Maintain a healthy diet?
- What are some things you do to reduce/manage stress in your life?
- Have you attempted to change an unhealthy behavior before? If yes, what was it?
How did you feel about it?

Internal Resources

Do you:

- Often set goals for yourself?
- Understand how your behavior affects you and others?
- Verbalize your wishes and desires directly?
- Value your strengths and talents?
- Consider the consequences of your actions/behaviors before acting?
- Follow your beliefs and values?
- Value/acknowledge your accomplishments?
- Attend to your spiritual needs (through church, house of worship, etc.)?
- Seek help as needed for personal problems?
- Articulate your interests?
- Have good decision-making skills?
- Accept responsibility for your actions?
- Express your emotions regularly and appropriately?
- Feel in control of your life?
- Effectively delay gratification or seek instant gratification?
- Generally cope with uncomfortable emotions in a positive way?

For active or past drug users: Recovery

Have you:

- Sought drug treatment?
- Explored your past/current drug use during treatment?
- Avoided people/places where drug use was prevalent?
- Followed through with aftercare?
- Maintained sobriety in the past?
- Attempted to change drug use behavior in the past?
- Attended support groups?
- Found a sponsor?
- Maintained contact with your sponsor?

ARTAS Client Satisfaction Questionnaire

Linkage Coordinator's Name: _____

Your Name or Client ID (optional): _____

Please circle the best answer to the questions below:

1. How satisfied are you with your experience participating in the ARTAS intervention?

Very Satisfied **Satisfied** **Neutral** **Dissatisfied** **Very Dissatisfied**

2. How satisfied are you with the services, if any, you were linked to during ARTAS?

Very Satisfied **Satisfied** **Neutral** **Dissatisfied** **Very Dissatisfied**

3. How satisfied are you with the skills you learned and/or enhanced by participating in the intervention?

Very Satisfied **Satisfied** **Neutral** **Dissatisfied** **Very Dissatisfied**

4. How satisfied are you with the linkage coordinator you worked with over the course of the intervention?

Very Satisfied **Satisfied** **Neutral** **Dissatisfied** **Very Dissatisfied**

Please write in your answers to the questions below.

5. What did you *like most* about participating in the intervention?

6. What would you *change* about the intervention?

7. Would you recommend ARTAS to anyone you know?

Yes **No** **Please explain why or why not? _____**

Thank you for your feedback.

Client Session Guide Helpful Tips

As a supplement to the Client Session Guide, the following are additional helpful tips to consider when implementing ARTAS.

1. Attending a Medical Appointment with the Client

If the client agrees, plan to attend the first medical appointment with them. The client should take the lead in the conversation with the health care provider and advocate for themselves during the appointment. **It is not your role to control the conversation during the appointment.** Unfortunately, there is no prescribed recipe to balance client involvement with you advocating on their behalf. However, two extreme scenarios to be avoided under all circumstances are:

- a. You and the medical staff talk about a client, their circumstances, or treatment as if the client was not present.
- b. You allow the client to struggle significantly while dealing with the provider and let critical issues go unaddressed.

While the goal of ARTAS is to link individuals to medical care, the desired outcome is for the medical appointment to be successful and for the client to feel comfortable and empowered to continue medical services. The client will judge your status as an effective and trustworthy ally based on the success or failure of the first medical appointment. To be seen as a trustworthy ally, prepare the client to increase the likelihood of a successful outcome.

2. Preparing the Client for a Medical Appointment

Inform the client in advance about what to expect during the visit. This information should be discussed in detail as soon as a client expresses interest in rapid linkage to care, or during the client session prior to the medical appointment. You and the client can write down any questions the client would like to discuss during their appointment. Writing questions down in advance will ensure the client does not get anxious and forget to ask an important question.

Provide the client with detailed information about the clinic/agency and staff. Much of this information will be available on the appointment card and includes, but is not limited to, the clinic name, doctor's name, address, hours, phone number, and appointment time. Additional information to be provided to the client includes directions to and from the clinic, transportation options provided by your agency, a reminder of where and when to meet, the personalities of various staff, services provided, anticipated wait time, and any other relevant information.

If you accompany the client, the client should know that they are expected to participate fully in the medical appointment and represent themselves. You are there for support and will only interject if the client asks for assistance and/or appears to need your assistance.

Tips for a Successful First Medical Appointment:

- Prior to the medical appointment, provide the client with detailed information about the provider they selected.
- Help the client prepare a set of questions, such as:
 - How often should I come visit you?
 - If I feel fine, do I still have to take my HIV medication?
- Discuss potential problems (such as the client forgetting what medications they are taking) that may occur during the appointment and brainstorm possible solutions with the client.
- Introduce the client to clinic staff, including screening staff, nurses, pharmacists, physicians, and social workers.
- Participate in all meetings between the client and clinic staff, if requested by the client.
- Explain the rationale behind different processes (administrative) during the appointment to the client.
- Interpret questions and/or information being given to the client, as necessary. If necessary, ask clarifying questions of clinic staff.
- After the appointment, review with the client what happened during the visit and how the client felt.
- Schedule a brief follow-up telephone call with the client to process the visit.
- Schedule an in-person session with the client to complete the transition process.

In conclusion, the client must attend the first medical appointment *thoroughly briefed* by you and *empowered to act on their own behalf*. During the appointment, you must continually assess the degree to which you should facilitate the client's involvement or act assertively on the client's behalf.

3. Structure of Client Session

You will have to adjust the time of each session to the individual ARTAS client. Due to the intensive, short-term nature of the intervention and the variation in time needed for each client session, you should schedule only two to three clients in a day until you become more familiar with the client and their needs. Because a client session may take a few hours, you may want to schedule one client in the morning and one client in the afternoon to allow sufficient time for the session. During the ARTAS-II study, the median number of sessions conducted per client was two sessions. The median time spent on all activities per client was 5.8 hours (the mean was 7.2 hours), and the range was from 0 to 36.7 hours per client.

Your caseload should be kept low (25–30 clients at a given time) to accommodate long sessions with each client and for extensive follow-up after missed appointments. If the client is late to a session, use it as an opportunity to identify a barrier to effectively linking with medical care as opposed to seeing it as a client weakness. Part of your work with the client can be to help them identify the source of their lateness and plan to solve the

problem.

4. Meeting Space

While meeting each client in their environment and outside the office whenever possible is a core element of the intervention, your agency may want to create and train you on general safety guidelines. If you are uncomfortable with a meeting place or meeting with a client at night, you may bring a colleague (if approved by the client) or change the meeting time or location while still ensuring the client is comfortable. Suggested locations include your agency's office, a clinic or hospital, a public library, a restaurant, a community partner's office, or a clinic.

5. Telephone Contacts with the Client

If your primary method of ARTAS delivery is in-person, then telephone communications between you and the client are intended to be used in the following ways:

- Initiate the ARTAS intake process (e.g., to discuss the intervention with the client and determine whether they are interested and eligible to participate).
- Reinforce, review, or modify logistics for an upcoming client session (e.g., the meeting time).
- Identify any barriers that arose since the last client session and may affect the client's ability to attend the next session (e.g., childcare is now a barrier).
- Touch base between client sessions if it is an extended amount of time or if you feel the client needs encouragement or a reminder of the next client session.

If the primary method of ARTAS delivery is in-person, then telephone communications are **not** intended to:

- Replace in-person client sessions.
- Be lengthy.
- Be used to identify strengths.

If your agency is equipped and prepared to offer ARTAS using a virtual delivery, then telephone communications may be used to conduct what would otherwise be in-person client sessions, and the discussion topics and activities would be the same. Additional planning and logistics will need to be established before your agency can begin the provision of the ARTAS intervention virtually.

6. Approaches to Completing Paperwork

Completing required paperwork for ARTAS and for your agency's regular administrative and enrollment processes places an additional burden on your time. Moreover, your agency's required paperwork may focus on *inabilities* and, therefore, not adhere to the core elements. If your agency's clinical forms are not adjusted in the pre-implementation phase to make them more strengths-focused, then the ARTAS program director/manager will have to negotiate possible solutions with the clinical director or executive director to ensure all required paperwork is completed. In the case of ARTAS paperwork, the

strengths perspective must be maintained.

Below are two options available to complete paperwork with the client. Whenever possible, your agency should try to make the paperwork for ARTAS and other programs as complementary as possible. Choose whichever option best fits your style and/or your agency's needs. The options are:

Option 1: Clearly differentiate the agency-required documents from the ARTAS-required documents and complete the agency-required documents first. Make it a point to differentiate the ARTAS paperwork from the agency-required paperwork during the first client session. By doing so, you clear up any confusion the client may have if the agency-required documents focus on deficiencies or inabilities.

When the agency-required paperwork is finished, tell the client you will now move in a new direction. Set aside the paperwork, and continue with the activities listed in Session One.

OR

Option 2: Emphasize the ARTAS-required documents by addressing them first. Begin the session by very quickly addressing any paperwork that is essential to complete first, such as consent forms. Continue with the activities listed in Session One. Whenever it feels appropriate, tell the client about the agency-required documents. Since these documents may highlight the client's deficiencies or inabilities, it is important to:

- Not overemphasize the client's deficiencies, inabilities, or weaknesses.
- Maintain good eye contact.
- Practice effective communication skills.
- End the session with a summary of the client's strengths.

Aside from the agency-required documents and forms that are to be completed together, complete paperwork after your session with the client.

7. Significant Others

Explore the role of significant others (partners, family, friends, or someone else important in the client's life) in either promoting or interfering with a client's linkage to medical care and be prepared to discuss this issue with the client. Significant others can influence a client following through with their medical appointment in many ways. In some instances, significant others can assist with linkage; in others, their involvement could interfere with linkage and follow-through.

8. Providing Incentives for Clients

Follow your agency's policies when deciding whether to provide incentives for clients, or create an ARTAS-specific policy around this issue. Incentives can be helpful in facilitating

client involvement and connecting with them. Incentives are a great way to retain clients and keep them involved in the process. Your agency may want to consider creative strategies to get incentives donated. A few examples include (1) asking a local grocery store to donate gift cards for food purchases, (2) asking a local gas station to donate gas cards, (3) asking a local restaurant to donate gift cards (this could be especially useful if you and the client meet for several hours and it is time for a meal), or (4) asking a phone company to donate calling cards. If the agency does not allow you to transport clients, it may be useful to provide them with transportation money or vouchers to enable clients to travel to each client session and medical appointment.

9. Finding Clients Who Drop Out

Once you make initial contact with the client, the relationship will last for five sessions or 90 days, whichever comes first. If a client does not follow through with ARTAS or is unable to be reached, you should attempt to contact the client at least through the 90-day period. After this time, you should decide how and whether to pursue the client on a case-by-case basis. A client who has clearly indicated that they do not wish to be contacted should be asked why they are dropping out but not be pursued further.

This section has provided in-depth information on the activities and skills that help facilitate effective implementation of ARTAS. The next section will discuss ways to integrate ARTAS into the implementing agency's services and evaluate the intervention.

Section 8: Linkage Coordinator Supervisor Guide

Antiretroviral Treatment and Access to Services (ARTAS)

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

Linkage Coordinator Supervisor Guide

July 2022

Linkage Coordinator Supervisor Guide Overview

The Linkage Coordinator (LC) Supervisor Guide is written for the LC supervisor and contains guidance for the implementation of ARTAS and supervision of the LC.

The supervisor plays an important role in ensuring that the LC implements the intervention with fidelity. Regular supervision of the LC is one of the most important activities for successfully implementing ARTAS. At the most fundamental level, your goal is to support the LC in their efforts to link clients to medical care. To promote that goal, you should:

- Support each LC to maintain adherence to the core elements of the intervention.
- Provide fresh, creative, and strengths-based solutions to barriers the LC encounters with clients.
- Support the LC to maintain a strengths-based perspective as they encounter challenging clients and work within various deficit-focused settings.
- Guard against intervention drift, or returning to a pre-ARTAS, deficits-based state of mind.

Interactive supervision should take place on a regular basis and not only in response to a difficult case or a troubled LC. Listed below are guidelines on creating a strengths mindset among the ARTAS staff, conducting case reviews and staff meetings with the LC(s) and ARTAS staff, and using shadowing and coaching exercises to assess and train the LC.

The LC Supervisor Guide consists of the following sections:

1. Implementing a Strengths-Based Approach to Supervision
2. Case Review
3. Staff Meetings
4. Supervisor's Meetings with Clients
5. Shadowing/Coaching Exercises

This guide also contains the following forms:

- Supervisor/LC Strengths Assessment Forms and example
- Shadowing exercise assessment

1. Implementing a Strengths-Based Approach to Supervision

While a strengths-based approach to supervision is not a formal model, there are four very important reasons to adopt such an approach during the implementation of ARTAS:

- Emphasizing strengths builds an effective and trusting relationship between you and the LC. A trusting relationship gives the LC a trusted ally within the agency. A trusting relationship focused on their strengths, rather than deficits, and LC-driven goals improves job performance, which ultimately links more clients to medical care.
- Modeling strengths-based behaviors, such as highlighting the LC's strengths and using responsive listening techniques on a regular basis, to reinforce how the LC should interact with clients.
- Encouraging each LC to be more optimistic and innovative in their work and less resistant to a new approach to case management.
- Shifting the agency's collective mindset—at least for the ARTAS staff—toward adopting a strengths-based perspective in all aspects of their work.

One way to think about it is to reframe the core elements of ARTAS to apply to strengths-based supervision. For example, you should:

- *Conduct a modified strengths-based assessment to encourage the LC to identify and use their strengths and abilities to accomplish their ARTAS-related goals.* Use a modified version of the client strengths assessment (the [Supervisor/LC Strengths Assessment on pages 144](#) of this guide) to help the LC identify professional and personal strengths and abilities. You will want to conduct the first assessment as early as possible—in the pre-implementation phase or within the first week of work. Moreover, you should regularly acknowledge and reinforce the LC's strengths during a case review and staff meetings.

As a result, rather than focusing on deficiencies (their own or clients') the LC will find the strengths-based perspective or “strengths attitude” to be normal and natural.

- *Perform LC-centered goal-setting and create a plan*, modeled after the ARTAS Session Plan used with clients. You should ask each LC what their goals are for the next year (or whatever time frame works for the agency). You can then model the techniques to develop an LC plan with goals, objectives, and activities (similar to the client session plan). The LC should identify a goal as well as:
 - Potential barriers
 - Activities to accomplish the goal
 - A target date for each activity
 - The person responsible for each activity
 - A personal strength associated with each activity

Similar to working with clients, you should work together with each LC on this process.

Each LC should set their own goals because they are ultimately the person responsible for achieving them. Each LC knows what they need and are able to do based on their individual situation. LC-driven goals can serve as the foundation for professional development opportunities. See page 144 of this guide for the instructions and form for you and the LC to complete during this process.

- *Establish an effective working relationship between you and each LC.* The nature of the relationship between you and the LC is distinctly different from the relationship between the LC and clients. However, the basic qualities of an effective relationship are still pertinent: trust, openness, effective communication, and clear delineation of responsibilities. The LC is likely to respond more effectively to suggestions and guidance if they are made within a mutually respectful relationship.

As mentioned earlier, your most important role is to assess the LC's ability to establish effective working relationships with clients. However, you and the LC must first establish your own working relationship. Only then are you able to evaluate the LC's ability to build effective relationships with clients. See the Maintenance section of the Implementation Manual for information on gathering client feedback.

- *View community partners and clients as resources and identify informal sources of support.* During the implementation study (ARTAS-II), a frequent complaint among the LCs who operated outside an office setting was that their supervisors did not *know* what it was like “out there.” Just as an LC benefits from operating in the client's environment, you will benefit from working with the LC while they meet with clients inside and away from the office. Shadowing the LC in the field gives you a firsthand appreciation for what it is like for the LC to engage with clients, complete client session plans and other required paperwork, and promote linkage to medical care.
- *Conduct supervision as an active, community-based activity.* Unlike most forms of supervision, ARTAS involves experiential learning and creative observation of employees. Some examples include shadowing exercises, coaching exercises such as role-playing and other forms of experiential learning, working within the community to gather feedback from partner agencies and clients, and obtaining feedback from the LC on the supervisor/LC relationship.

2. Case Review

Strengths-focused case review accomplishes several desirable outcomes for the intervention:

1. Improving the quality of services provided to clients. The exchange of ideas between you and the LC results in creative problem-solving to address clients' situations.

2. Constantly reinforcing the ARTAS core elements and a “strengths attitude” for the LC. For example, you can help the LC learn and practice techniques from other client-centered approaches to counseling, such as motivational interviewing (specifically responsive listening), to fully involve clients in the process.
3. Anticipating potentially troubling situations between clients and an LC and intervening early.
4. Reinforcing the LC’s integral role in the implementation of ARTAS.

Case review provides an opportunity to assess the implementation and delivery of ARTAS. During the case review, if you have more than one LC on staff, you will be able to meet with each LC at once. This gives each LC an opportunity to discuss successes with colleagues and with you and to brainstorm solutions in working with challenging clients.

Time should be set aside each week for case review. Depending on the LC’s caseload and the barriers being faced by the clients, the case review may not take the whole time allotted. The most important point is that time is dedicated to having these discussions. Moreover, these meetings should be seen as a team-building experience for you and the LCs, and as such are valued time spent together to learn from one another.

To best facilitate discussion during a case review, each LC should complete one [Case Review Form per client \(on page 126-127\)](#) of the Client Session Guide). The form is designed to encourage you and the LC to adhere to a strengths-based approach during the case review. Moreover, the form serves as a reminder to the LC to *always* view clients from a strengths-based perspective, and not only when clients are present. To maintain a strengths-based attitude during the case review, the format for each case review session should include:

1. Summary of:
 - a. Individual client’s strengths and abilities, individual- and system-level barriers, and goals.
 - b. Early attempts by the LC and client to make contact with each other.
 - c. Reasons why the client decided to participate in ARTAS.
2. Discussion of:
 - a. Other LCs’ experiences helping clients with similar barriers.
 - b. Possible solutions for the LC who is having a problem helping the client being discussed.
3. Creation of:
 - a. Action steps for the LC who is having a problem.
 - b. A plan for you to meet with the client and the LC, if necessary.

If a problem discussed during the case review needs further attention, then you may want to meet with the client and the LC. Due to scheduling constraints, difficulty getting the client’s permission, and/or the sensitive nature of the client–LC relationship, meeting with the client should be reserved for special circumstances.

(Note: During the case review and on the Case Review Form, there should be no discussion of the client’s problematic behavior or previous failures. However, “inherent limitations” are allowable. Inherent limitations are characteristics that are not strengths but must be acknowledged by the LC. These characteristics include physical disabilities, medical conditions, special cognitive needs, and/or psychiatric challenges, particularly depression or suicidal tendencies. Recognition of inherent limitations does not imply that the client cannot be successful. It means that both client and LC should consider these limitations during the goal-setting process. Moreover, the presence of inherent limitations must never *define* the client as “disabled” or “mentally ill” or cast them in a negative light. The usage of such terms is counter to the core elements of ARTAS.)

3. Staff Meetings

Holding regularly scheduled staff meetings is recommended for the healthy facilitation and maintenance of ARTAS. The meetings should be held on a regular basis (once or twice a month) with compulsory participation by the intervention staff: program director/manager, evaluator, you, and the LC(s). The purpose of staff meetings is to provide an opportunity for:

- Information sharing and intervention updates between all intervention staff.
- Reviewing core elements and key characteristics of ARTAS.
- Discussing barriers to following ARTAS procedures.
- Developing teamwork and support for one another.
- Discussing management issues and their effect on staff.

Regular staff meetings allow for regular communication, acknowledgment of accomplishments, and identification of barriers to be addressed in a timely manner. If desired, your staff may wish to take notes and distribute them afterward. To share the responsibility and not overburden one staff member, the project director/manager may want to rotate the responsibility among the LCs, if there is more than one LC.

4. Supervisor’s Meetings with Clients

When you have contact with an LC’s client—whether a formal or informal meeting—you have a unique opportunity to hear *how* the client talks about the LC and their work together. You should pay special attention to the language used by the client. If the LC adheres to the core elements of ARTAS, you should hear things like:

- *“We talk about what I am **good at**.”*
- *“We have a written plan to **complete my goals**.”*
- *“I can talk to them **about how I feel** about getting treatment.”*
- *“I feel that I have an ally in this organization.”*
- *“The LC is confident that I can accomplish my goals”*

To evaluate each LC, you should answer this question: Did the client talk about their own strengths and/or about how the client and LC discussed the client’s strengths together?

Did the client state that the LC expresses empathy and/or belief in the client?

If you do not hear these sentiments, you must decide what action to take. You may choose to observe the LC for half a day and use the shadowing protocol to assess their interactions with clients. From your observations, you can identify what went well and what could be improved. You can then coach the LC on the areas to be improved or arrange for the LC to receive additional training.

5. Shadowing/Coaching Exercises

The process of shadowing and coaching allows each LC to be observed by you to ensure the core elements of ARTAS are implemented during the client sessions.

Shadowing helps you observe how well each LC is (1) building relationships with their clients, (2) focusing on the clients' strengths, (3) using formal and informal sources of support to help clients overcome individual- and system-level barriers, and (4) identifying potential areas for improvement. If your agency chooses to use the shadowing exercise, you and the program director/manager should determine how often to conduct the exercise with each LC. As mentioned earlier, a new LC may find it beneficial to shadow an experienced LC using this same process and template. A [Shadowing Exercise Assessment template is included on page 149](#) of this guide. To get the most out of the process, key elements of shadowing that should be adhered to include:

- Shadowing is observational, not hands-on.
- The activity should be scheduled in advance with the LC and the client. Scheduling the shadowing exercise will reduce interruptions of the observation process. However, it is important to **get the client's approval before scheduling the observation** and explain the process thoroughly to them, i.e., that you are observing and assessing the LC and their interaction, and *not the client*.
- During the shadowing process, you may wish to take written notes about the LC's performance to provide accurate feedback. You should be very careful with this exercise. Either **remember key points without writing** them down or inform the client in advance that **any notes taken will be about the LC and not about the client**. Obtain the client's permission before taking written notes.
- Be sure to make note of things that went well during the client session *and* opportunities for improvement, remembering a strengths-based approach.
- Have a clear understanding of the ARTAS intervention, client session objectives, and core elements.

Coaching is a process that enables individual staff and the agency to implement ARTAS with fidelity. Once you shadow an LC, a plan should be created to begin coaching the LC in the implementation of ARTAS and the necessary skills. During this exercise, you can coach the LC in communication, behavior change theories, cultural competency, or other areas as needed. As the coach:

- You should have significant experience in providing case management, an understanding of ARTAS and the behavior change theories on which it is based, strong communication skills, and an understanding of how culture affects clients' outcomes. Experience with client-centered approaches, such as motivational interviewing skills, can be useful.
- You should explore the LC's needs, skills, and thought processes to assist that LC in conducting the intervention.
- You must support the LC in setting appropriate goals and methods of assessing progress in relation to these goals.
- You must use creative techniques and tools to assist the LC in understanding and applying the intervention correctly. These techniques include role-play, training, and modeling.
- You must maintain unconditional positive regard for the LC. The coach should always be supportive and nonjudgmental.
- You must evaluate the outcomes of the process, using objective measures wherever possible to ensure the LC/client relationship is successful and the client is achieving their personal goals.
- You must encourage the LC to continually improve their skills in implementing ARTAS.

Regular supervision of the LC and communication between you and the LC are two very important activities to successfully implement ARTAS. The exercises discussed above should be seen as recommended activities for your agency to engage in to improve the intervention implementation.

Linkage Coordinator Strengths Assessment

The purpose of the linkage coordinator (LC) strengths assessment is to help the LC identify personal and professional strengths, abilities, and skills to accomplish their professional goals. The LC strengths assessment draws on past successes to create a summary of an LC's experiences, both personal and professional.

Below are recommended instructions for conducting the LC strengths assessment. How the assessment is conducted will vary greatly based on your agency's employee performance review process.

INSTRUCTIONS:

1. Clearly introduce the intent of the strengths assessment and how it connects to the LC's professional goals.
2. Choose one of two options to complete the assessment with the LC:
Option 1: Simply talk to the LC about their past and current work experience. This option occurs in a natural but guided conversation designed to help the LC think about and identify strengths and abilities. You should listen for stories told that reflect the LC's *strengths, abilities, and skills*. You may be familiar with the LC's strengths from the interviewing process, especially if the LC is new to the agency. Ask open-ended questions and use reflective listening techniques to encourage the LC to talk about positive rather than negative experiences. For example, *"You mentioned that in your last job you were responsible for 100 clients at one point. Tell me more about that experience and how you handled it."*

OR

Option 2: Start the conversation about strengths using general, but direct, questions such as:

- *What are your strengths and abilities?*
 - *When have you successfully overcome barriers at work? What did you do to overcome them?*
 - *What are you good at, either professionally or personally (hobbies or interests)?*
 - *Tell me about a time when you felt like most things were going well in your job. What were you doing to make them go well?*
3. During the conversation (regardless of which option you choose), listen for examples of where the LC identifies their strengths. Make a list of the LC's strengths, abilities, and skills identified by the LC in their stories during the conversation. Use the LC's own words. The Linkage Coordinator Strengths Assessment form on page 146 is an

example that can be tailored by your agency. It is important for you and the LC to see, in writing, a list of their positive attributes.

4. Unlike the LC/client interaction, the strengths assessment and goal-setting activity (typically captured on the session plan for clients) are combined in one document. This will reduce the amount of paperwork you must complete for each employee.

Please add space for additional goals, objectives, and activities as needed.

5. Ask the LC to use the “LC’s Copy” to record their strengths, skills, and abilities identified. The LC may wish to keep a copy for their records.

(Note: While the strengths assessment exercise is designed to solicit examples of previous successes from the LC, you should never view the assessment process as static. That is to say, it is an ongoing process rather than a one-time, discrete activity.)

Linkage Coordinator STRENGTHS ASSESSMENT FORM

Supervisor's Copy

LC's Name:

Date:

- 1. What strengths, skills, or abilities did the LC identify (either directly or indirectly)?**
 - a. Strengths:
 - b. Skills:
 - c. Abilities:

- 2. What examples did the LC give about a time when they successfully overcame barriers or challenges at work?**
 - a. How did they overcome the barrier(s)?

- 3. What did the LC explicitly say they are good at, either professionally or personally?**
 - a. What did the LC implicitly say they are good at (i.e., what did you hear them say)?
 - b. Did the LC agree with what you heard once you repeated it back?

- 4. What example(s) did the LC give about a time/experience when they felt like most things were going well at their job? What were they doing to make them go well?**

Goal 1:

Objective 1:

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

Objective 2:

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

Linkage Coordinator STRENGTHS ASSESSMENT FORM

Linkage Coordinator
Copy

LC's Name:

Date:

1. My strengths, skills, or abilities identified:

- a. Strengths:
- b. Skills:
- c. Abilities:

2. Examples I gave about a time(s) that I successfully overcame barrier(s) in my job:

- a. Things I did to overcome the barrier(s):

3. Things I'm good at, either professionally or personally:

4. Example(s) of when I felt like most things in my professional life were going well:

- a. Things I did to make them go well:

Goal 1:

Objective 1:

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

Objective 2:

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

Linkage Coordinator STRENGTHS ASSESSMENT FORM

LC's Name: Ms. Angie

Date: January 20, 2018

1. **What strengths, skills, or abilities did the LC identify (either directly or indirectly)?**
 - a. Strengths: Very personable and can talk to just about anyone.
 - b. Skills: Detail-oriented; strong facilitation and case management skills.
 - c. Abilities: Works well with clients.
2. **What examples did the LC give about a time when they successfully overcame barriers or challenges at work?** She once managed over 100 clients at a time. She identified numerous barriers, such as little support from her supervisor and losing clients due to a lack of time for follow-up.
 - a. How did they overcome the barrier(s)? She spoke with her manager to explain she needed more support from him, and she organized the other CMs to request support from the supervisor as well. As a result, they instituted weekly case review meetings to discuss client cases with which they were having difficulty. The CMs worked collectively with their supervisor to create a protocol to follow up with clients the CM thought needed additional attention and encouragement to attend their appointments.
3. **What did the LC explicitly say they are good at, either professionally or personally?** She said she's good at working with people and getting groups to come to a collective decision.
 - a. What did the LC implicitly say they are good at (i.e., what did you hear them say)? From her description of how she follows up with clients, I see she's very detail-oriented, even though she didn't say so.
 - b. Did the LC agree with what you heard once you repeated it back? Yes.
4. **What example(s) did the LC give about a time/experience when they felt like most things were going well at their job? What were they doing to make them go well?** We did not get to this example. I'll ask her at a later date.

Goal 1: Be trained on ARTAS before seeing my first client.

Objective 1: Find a quality ARTAS training by April 1st.

Activity	Related Strengths	Potential Barriers	Target Date	Person(s) Responsible
1. Conduct research on ARTAS trainings.	Good computer skills.	No one in the agency knows how to obtain ARTAS training.	By Feb. 15	LC
2. Call case managers and partners to ask about available ARTAS trainings and their personal experiences at the training.	Strong networks with case managers and the community from previous job.		By Mar. 15	LC

Shadowing Exercise Assessment

The following scale is designed to assess how closely the basic core elements of ARTAS are being implemented by the LC during each cycle of ARTAS.

This assessment can also be used as a learning tool for new LCs as they are becoming familiar with the intervention. LCs can use this assessment while shadowing an experienced LC to focus their observations and identify how the LC integrates the core elements into the client session.

Please respond to each of the statements below by filling in the circle to indicate your level of agreement or disagreement with each statement.

STRENGTHS	Strongly Disagree (1)	Disagree (2)	Uncertain (3)	Agree (4)	Strongly Agree (5)
1. LC encourages and promotes the identification of past and present strengths, including abilities, achievements, interests, skills, and resources.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. LC asks detailed questions about client's strengths.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. The strengths assessment is regularly updated throughout the LC/client relationship as new strengths are identified. (Note: This can be assessed by reviewing the client's file to ensure that the strengths assessment has been regularly updated, or, if it has not, that the reasons for this are documented.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. During client sessions, the LC explains how the strengths assessment can be helpful to achieving personal goals.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Accomplishments since the last client session are acknowledged during each session between the client and LC.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. LC summarizes the client's strengths, or asks client to do so, at the completion of each session.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Clients are offered a copy of the strengths assessment at the end of each session.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CLIENT-DRIVEN	(1)	(2)	(3)	(4)	(5)
8. LC checks in with the client and asks what they wish to accomplish.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. The session plan is based on the strengths and needs of the client as identified in the strengths assessment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. All steps in the session plan are built on the “goals-objective-activity” paradigm.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

GOAL-SETTING	(1)	(2)	(3)	(4)	(5)
11. Goals are written in the client’s own language.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Objectives and activities are written in the client’s own words, or if paraphrased, the LC checks with client to confirm accuracy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. All objectives and strategies are specific, measurable, achievable, relevant, and time-bound.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. During every client session, the LC and client update the session plan.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. All steps in the session plan (goal, objectives, and activities) are written positively, as something the client/LC will attempt to do.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Information is gathered at client’s pace.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

RELATIONSHIP	(1)	(2)	(3)	(4)	(5)
17. LC uses techniques such as responsive listening to establish rapport with client.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. LC demonstrates empathy and interest in client’s story.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. When a client describes themselves and/or experiences, the LC assists the client in identifying their strengths embedded in the client’s story.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. LC discusses roles, responsibilities, and mutual expectations of LC/client relationship.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

RELATIONSHIP (cont.)	(1)	(2)	(3)	(4)	(5)
21. LC informs the client of their rights.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Boundaries are flexible, but the LC is always respectful of client's needs and ethical considerations.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. LC and client are involved in an activity that is enjoyable to the client.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ACTIVE CASE MANAGEMENT AND OUTREACH	(1)	(2)	(3)	(4)	(5)
24. Once a referral is made, LC does whatever it takes to meet with a new client.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. LC schedules meetings at a time that is most convenient for the client.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Majority of client sessions happen in their environment and outside the office, whenever possible.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

INFORMAL RESOURCES	(1)	(2)	(3)	(4)	(5)
27. The session plan uses the involvement of naturally occurring community supports identified in the strengths assessment (e.g., family, community members, friends, and partners).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. LC and client do activities designed to increase the client's contact with community resources.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Session Activities	Covered Yes-1 No-2	Why were the activities not covered during the client session?
SESSION ONE ACTIVITIES		
A: Introduce the goals of case management and ARTAS.		
B: Discuss concerns about recent HIV diagnosis.		
C: Begin to identify personal strengths, abilities, and skills and assess the role of others in impeding or promoting access to services.		
D: Encourage linkage to medical care.		
E: Summarize the session, the client's strengths, and agreed-upon next steps.		
F: Plan for the next session(s), with the medical care provider and/or you.		
SESSION TWO ACTIVITIES		
A: Solicit client issues and questions from the initial session.		
B: Continue identifying personal strengths, abilities, and skills.		
C: Encourage linkage to medical care.		
D: Identify and address personal needs and barriers to linkage.		
E: Summarize the session, the client's strengths, and agreed-upon next steps.		
F: Plan for the next session(s), with the medical care provider and/or you.		
SESSION THREE ACTIVITIES		
A: Solicit client issues and questions from Session Two.		
B: Continue identifying personal strengths, abilities, and skills.		
C: Encourage linkage to medical care.		
D: Identify and address personal needs and barriers to linkage.		
E: Summarize the session, the client's strengths, and agreed-upon next steps.		
F: Plan for the next session(s), with the medical care provider and/or you.		
SESSION FOUR ACTIVITIES		
A: Solicit client issues and questions from Session Three.		
B: Initiate the disengagement process.		
C: Continue identifying personal strengths, abilities, and skills.		

Session Activities	Covered Yes-1 No-2	Why were the activities not covered during the client session?
SESSION FOUR ACTIVITIES (cont.)		
D: Encourage linkage to care / identify and address barriers to linkage.		
E: Summarize the session, the client's strengths, and agreed-upon next steps.		
F: Plan for the next session(s), with medical care provider and/or you.		
CLOSE-OUT SESSION ACTIVITIES		
A: Review the disengagement process for clients linked to medical care. OR		
B: Review the disengagement process for clients not yet linked to medical care.		
C: Transition to long-term / Ryan White case management.		

What went well?

What could be done differently?

What are your recommendations for follow-up? Training? Coaching? Other? Please explain.

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Appendices

Appendix A: Research Articles and Resources

The ARTAS original research article, “Structural Factors and Best Practices in Implementing a Linkage to HIV Care Program Using the ARTAS Model,” is available for download at the [BMC Health Services Research website](#).

The ARTAS-II research article, “Brief strengths-based case management promotes entry in HIV medical care: results of the antiretroviral treatment access study-II,” is available for download at the [National Center for Biotechnology Information website](#).

A 2020 research article, “Modified Antiretroviral Treatment Access Study (MARTAS): A Randomized Controlled Trial of the Efficacy of a Linkage-to-Care Intervention Among HIV-Positive Patients in Ukraine,” which studied an adapted version of ARTAS, focused on linking adults living with HIV from drug dependence, STI, and infectious disease clinics to care. It is available for download at the [National Center for Biotechnology Information website](#).

Additional resources can be found on [CDC’s Effective Interventions](#) website and CDC.gov ([Starting the Conversation: HIV Treatment & Care](#) / [Starting the Conversation: HIV Treatment as Prevention](#))

Appendix B: Pre-implementation Forms

B.1 Agency Readiness Checklist

In the blank space provided, mark whether the agency has the indicated capability by placing a check under “Yes” or “No” in the appropriate column. For any “no” answer regarding capacity, the agency should list the necessary next steps to increase capacity in the Comments | Next Steps column. For example, if the agency does not have experience providing case management services, then it should make a note of potential agencies or clinics to subcontract with to complete this component of the intervention.

Case Management Readiness	Yes	No	Comments Next Steps
1. Does your agency provide case management services?			
2. Do you have staff with experience providing case management?			
3. Do you have staff with experience in strengths-based service delivery?			
4. Do you have the resources to obtain additional case management and strengths-based service delivery training and education for staff?			
HIV Readiness	Yes	No	Comments Next Steps
1. Does your agency provide services to persons with HIV (PWH)?			
2. Does your staff have knowledge of and experience providing services to PWH?			
3. Have you identified additional training and educational resources to increase staff capacity and knowledge of providing services to PWH?			
4. Do you have the resources to obtain additional HIV training and education for staff?			
Agency Readiness	Yes	No	Comments Next Steps
1. Do you have funding for ARTAS?			
2. Do you have support from your board of directors and key agency staff for the intervention?			
3. Does all agency staff understand the importance, content, and mission of ARTAS?			
4. Do you have staff who can implement ARTAS? <i>Program director/manager</i> <i>Linkage coordinator (LC) supervisor</i> <i>Evaluator</i> <i>LC(s)</i>			
5. Has your staff (specifically LC supervisor and LCs) participated in the ARTAS training?			

6. Have you identified additional training needs (communication skills, cultural competency)?			
Agency Readiness	Yes	No	Comments Next Steps
7. Have you identified agency policies/procedures that may need to be revised to support ARTAS?			
8. Do you have office space for the staff of ARTAS?			
8(a) Is there office space for LCs at the referral sites, if desired?			
9. Do you have the supplies and equipment to implement ARTAS? Examples include computers and cell phones for LCs.			
10. If necessary, do you have the capacity to develop a monitoring and evaluation plan?			
11. If necessary, do you have the technological capacity to collect and analyze data?			
12. If necessary, is staff proficient in the software needed for these activities?			
Community Readiness	Yes	No	Comments Next Steps
1. Do you have relationships with potential community partners such as HIV testing sites, medical providers, case management services, and other support services?			
2. Do you have clear, specific, ARTAS-related roles for community partners within the community's system of care?			
3. Do you have formal contracts and/or established referral protocols with existing community partners? These can be a starting point to launch ARTAS.			
4. Have you identified resources in the community to secure transportation subsidies or incentives for clients?			
5. Do you have staff or a consultant who can create marketing materials to promote ARTAS to community partners?			

B.2 Identifying Barriers and Solutions Example Form

This example lists possible solutions, in italics, for the agency to consider. Since agencies' structures and implementation plans may vary, the solutions listed are suggestions to consider. Space is provided for the agency to add additional barriers, solutions, and the person(s) responsible for monitoring and/or alleviating the barrier.

Identifying Barriers and Solutions Form
Potential Barrier: <i>Linkage coordinator (LC) assigned to non-ARTAS tasks</i>
Problem(s): <i>Volume of non-ARTAS tasks assigned to the LC does not allow them adequate time to effectively complete ARTAS-related activities.</i>
Solution(s): <i>Dedicate the LC's time solely to ARTAS. Small caseloads allow the LC to provide individualized, intensive services to each client. This includes but is not limited to: following up with clients, completing paperwork, attending sessions and appointments outside of the agency, and cultivating and maintaining effective relationships with clients and community partners.</i>
Person responsible: <i>Program director/manager (with input from the supervisor)</i>
Potential Barrier: <i>Too little time for clinical supervision</i>
Problem(s): <i>Fidelity to the intervention was lost because the LC did not adhere to the core elements of ARTAS.</i>
Solution(s): <i>Schedule regular meetings with all ARTAS staff, and schedule meetings between the supervisor and the LC(s) to review client progress and to discuss any challenges. Routine supervision was identified as very important to ensure fidelity to the ARTAS intervention; without this, it may be easy for the LC to inadvertently stray from the core elements.</i>
Person responsible: <i>Supervisor (with cooperation from the LC)</i>
Solution(s): <i>Send the LC and supervisor to ARTAS training.</i>
Person responsible: <i>Program director/manager or supervisor</i>
Potential Barrier: <i>Poor internal buy-in from other case managers (CMs)</i>
Problem(s): <i>The difference in caseloads between long-term / Ryan White CMs and the LC may be striking, and it may cause tension between the two.</i>
Solution(s): <i>Early on, explain the short-term, intensive nature of ARTAS. Make it clear how ARTAS complements other case management and counseling services provided within the agency.</i>
Person responsible: <i>Program director/manager</i>
Solution(s): <i>Arrange for the LC to complete all required documents and enrollment forms for each client before transferring them to the long-term / Ryan White CMs.</i>
Person responsible: <i>Program director/manager or supervisor</i>
Potential Barrier: <i>Poor buy-in from external CMs and other partners</i>
Problem(s): <i>Community partners may feel threatened when they first learn about ARTAS. They may see the intervention as competition and think it will take clients away from their services.</i>
Solution(s): <i>Early on, explain the short-term, intensive nature of ARTAS. Make it clear how ARTAS complements other case management and counseling services provided within the community. Explain that ARTAS has the sole goal of linking clients to care; clients can come to Ryan White / long-term case management already linked to care so these CMs can focus on clients' other needs such as housing, nutrition assistance, and employment.</i>
Person responsible: <i>Program director/manager</i>
Solution(s): <i>Arrange for the LC to complete all required documents and enrollment forms for all clients</i>

<i>before transferring them to the long-term / Ryan White CMs.</i>
Person responsible: Program director/manager or LC
Solution(s): Use the job title “linkage coordinator” (as opposed to “linkage case manager”) to avoid confusion with long-term / Ryan White CMs.
Person responsible: Program director/manager
Potential Barrier: Limited or no availability of clinic appointments to facilitate rapid linkage and rapid ART start
Problem(s): LCs are unable to find timely appointments within their own clinical site (if applicable) or with external clinical partners for clients to facilitate rapid linkage. The earliest clients are able to see a doctor is two weeks from first meeting with the LC.
Solution(s): Identify clinics in the neighborhood who could be potential partners. Schedule meetings with clinic representatives to explore a potential partnership and possibility of having same-day appointments or appointments within seven days.
Person responsible: Program director/manager
Potential Barrier: Lack of clarity among community partners
Problem(s): Confusion among community partners about their roles and the roles of others in the intervention may lead to low referral rates and ineffective partnerships.
Solution(s): Provide ongoing education to community partners. Possible formats include one-on-one meetings and formal or informal presentations. Emphasize the goal of ARTAS, how it can enhance their existing services, and other benefits to their agency and clients.
Person responsible: LC
Solution(s): Develop clear, easy-to-understand marketing materials and a marketing plan to educate community partners about ARTAS.
Person responsible: LC
Solution(s): Develop and sign an MOA with each community partner that (1) clearly states each agency’s roles and responsibilities and (2) spells out the agreed-upon referral process.
Person responsible: LC
Potential Barrier: Logistical challenges
Problem(s): Logistical barriers, such as inadequate office space for LC to meet with clients and/or hold office hours at the testing site(s), will likely arise.
Solution(s): Provide the LC with a cell phone and institute an on-call system with the referral sites. This will allow the LC to go to the testing site when a client tests positive or to speak with the client on the phone soon after the test results.
Person responsible: Program director/manager
Solution(s): Develop and sign an MOA with each community partner that spells out any logistical processes that are involved in the agreed-upon referral process.
Potential Barrier: Low referral rates
Problem(s): It may take some time for the testing sites to adjust to the new referral system. Passive referrals may continue because staff members are not accustomed to the ARTAS referral protocol.
Solution(s): Develop and sign an MOA with each community partner that spells out any logistical processes that are involved in the agreed-upon referral process.
Person responsible: LC
Solution(s): Keep in regular contact with referral sites to maintain effective working relationships with the community partners, update them on progress being made, and remind them about the referral process.
Person responsible: LC

B.3 Community Partner’s Buy-in Worksheets

Community-Based Organizations (CBOs) / Non–Health Department Settings

The worksheets contain a list of suggested activities and a column for the staff to record pertinent information, such as key community partners. Examples are provided in *italics*. The activities are in **bold** text, and the steps to complete the activity are listed in the rows shaded in gray.

1. Identify your community partners.	
Potential community partners include:	List your agency’s community partners:
Your agency’s board of directors / executive board	
Staff members from your agency who will have a role in the operation of the intervention (examples below): <ul style="list-style-type: none"> ● <i>Program director/manager</i> ● <i>Supervisor</i> ● <i>Linkage coordinators (LCs)</i> ● <i>Evaluator</i> 	
Local agencies from which you could receive referrals (examples below): <ul style="list-style-type: none"> ● <i>Health clinics</i> ● <i>Sexually transmitted disease clinics</i> ● <i>Counseling and testing sites</i> ● <i>Hospitals (inpatient)</i> ● <i>CBOs providing HIV prevention services, including counseling and testing</i> ● <i>AIDS service organizations</i> ● <i>Walk-in clinics such as urgent care centers or emergency rooms</i> ● <i>Private doctors and private practices</i> ● <i>Correctional system (jails/prisons)</i> ● <i>Drug treatment centers</i> ● <i>Mental health centers</i> ● <i>Other sites with which staff have relationships</i> 	
Medical care providers to whom you could link clients (examples below): <ul style="list-style-type: none"> ● <i>Health clinics</i> ● <i>Private doctors</i> ● <i>Other healthcare providers serving persons with HIV (PWH)</i> 	
Long-term case management providers to whom you could transition clients (examples below): <ul style="list-style-type: none"> ● <i>Ryan White case management providers</i> ● <i>Other case management agencies serving PWH</i> 	

1. Identify your community partners (cont.)	
Organizations that could provide other assistance or resources (examples below): <ul style="list-style-type: none"> • <i>Other agencies providing support services, such as substance abuse treatment, mental health services, housing assistance</i> • <i>Agencies that can provide transportation or transportation subsidies</i> • <i>Merchants to provide incentives for clients</i> • <i>Printers and publishers who can produce marketing materials for the intervention</i> 	
Potential community partners include:	List your agency's community partners:
Other agencies with which your agency needs to maintain good community or professional relations (examples below): <ul style="list-style-type: none"> • <i>Local and state health departments</i> • <i>Your funding source(s)</i> • <i>Local medical and mental health associations</i> • <i>Community organizations</i> 	
2. Obtain buy-in from your community partners.	
Inform them about the intervention:	
What specific roles do you want each community partner to play (examples below)?	List which community partner you will ask to fill each role:
<ul style="list-style-type: none"> • <i>Refer recently diagnosed, or out-of-care, individuals to the intervention.</i> 	
<ul style="list-style-type: none"> • <i>Be a resource to which you can refer clients.</i> 	
<ul style="list-style-type: none"> • <i>Be a resource to which you can refer clients for long-term case management and/or other services.</i> 	
<ul style="list-style-type: none"> • <i>Donate small incentives or provide transportation subsidies for clients.</i> 	
<ul style="list-style-type: none"> • <i>Produce marketing materials.</i> 	
<ul style="list-style-type: none"> • <i>Speak in favor of ARTAS in conversations with their associates.</i> 	
Send a letter to introduce ARTAS to them:	
<ul style="list-style-type: none"> • Use plain language in the letter so it is easily understood. • Provide information about the intervention, its importance, how it can contribute to the existing system of care and the community partners' work, and what role the community partner might have in the intervention. • Inform them of any upcoming meetings/presentations about ARTAS. 	
Hold a community partner meeting to explain ARTAS, answer questions, and introduce LCs and other key staff.	
Follow up with community partners who could not attend the initial meeting. Schedule a time to give a presentation or hold a luncheon or one-on-one meeting at their agency to introduce ARTAS.	

2. Obtain buy-in from your community partners (cont.)

Obtain their support:

Describe specific roles they could play.

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

Involve them:

Establish memoranda of agreement (MOA) with community partners. Create an MOA with the referral agency that includes an ARTAS-specific referral protocol.

Keep in regular contact with community partners to maintain good relationships with them.

Stay in regular contact with medical providers and long-term case management agencies to which they refer clients.

Continue to educate others about ARTAS during any regularly scheduled meetings of HIV service providers, medical providers, and counseling and testing providers.

Community Partners' Buy-in Worksheet: Health Department

The worksheets contain a list of suggested activities and a column for the staff to record pertinent information, such as key community partners. Examples are provided in *italics*. The activities are in **bold** text, and the steps to complete the activity are listed in the rows shaded in gray.

1. Identify your community partners.	
Potential community partners include:	List your agency's community partners:
State health department staff, including administrators and other key state and local government staff.	
Staff members from your agency who will have a role in the overall implementation and operation of the intervention: <ul style="list-style-type: none"> ● <i>Program director/manager or contracts manager</i> ● <i>Evaluator</i> 	
Local agencies with which you will subcontract to implement the intervention: <ul style="list-style-type: none"> ● <i>Case management providers serving persons with HIV (PWH)</i> ● <i>Community-based organizations (CBOs) serving PWH</i> ● <i>AIDS service organizations (ASOs)</i> ● <i>Other case management providers</i> 	
Staff members from the subcontracting agency who will have a role in the operation of the intervention: <ul style="list-style-type: none"> ● <i>Program director/manager</i> ● <i>Supervisors</i> ● <i>Linkage coordinator (LC)</i> 	
Local agencies from which you could receive referrals: <ul style="list-style-type: none"> ● <i>Health clinics</i> ● <i>Sexually transmitted disease clinics</i> ● <i>Counseling and testing sites</i> ● <i>Hospitals (inpatient)</i> ● <i>CBOs providing HIV prevention services, including counseling and testing</i> ● <i>ASOs</i> ● <i>Walk-in clinics such as urgent care centers or emergency rooms</i> ● <i>Private doctors and private practices</i> ● <i>Correctional system (jails/prisons)</i> ● <i>Drug treatment centers</i> ● <i>Mental health centers</i> ● <i>Other sites with which staff have relationships</i> 	
Medical care providers to whom you could link clients: <ul style="list-style-type: none"> ● <i>Health clinics</i> ● <i>Private doctors</i> ● <i>Other health care providers serving PWH</i> 	

1. Identify your community partners (cont.)	
Long-term case management providers to whom you could transition clients: <ul style="list-style-type: none"> • <i>Ryan White case management providers</i> • <i>Other case management agencies serving PWH</i> 	
Potential community partners include:	List your agency's community partners:
Organizations that could provide other assistance or resources: <ul style="list-style-type: none"> • <i>Other agencies providing support services, such as substance abuse treatment, mental health services, housing assistance, food banks</i> • <i>Agencies that can provide transportation or transportation subsidies</i> • <i>Merchants to provide incentives for clients</i> • <i>Printers and publishers who can produce marketing materials for the intervention</i> 	
Other agencies with which your agency needs to maintain good community or professional relations: <ul style="list-style-type: none"> • <i>Your funding source(s)</i> • <i>Local medical and mental health associations</i> • <i>Community organizations</i> 	
2. Obtain buy-in from your community partners.	
Inform them about the intervention:	
What specific roles do you want each community partner to play (examples below)?	List which community partner you will ask to fill each role:
<ul style="list-style-type: none"> • <i>Refer recently diagnosed, or out-of-care, individuals to the intervention.</i> 	
<ul style="list-style-type: none"> • <i>Be a resource to which you can refer clients.</i> 	
<ul style="list-style-type: none"> • <i>Be a resource to which you can refer clients for long-term case management and/or other services.</i> 	
<ul style="list-style-type: none"> • <i>Donate small incentives or provide transportation subsidies for clients.</i> 	
<ul style="list-style-type: none"> • <i>Produce marketing materials.</i> 	
<ul style="list-style-type: none"> • <i>Speak in favor of ARTAS in conversations with their associates.</i> 	
Send a letter to introduce ARTAS to them:	
<ul style="list-style-type: none"> • <i>Use plain language in the letter so it is easily understood.</i> • <i>Provide information about the intervention, its importance, how it can contribute to the existing system of care and the community partners' work, and what role the community partner might have in the intervention.</i> • <i>Inform them of any upcoming meetings/presentations about ARTAS.</i> 	
Hold a community partner meeting to explain ARTAS, answer questions, and introduce LCs and other key staff.	
Follow up with community partners who could not attend the initial meeting. Schedule a time to give a presentation or hold a luncheon or one-on-one meeting at their agency to introduce ARTAS.	

Obtain their support:
2. Obtain buy-in from your community partners (cont.)
Describe specific roles they could play.
Emphasize the benefits of their involvement and how it will make their work easier. Also emphasize the benefits to the community the agency serves.
Involve them:
Establish memoranda of agreement (MOA) with community partners. Create an MOA with the referral agency that includes an ARTAS-specific referral protocol.
Keep in regular contact with community partners to maintain good relationships with them.
Stay in regular contact with medical providers and long-term case management agencies to which they refer clients.
Continue to educate others about ARTAS during any regularly scheduled meetings of HIV service providers, medical providers, and counseling and testing providers.

B.4 Cost Categories for the Implementation of ARTAS

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

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

Personnel Costs

Personnel categories	Number of personnel needed	Percentage of time spent for pre-implementation	Percentage of time needed for implementation
Program director/manager	1	25–40%	25–40%
Contracts manager	1	25%	25%
Evaluator	1	15%	15%
Supervisor	1	7%	7%
Linkage coordinator (with a caseload of 25–30 clients)	?	100%	100%

(Note: All personnel will also have fringe benefits costs, which vary from agency to agency.)

Facility Costs

Facility categories	Estimated cost (\$)	Percentage used for pre-implementation	Total cost for pre-implementation (estimated cost x % used during pre-implementation)	Percentage used for implementation	Total cost for implementation (estimated cost x % used during implementation)
Office rent					
Utilities (e.g. Internet)					
Telephone/Fax					
Maintenance					
Insurance					

Equipment Costs

Equipment categories	Estimated cost (\$)	Percentage used for pre-implementation	Total cost for pre-implementation (estimated cost x % used during pre-implementation)	Percentage used for implementation	Total cost for implementation (estimated cost x % used during implementation)
Computers					
External microphone or headset					
Cellphone					
Equipment maintenance					

Supply Costs

Supply categories	Cost per unit (\$)	Number needed for pre-implementation	Total cost for pre-implementation (number needed x cost per unit)	Number needed for implementation	Total cost for implementation (number needed x cost per unit)
Copying and printing (per page)					
Paper (per ream)					
Pens (per dozen)					
Client incentives		N/A	N/A		

Marketing and Recruitment Costs

Marketing and recruitment categories	Estimated cost per item (\$)	Number needed for pre-implementation	Total cost for pre-implementation (number needed x cost per unit)	Number needed for implementation	Total cost for implementation (number needed x cost per unit)
Printed brochures					
Printed posters					
Meeting space					
Incentives					

Travel and Transportation Costs

Travel and transportation categories	Estimated cost per mile (\$)	Number of miles traveled for pre-implementation	Total cost for miles traveled for pre-implementation (number needed x cost per mile)	Number of miles traveled for implementation	Total cost for miles traveled for implementation (number needed x cost per mile)
In-person training costs (travel, hotel, transportation to and from training site)					
Linkage coordinator travel to/from client sessions					
Client transportation					

Other Costs

Categories	Estimated cost (\$)	Percentage used for pre-implementation	Total cost for pre-implementation (estimated cost per item x % used during pre-implementation)	Percentage used for implementation	Total cost for implementation (estimated cost per item x % used during implementation)
Indirect costs					
Insurance					
Employee benefits					
Car insurance					

B.5 ARTAS Behavior Change Logic Model

Problem Statement: The priority populations for ARTAS are persons with HIV over the age of 18, who have been recently diagnosed with HIV or are attempting to re-engage in HIV medical care. The primary goal of this intervention is to facilitate linkage (or re-linkage) to medical care for the treatment of HIV as soon as the person is willing. The benefits of ARTAS come from facilitating linkage with medical care which, in turn, results in better health outcomes and improved rates of viral suppression. Viral suppression reduces the risk of transmission. The contextual factors associated with recently diagnosed persons not linking to care include their inability to navigate the system to link to medical care, lack of knowledge about HIV, and lack of information and/or resources about how to access care.

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

B.6 ARTAS Implementation Summary

The **ARTAS Implementation Summary** summarizes *how* the behavior change logic model is intended to be implemented or the central requirements put into practice.

<p style="text-align: center;">INPUTS</p> <p><i>Inputs are the resources needed to implement and conduct intervention activities. Resources include funds, staff, volunteers, facilities, supplies, equipment, training and capacity building assistance (CBA), and policies, plans, and procedures.</i></p>	<p style="text-align: center;">ACTIVITIES</p> <p><i>Activities are the actions required to prepare for and conduct the intervention. There are two sets of activities: those needed to get the intervention started and those needed to implement and conduct intervention activities.</i></p>	<p style="text-align: center;">OUTPUTS</p> <p><i>Outputs are the deliverables or products that result from implementation activities. Outputs provide evidence of service delivery.</i></p>
<p>Experienced and culturally competent staff</p> <p>Agency buy-in</p> <p>Community support of the intervention</p> <p>External training and technical assistance</p> <p>Baseline information about priority population’s behaviors and influencing factors associated with HIV transmission</p>	<p>Closely review the ARTAS implementation manual.</p> <p>Conduct an agency strengths assessment and review policies/procedures to ensure the support of the ARTAS core elements.</p> <p>Identify potential barriers to implementation and possible solutions.</p> <p>Conduct an agency readiness assessment and identify technical assistance needs.</p> <p>Request technical assistance from project officer and/or CBA provider.</p> <p>Hire, train, and build skills of ARTAS staff.</p> <p>Gather baseline data and/or information about priority population rates of linking to care.</p> <p>Amend existing agency policies/procedures as needed or create new ones.</p> <p>Create a marketing plan and materials.</p> <p>Determine client eligibility and recruitment processes.</p> <p>Determine client referral strategies.</p>	<p>Number of staff hired in [time frame]</p> <p>Number of staff trained in [time frame]</p> <p>Number of community partners reached to participate in ARTAS through a memorandum of agreement</p> <p>Percentage of planned number of partners secured in [time frame]</p> <p>Percent increase in community partners providing referrals in [time frame]</p> <p>Number of clients enrolled in ARTAS</p> <p>Percentage of planned number of clients recruited/approached for ARTAS in [time frame]</p> <p>Number of clients referred in from other agencies</p> <p>Number of clients linked to care</p> <p>Percentage of planned number of clients linked to care in [time frame]</p>

<p style="text-align: center;">INPUTS</p> <p><i>Inputs are the resources needed to implement and conduct intervention activities. Resources include funds, staff, volunteers, facilities, supplies, equipment, training and capacity building assistance (CBA), and policies, plans, and procedures.</i></p>	<p style="text-align: center;">ACTIVITIES</p> <p><i>Activities are the actions required to prepare for and conduct the intervention. There are two sets of activities: those needed to get the intervention started and those needed to implement and conduct intervention activities.</i></p>	<p style="text-align: center;">OUTPUTS</p> <p><i>Outputs are the deliverables or products that result from implementation activities. Outputs provide evidence of service delivery.</i></p>
	<p>Educate agency staff about ARTAS.</p> <p>Recruit and educate community partner staff about ARTAS.</p> <p>Inform local public health officials about ARTAS and ask for support.</p> <p>Become familiar with community partners such as clinics and medical providers.</p> <p>Assess need for tailoring or adaptation of intervention.</p> <p>If necessary, tailor and adapt key characteristics of ARTAS and other intervention materials to the priority population.</p> <p>Obtain and use consumer and community community partner input.</p> <p>Develop a monitoring and evaluation (M&E) plan including tools, data collection, data analyses, interpretation, and reporting.</p>	<p>Average number of sessions completed by clients prior to linkage to care</p> <p>Number of clients not linked to care (i.e., attrition rate)</p> <p>Percentage of planned number of clients completing the ARTAS sessions in [time frame]</p> <p>Number of clients referred out to social services</p> <p>Percentage of planned number of clients referred to other social services in [time frame]</p> <p>Percentage of ARTAS clients who were very satisfied/satisfied with ARTAS in [time frame]</p> <p>Percent increase of clients linked to medical care in [time frame]</p> <p>Number and types of non-medical care services clients were referred to (e.g., housing, food, transportation)</p>

B.7 ARTAS Work Plan

The **ARTAS Work Plan** depicts the phase in which each activity listed on the ARTAS Implementation Summary should be conducted. (Note: Several activities are conducted during one or more phases (Pre-implementation, Implementation, and Maintenance)).

Activity	Getting Started	Implementation	Maintenance
Closely review the ARTAS Implementation Manual.			
Conduct an agency strengths assessment and review policies/procedures to ensure the support of the core elements.			
Identify potential barriers to implementation and possible solutions.			
Conduct an agency readiness assessment and identify technical assistance (TA) needs.			
Request TA from project officer and/or capacity building assistance provider.			
Hire, train, and build skills of ARTAS staff.			
Gather baseline data and/or information about priority population rates of linking to care.			
Identify and develop formal partnerships with clinical partners that clients will be referred to for HIV care, including rapid linkage.			
Amend existing policies/procedures as needed or create new policies/procedures.			
Create a marketing plan and materials.			
Determine client eligibility and recruitment process.			
Determine client referral strategies.			
Educate agency staff about ARTAS.			
Recruit and educate community partners.			
Inform local public health officials about ARTAS and ask for support.			
Become familiar with community partners.			
Assess needs for tailoring and adapting.			
If necessary, tailor and adapt the key characteristics of ARTAS and other intervention materials to the priority population.			
Obtain and use consumer and community community partner input.			
Develop a program monitoring and evaluation (M&E) plan.			

B.8 Effective Communication Skills

Effective communication skills are beneficial to building relationships with clients. Techniques can be drawn from other client-centered approaches to counseling, such as motivational interviewing. Techniques to achieve responsive listening include: affirming, reflecting, summarizing, asking open-ended questions, and verbal/nonverbal communication.

Responsive Listening: Communication is a two-way process: speaking and listening. Responsive listening says to a client, *“You are being heard and understood.”*

A responsive listener:

- Concentrates on the client.
- Observes the client’s voice and inflection and pays attention to facial expressions and other nonverbal clues for more insight into what is being communicated.
- Listens without interrupting the client.
- Paraphrases or asks clarifying questions to confirm they understand the client’s intended message (e.g., *“What I heard you say was...is that correct?”* or *“Am I correct by saying that you meant...?”*).
- Provides feedback to the client.

The LC should find ways to overcome certain internal and external barriers to effective listening. Internal barriers include:

- Hearing what is expected, not what is said
- Defensiveness on part of the LC or client
- Stereotyping
- Not seeking clarification about what the client said

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

To assess personal listening skills, the LC may want to take the **Responsive Listening Self-Assessment (Pg. 180)**. The LC can also practice with a trusted colleague or friend and ask them to provide honest feedback. In each client session, it is important for the LC to pay attention to and work on the listening skills they need to improve.

Open-Ended Questions: These are questions that cannot be answered with a brief statement or one-word answers such as “yes” or “no.” Some examples of open-ended questions include:

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

Polite imperatives can be substituted for open-ended questions:

- Tell me about your biggest concern.
- Tell me how you got through that.
- Tell me about your thoughts about linking to medical care.

As with responsive listening, asking open-ended questions takes practice. One good way for the LC to increase their ability to ask open-ended questions is to begin with “what” or “how” when asking questions of a client. Beware: not all “what” or “how” questions are open-ended. An example of a closed-ended question disguised as an open-ended one is:

- What do you want to do now, make an appointment or wait until tomorrow?

Furthermore, just because a question is open-ended does not mean it is a good question. Be careful not to use “why” questions when possible. “Why” questions can be interpreted as judgmental and/or accusatory. Examples of the types of questions to avoid include:

- What makes you so sure that you’ll stay healthy without medical care?
- Why did you think it would be okay to cancel your appointment?
- What are some reasons why a person might ignore their doctor’s advice?

It is sometimes appropriate to ask closed-ended questions, such as when closing out the session. Some other opportunities for closed-ended questions include when confirming the next client session appointment and asking if they would like the LC to call them with a reminder.

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

Affirming responses let the client know the LC is listening (and observing) and provide an opportunity for the LC to support the client’s actions toward linkage to medical care. Some examples of affirmations are:

- *“I appreciate you taking the time to make it here today.”*
- *“You’ve been through a lot, and the fact that you’re taking action shows a great deal of inner strength.”*
- *“This is great! Where did you find all this information?”*

Affirming also provides a chance to elaborate on a strength, resource, or asset. The elaboration can operate in two directions, both of which are effective. When a client shows a **specific** strength, the LC can elaborate by **generalizing**:

- *“You got here early again. You’re a punctual person.”*

When the client shows or mentions a more **general** strength, the LC’s elaboration can help the client see how that strength can be put to a **specific use**:

- *“You’re very persistent. I bet that will come in handy when you go to the clinic next week.”*

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

LC: *“It took a lot of planning and effort to make it to your first clinic appointment. You did well.”* [Affirmation of effort]

Client: *“Anyone could do that.”* [Minimizing effort]

LC: *“Well, I don’t know. I know people who wouldn’t have had the energy or foresight to get the bus schedules, plan for someone to watch their kids, find a friend with a car when the bus didn’t show up, and remind the receptionist about their appointment time when she didn’t call their name... You’re really persistent.”* [Affirmation of both effort and the personal quality of persistence]

Client: *“My parents taught me that.”* [Accepting affirmation of effort, but minimizing responsibility for the persistence asset]

LC: *“Well, they were good teachers and you turned out to be a very persistent person.”* [Notice the LC’s use of the present tense, reaffirming the personal asset]

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

Client: *“My boyfriend is going to be really upset.”*

LC: *“Your boyfriend is going to be upset when you tell him about your test results.”*

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

Client: *“My boyfriend is going to be really upset.”*

LC: *“You’re worried about what he might do.”*

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

Client: *“My boyfriend is going to be really upset.”*

LC: *“Are you worried about that?”*

Now the client is likely to defend being worried or not worried, rather than continuing to

speaking freely about the relationship or the anticipated problem. In general, reflective statements are less likely to generate a defensive response. The LC can provide the impetus for the client's further exploration by slightly understating what the client has said. For example:

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

LC: *"This is pretty rough."*

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

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

Summarizing: Summarizing is the practice of restating or reframing what the client says, usually in a condensed form. Summarizing is used to:

- Reinforce motivational statements or talk about making a change to current behavior.
- Call attention to elements of resistance, ambivalence, or reluctance to seeking treatment.
- Check for accuracy.
- Move toward a plan to change, if appropriate.

Below is a sample dialogue using the summarizing technique:

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

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

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

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

Try summarizing if you feel stuck or if you lose track of what the client is saying.

This method allows the LC to assess their understanding of the client's problem or statement and tells the client they are paying attention. For example: "Excuse me. You're touching on some really important issues, and I want to make sure I don't miss anything. First, you said that... And then... Next, you talked a little about... Is that right so far?"

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

Verbal and Nonverbal Communication: Effective communication includes understanding both verbal and nonverbal communication. Examples of effective verbal communication include good volume and a friendly tone. Nonverbal communication includes:

- Nodding in agreement
- Fidgeting
- Eye contact (or no eye contact)
- Body posture
- Hand gestures
- Facial expressions

Use silence as a part of the LC's communication repertoire. CMs, including LCs, are usually active communicators. This is an important, useful quality. However, silence is also a powerful stimulus that can lead clients to important expressions of thought or emotion. If the client is getting too uncomfortable with the silence, use a simple reflection (e.g., "This is really hard for you to talk about...") and then try more silence. Silence can indicate that the LC's statement has had an effect on the client, and the client is trying to process this information.

Use confirmations to let the client know the LC is listening when a client is speaking freely and the LC is confident that they do not need to provide verbal feedback. Common confirmation responses include head nods, maintaining eye contact, or brief verbal confirmations such as "Okay," "Yeah," "Mm hm," and "I see."

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

Responsive Listening Self-Assessment Tool

Instructions: Review each skill and place a check in the column that best indicates how often the LC actually uses this listening skill when talking with others. This is a self-assessment, so be honest. After completing this self-assessment, role-play a client scenario with a close friend or colleague and ask them to complete this same assessment. Then, compare their results with the self-assessment. Their feedback will help the LC identify strengths and the skills used regularly. The results of this tool will also help the LC identify what skills are not being used so they can be improved upon. Practice strengths and improvement areas with each ARTAS client.

Skill	Usually Do	Sometimes Do	Should Do More Often
1. I try to make others feel at ease when I am talking with them.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. When I listen, I can separate my own ideas and thoughts from the person who is speaking to me and be unbiased.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I can listen to others with whom I disagree.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I observe others' verbal and nonverbal behaviors.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I let others finish speaking before I begin.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I listen to what others say rather than assuming that I know what they are going to say.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. As I listen, I try to understand how others are feeling.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. I ask others to clarify or repeat information when I am unsure what was meant.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I can remember the important details of what others tell me during conversations.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I restate information to make sure that I understood it correctly.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. I try to focus on what others are saying and give them my full attention.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Adapted from a 2005 manual developed by the Federal Emergency Management Agency (FEMA).

B.9 Agency/Clinic Need-to-Know Information Form

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

1. What services does the agency/clinic offer? **(Check all that apply):**

- | | |
|--|--|
| <input type="checkbox"/> General health care | <input type="checkbox"/> Benefits management and insurance navigation |
| <input type="checkbox"/> Mental health treatment | <input type="checkbox"/> Housing referrals |
| <input type="checkbox"/> Substance abuse treatment | <input type="checkbox"/> Dental services |
| <input type="checkbox"/> Syringe services | <input type="checkbox"/> Domestic violence counseling |
| <input type="checkbox"/> HIV-related medical care | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> HIV prevention | <input type="checkbox"/> Telehealth services |
| <input type="checkbox"/> PrEP | <input type="checkbox"/> Gender-affirming services and hormone therapy |
| <input type="checkbox"/> Condom distribution | <input type="checkbox"/> Others (please specify) |
| <input type="checkbox"/> Navigation services | |
| <input type="checkbox"/> HIV testing | |

2. Does your agency (or you personally) have an existing relationship with this agency/clinic and/or its staff? (Yes or No) _____

If yes:

- What is the nature of the relationship?
- Is the relationship a strong and effective one?
- What are the areas for improvement?
- Who has the responsibility (or capability) to create opportunities to improve the relationship?

3. Is the agency able to receive new clients? (Yes or No) _____

4. What is the clinic/agency's eligibility criteria?

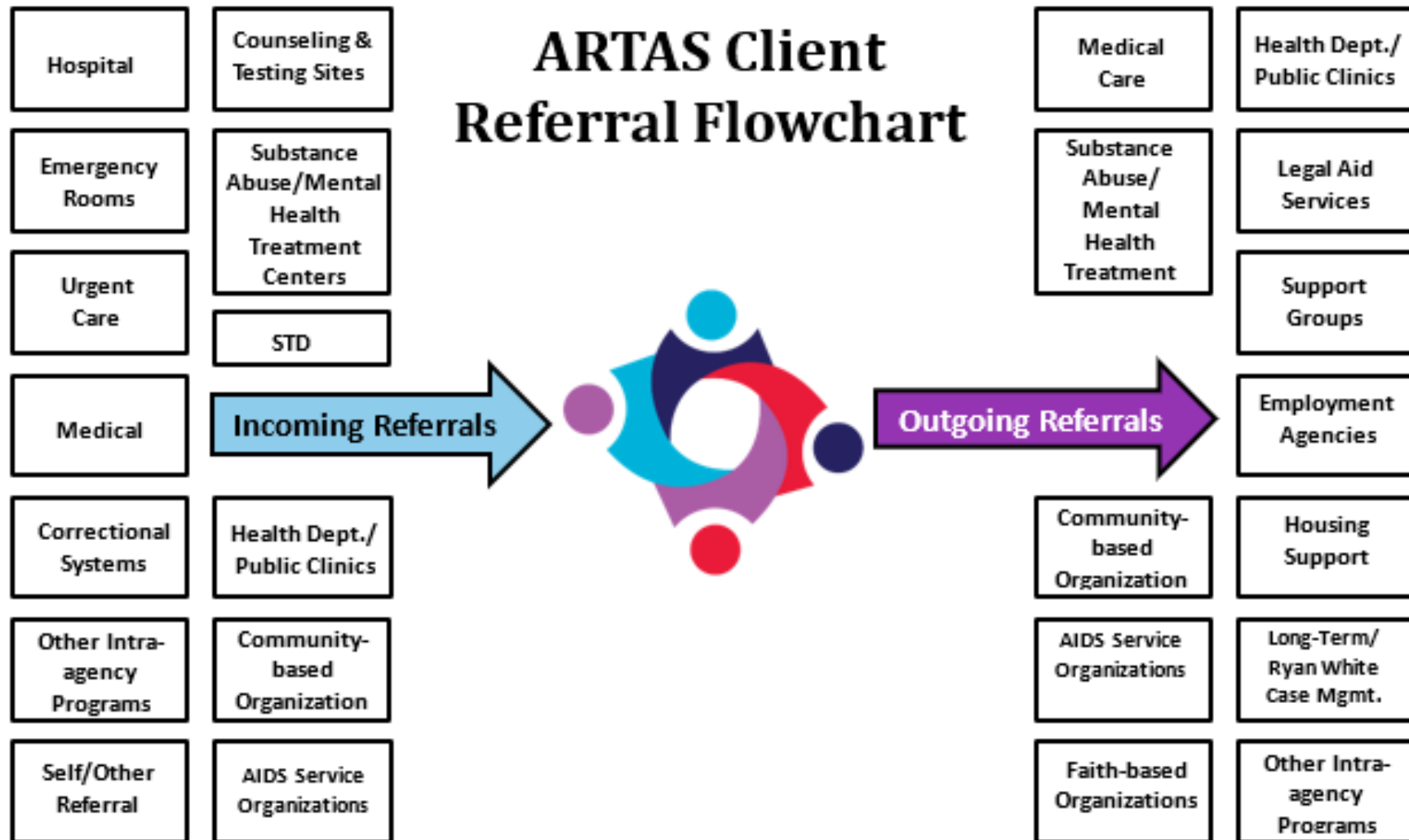
5. What populations does the agency serve (e.g., persons who use substances, Hispanic or Latino persons, women)?

6. How soon are new clients seen by the agency?

7. What partner agency activities or policies may conflict with the core elements of ARTAS (i.e., building an effective working relationship between the LC and each client, focusing on the client's strengths, facilitating the client's ability to identify and pursue their own goals, and maintaining a client-driven approach)?

8. What activities or policies may conflict with the strengths-based nature of ARTAS and impede its successful implementation?
9. Does the agency/clinic have policies or procedures that are not supportive of ARTAS implementation? Do any policies and procedures interfere with the establishment of a collaborative, trusting relationship compatible with a strengths-based, client-centered approach?
 - a. If yes, list those policies and procedures here:
10. What are the clinic/agency's hours? Do they have nontraditional hours (i.e., evenings and weekends)?
11. Are there specific days of the week or times of the day that are typically less busy than others?
12. What personal documents (e.g., identification [government-issued ID, driver's license] and insurance eligibility and/or documentation) are required from clients to successfully apply for services?

B.10 ARTAS Client Referral Flowchart



B.11 Memorandum of Agreement Template

The following template is a guide to assist your agency in the creation of a memorandum of agreement (MOA) with your community partners. This includes community partners for both incoming and outgoing referrals, as discussed in the Pre-Implementation and Implementation sections of the Implementation Manual. Developing an MOA allows agencies to address potential problem areas, save time, and avoid misunderstandings.

The MOA will typically consist of two main sections:

- a. Agency Responsibilities
- b. Points of Contact

In the template beginning on the next page, the text in *italics* provides directions to follow when writing an MOA with a community partner. All other text provides guidance on what to include in each section. All information entered should be as detailed as possible, including but not limited to due dates, person responsible, etc.

Memorandum of Agreement

Between
[INSERT NAME: ARTAS Implementing Agency]
AND
[INSERT NAME: Partner Agency]

Purpose: The Memorandum of Agreement (MOA) begins with a statement explaining its purpose. Generally, the purpose is to clearly define each agency's roles and responsibilities in implementing the Antiretroviral Treatment and Access to Services (ARTAS) intervention.

A. Agency Responsibilities

In this section, define the responsibilities of the ARTAS implementing agency and the partner agency. Below are some suggested responsibilities, but the implementing agency should expand this list according to its needs. The responsibilities of the partner agency will also vary based on whether the partnership is for incoming or outgoing referrals.

Both parties will:

- Implement the core elements of ARTAS with fidelity.
- Agree to collaborate for successful implementation of the intervention.

Partner agency will:

(Incoming Referral)

- Have an in-depth understanding of ARTAS and be able to educate each client about the intervention.
- Refer all clients to ARTAS by following the documented ARTAS referral protocol.
- Inform [INSERT NAME: Implementing Agency] of any staff changes that will affect the referral process.

(Outgoing Referral)

- Have an in-depth understanding of ARTAS.
- Report back to the linkage coordinator (LC) on any client referrals on a monthly basis.
- Inform [INSERT NAME: Implementing Agency] of any staff changes that will affect the referral process.

[INSERT NAME: ARTAS Implementing Agency] will:

- Educate [INSERT NAME: Partner Agency] about ARTAS.
- Document the referral protocol in writing, specifying each agency's role, and ensure that [INSERT NAME: Partner Agency] understands the process.
- LC will regularly (at intervals determined by the implementing agency) visit [INSERT NAME: Partner Agency] to review ARTAS and the referral process. At this time, LC will assess the need for any additional materials and/or any staffing changes that will affect the referral process.
- LC will become familiar with any formal and informal processes of [INSERT NAME:

Partner Agency] that affect referrals and/or client care.

- For incoming referrals: LC will update [INSERT NAME: Partner Agency] about the client’s status at the end of ARTAS (e.g., linked to care).
- For outgoing referrals: LC will inform [INSERT NAME: Partner Agency] when a client is referred to the agency.

B. Points of Contact

This section should list which individuals will serve as contacts for each agency for communication related to this MOA. These individuals should include, but are not limited to:

- ARTAS project director
- LC(s)
- Representative from partner organization

Confidentiality

The MOA should address issues of confidentiality that will arise during the course of ARTAS. It is likely that agencies will already have confidentiality policies in place, but this section should reiterate those most important to ARTAS. It is also important to include any policies that may be an extension of or adaptation to existing agency policies.

Some points to include in this section are:

- Confidential information (such as client records) can be shared between the implementing and partner agency only with written consent from the client.
- The implementing and partner agencies will safeguard the use of and access to all client information.
- Reasonable steps must be taken to ensure that client records are stored in a secure location and are not available to unauthorized persons. Client records should be transferred or disposed of in a manner that protects confidentiality and is consistent with state or local laws governing patient records.

Agencies should adapt this section to reflect the confidentiality issues they face in implementing ARTAS.

Effective Date of Agreement

In this section, specify when the MOA becomes effective (generally upon the signature of both agencies), for how long (generally a period of one year), and how the agreement can be modified or terminated.

Agreed:

 (Signature ARTAS Project Director)

 (Title)

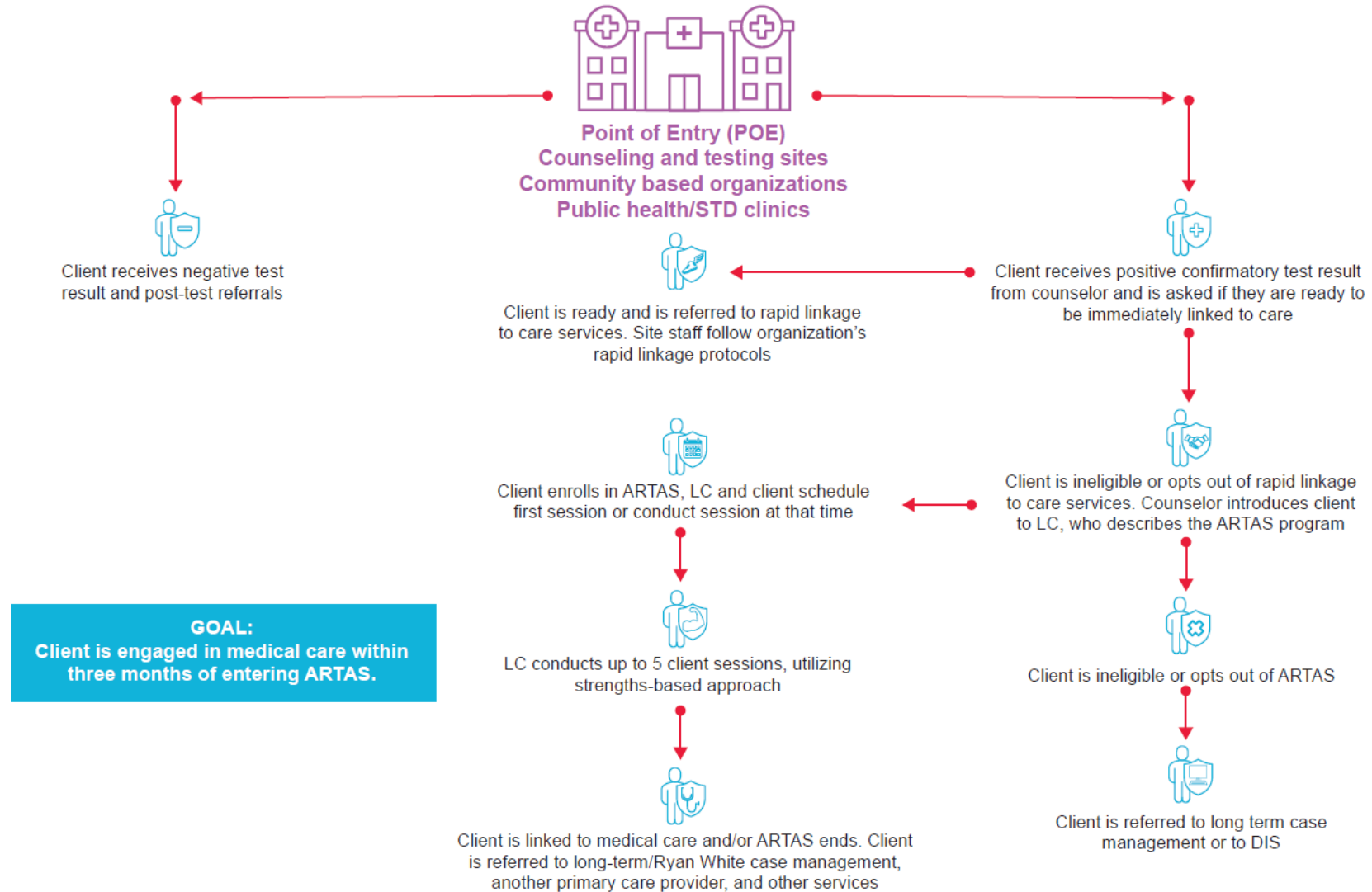
 (Date)

 (Signature Partner Agency Representative)

 (Title)

 (Date)

B.12 Suggested Client Enrollment Flow Process



B.13 Community Mapping

Community mapping is the process of cataloging the resources in a community. With respect to ARTAS, the resources to be identified are community partners that can either refer clients to ARTAS for short-term case management to get linked to care or provide medical care and long-term case management to ARTAS clients. To identify these resources, the LC will conduct research in the community or identify existing resource inventories that may need to be updated.

The Community Asset Inventory Tool below has been developed for the LC to use when identifying relevant assets in the community.

Community Asset Inventory Tool

Organization Name	Contact Person	Phone/Fax/Email	Services Provided	Hours of Operation	Eligibility Requirements	Other

Appendix C: Monitoring and Evaluation Forms

C.1 ARTAS Fidelity Assessment Quarterly Report Template

Core Elements	Achieved=0 Modified=1 Dropped=2	Explanation (indicate <i>how</i> and <i>why</i> any of the core elements were modified or dropped)
1. Build an effective, working relationship between the linkage coordinator (LC) and each client.		
2. Focus on the client's strengths, not weaknesses, by: a. Conducting a strengths assessment. b. Encouraging each client to identify and use their strengths, abilities, and skills to link to medical care and accomplish other goals.		
3. Facilitate the client's ability to: a. Identify and pursue their own goals, whatever they may be. b. Develop a step-by-step plan to accomplish those goals using the ARTAS Session Plan.		
4. Maintain a client-driven approach by: a. Conducting between one and five structured sessions with each client. b. Conducting active, community-based case management by meeting each client in their environment and outside the office, whenever possible. c. Coordinating and linking each client to available community resources, both formal sources (e.g., housing agencies, food banks) and informal sources (e.g., friends, support groups, spiritual groups) based on each client's needs. d. Advocating on each client's behalf, as needed, to link them to medical care and/or other needed services.		

NOTE: In using this template, please indicate whether any of the core elements have been completed, modified, or dropped by putting the appropriate number in the middle column. In the right column, explain how and why any of the core elements were modified or why they were dropped. **Remember that the four core elements cannot be added to, modified, or deleted. If so, the agency is not implementing the ARTAS intervention.**

If there are zeroes (0) in every row, ARTAS is being implemented with fidelity, and the agency does not have to make adjustments to activities based on the core elements. **If there is a one (1) or two (2) in the middle column for any of the rows, ARTAS is not being implemented and changes must be made immediately.** Adjust the key characteristics, activities, and policies based on the explanations provided in the third column. For additional assistance, please contact the implementing agency's evaluator, project officer, and/or capacity building assistance provider to make the necessary adjustments to successfully implement ARTAS. Be sure to document all adjustments in the M&E plan and data collection activities.

C.2 ARTAS Performance Process Indicator Form

Note that the process objectives listed are simply suggestions; **the implementing agency is encouraged to modify them to meet its needs.** For all forms, please add or delete rows and columns as needed.

Linkage Coordinator (LC) Name: _____

Date Completed: _____

Process Objective 1: To conduct a minimum of four in-person client visits per week per LC. If you have more than four visits (not including phone communication), please insert rows and add client IDs. Please list all appointments and no-shows as well as emergency visits.

Client ID	Scheduled Appointment	Emergency Appointment	No-Show or Reschedule	Completed Appointment	Barriers or Additional Comments
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Total					

Process Objective 2: To coordinate needed services to meet the immediate needs of ARTAS clients.

Client ID	Coordinated Services List	Referral Made?	Follow-Up	Barriers or Additional Comments
		<input type="checkbox"/>	<input type="checkbox"/> Date: ___ / ___ / ___	
		<input type="checkbox"/>	<input type="checkbox"/> Date: ___ / ___ / ___	
		<input type="checkbox"/>	<input type="checkbox"/> Date: ___ / ___ / ___	
		<input type="checkbox"/>	<input type="checkbox"/> Date: ___ / ___ / ___	
Total				

Process Objective 3: Link new clients to care within five sessions or 90 days. Add all client IDs of clients whom you linked to medical care this week.

Client ID	Date of Medical Appointment	Cancelled/No-Show	Completed Appointment	Disengagement Plan	Barriers or Additional Comments
	___/___/___ Time:	<input type="checkbox"/>	<input type="checkbox"/>		
	___/___/___ Time:	<input type="checkbox"/>	<input type="checkbox"/>		
	___/___/___ Time:	<input type="checkbox"/>	<input type="checkbox"/>		
Weekly Total					
Cumulative Total					

Process Objective 4: Conduct six-month follow-up evaluation (according to schedule), if applicable for your agency.

Client ID	Date Follow-Up Due	Achieved	Not Achieved	Barriers or Additional Comments
		<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	
Weekly Total				
Cumulative Total				

Process Objective 5: Complete data entry on all clients for the week by close of business Friday.

Data Entered	Data Complete	What Items Are Incomplete?	Total Time Spent on Data Entry	Barriers or Additional Comments
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes			
<input type="checkbox"/> No	<input type="checkbox"/> No			

Adapted from the Virginia Department of Health's POWER Program.

C.3 ARTAS Partner Tracking and Recruitment Process Indicator Form

Note that the process objectives listed are suggestions; **the implementing agency is encouraged to modify them to meet its needs.** For all forms, please add or delete rows and columns as needed.

Linkage Coordinator (LC) Name: _____

Date Completed: _____

Process Objective 1: To conduct two in-person meetings per month with community partners' staff and distribute informational materials.

Site Location	Achieved	Not Achieved	Barriers	Additional Comments	Materials Distributed	Number of Materials Distributed
	<input type="checkbox"/>	<input type="checkbox"/>				
	<input type="checkbox"/>	<input type="checkbox"/>				
	<input type="checkbox"/>	<input type="checkbox"/>				
	<input type="checkbox"/>	<input type="checkbox"/>				
	<input type="checkbox"/>	<input type="checkbox"/>				
Monthly Total						
Cumulative Total to Date						

Process Objective 2: To call or visit each community partner (referral site) twice a month to check for referrals and other agency needs (e.g., distribute brochures, answer questions).

Site Location	Achieved	Not Achieved	Barriers	Additional Comments	Materials Needed and Quantity	Referrals Made?
	<input type="checkbox"/>	<input type="checkbox"/>				
	<input type="checkbox"/>	<input type="checkbox"/>				
Monthly Total						
Cumulative Total to Date						

Process Objective 3: To recruit four new community partners (either incoming or outgoing referrals) per year.

Site Name/Location	Achieved	Not Achieved	Barriers	Additional Comments
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
Yearly Total				
Cumulative Total to Date				

Adapted from the Virginia Department of Health's POWER Program