



# Bridge Counseling

Bi-monthly meeting with all Ryan White  
Regional Network of Care  
funded and non-funded partners.

Established Partnership Community Health  
and Ryan White  
- Not limited to medical and other  
healthcare services  
- Address the care and attention to the  
community as a

• Clients  
• Providers  
• Community Health Workers  
• Community Health Promoters

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This model successfully helps clients make  
changes because it emphasizes one's abilities to  
address barriers rather than one's inabilities

If not located, the Medical Assistant contacts case  
managers who might have more information about  
individual cases:  
• Has an appointment scheduled  
• Is still in the nurse-patient bar  
• Incomplete  
• Deceased  
• Cannot be located

Bridge Counseling is:  
Assisting HIV positive clients obtain or  
re-establish primary care. A State Bridge  
Counselor (SBC) collaborates with Regional HIV  
Care Network partners to work with newly  
diagnosed clients or those who have dropped out  
of care.

Region 1-Rural Western North Carolina  
Michelle Huggins, Lead DIS/State Bridge Counselor  
FQHC serves 685 HIV+ Clients  
Asheville, NC

SBCs & Newly Diagnosed  
DIS work to refer these individuals into care  
SBC follows patient to ensure individual attends first  
appointment with a prescribing provider

Bridge Counseling Process  
• The clinic runs a "No Service in 180 days" report  
• List is cross referenced with the CAREWare report  
• Medical assistant attempts to contact the patient directly

SBCs & Newly Diagnosed  
DIS work to refer these individuals into care  
SBC follows patient to ensure individual attends first  
appointment with a prescribing provider  
CARE = RETENTION + PREVENTION  
with Community

Regionally  
Bi-monthly meetings  
funded and no



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180 days\* report



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## Bridge Counseling Process

- The clinic runs a "No Service in 180 days" report
- List is cross referenced with the CAREWare report
- Medical assistant attempts to contact the patient directly

If not located, the Medical Assistant contacts case managers who might have more information about individual cases:

- Has an appointment scheduled
- Is still in the service area but no appointment scheduled
- Incarcerated
- Deceased
- Cannot be located

# Regional Network of Care

Bi-monthly meeting with all Ryan White funded and non-funded partners.

After each Network meeting,  
a Retention/Bridge  
Counseling Meeting follows

The list of patients that Local Bridge Counselors are unable to locate is turned over to the State Bridge Counselor for more intensive retention/re-engagement activities.

If contact is successful, SBCs assist the individual in resolving barriers to care through Strength Based Case Management Model

This model successfully helps clients make changes because it emphasizes one's abilities to address barriers rather than one's inabilities

## Established Protocol with Community Partners

SBCs and the RNOC work closely as a team to ensure:

- fast tracking of medical and case management services
- barriers to care are addressed i.e. lack of transportation, etc.

# SBCs & Newly Diagnosed

DIS work to refer these individuals into care

SBC follows patient to ensure individual attends first appointment with a prescribing provider

CARE + RETENTION = PREVENTION

Collaboration  
with Community

