Missouri HIV Lost to Care, Retention in Care & Peer Navigation (LRPN) Manual

Revised December 1, 2021

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Section 1.0: Program Overview

1.0 Program Overview

1.1 Lost to Care, Retention to Care, and Peer Navigation (LRPN) Manual Purpose

The LRPN Manual establishes policies and procedures for Ryan White LRPN Case Management (CM) services within Missouri. The LRPN Manual is an evolving document that works in conjunction with the Missouri HIV Medical Case Management Manual and Statewide Services Manual. This manual will focus on LRPN staff members' performance standards and the delivery of quality services provided to clients.

1.2 LRPN Purpose

The Department of Health and Senior Services (DHSS), Division of Community and Public Health, Disease, Bureau of HIV, STD, and Hepatitis (BHSH) is the responsible entity for the HIV LRPN program. The HIV LRPN services were established to address the ongoing epidemic of HIV infection in Missouri by ensuring that clients maintain their medical care, continue to reduce viral loads, and re-engage in care. The HIV LRPN program identifies and seeks to mitigate social determinants of health, including stigma, poverty, education, housing, transportation, gender orientation, access to healthcare services, etc. Each region may customize its exact service delivery standards based on client needs and agency resources.

1.3 LRPN Definitions

1. Lost to Care
    a. Lost to Care is defined as not receiving any HIV medical care or having at least one CD4 cell count or viral load test performed during the year of evaluation.

2. Retention in Care
    a. Retention in Care is defined as a patient's regular engagement with medical care at a health care facility after initial entry into the system.
    b. Critical factors in determining retention are as follows:
        i. **Missed appointments:** Capturing the number of missed appointments during a specified time period.
        ii. **Appointment Adherence:** Calculating the number of completed visits by the number of total scheduled visits.
        iii. **Visit Constancy:** The proportion of time intervals with at least one completed visit during an observation period.
        iv. **Gaps in Care:** Time interval between completed clinic visits.

3. Peer Navigation
    a. A Peer Navigator differs from the role of Case Manager due to them having personal experience and possessing the following qualifications:
        i. Be living with HIV,
        ii. Be twenty-one (21) years of age or older,
        iii. Possess a high school diploma or GED,
        iv. Have a minimum of one (1) year of experience in HIV care, HIV prevention, or a related field,
        v. Possess experience in providing HIV peer education, HIV-related volunteer work, HIV community outreach, or completion of a peer leadership training program.

1.4 Goal and Description

1. HIV LRPN programs will utilize surveillance, community referrals, and other data provided by DHSS to identify individuals who are at an increased risk of dropping out of HIV medical care and those who are already Lost to Care.
    a. HIV LRPN programs will ensure that people living with HIV can be successfully linked to and/or retained in HIV medical care services within 90 days of enrollment in LRPN. The intent is to identify and address health disparities and social and structural factors that may impact individual engagement in care. LRPN services will be offered at various ranges of intensity based on the needs of the client.
    b. HIV LRPN Program staff will provide a range of client-centered services to retain and re-engage clients in HIV medical care. HIV LRPN Service programs will:
        i. Provide clients with information, skills, and services needed to access and successfully navigate the HIV medical care system.
        ii. Support client access to comprehensive care, including prevention education, psychosocial services (mental health and substance use disorder treatment), housing, and employment assistance.
        iii. Build client self-management skills to support linkage to and retention in care.
        iv. Work closely with local disease intervention specialists and state agency surveillance staff to identify, locate, and re-engage individuals lost to HIV care.
        v. Provide any other needed client services along the HIV continuum of care.

1.5 Eligibility Criteria

1. Eligibility criteria for engagement in HIV Case Management must meet federal and programmatic requirements. Eligibility criteria allow the HIV Case Management System to serve clients and assure that resources are used efficiently and effectively.
    a. The following are the eligibility criteria necessary to be enrolled in the LRPN Service program:
        i. Diagnosed with HIV,
        ii. Be a resident of the state of Missouri,
        iii. 300% or below Federal Poverty Level (FPL), and
        iv. Not currently in HIV medical care (out of care for six (6) months or more)

Note: Certain regions' eligibility may include clients at risk of being lost to HIV medical care.

1.6 MO Ryan White Case Management Expectations

1. In alignment with Missouri HIV case management standards, LRPN case managers are expected to abide by the following policies and procedures outlined in *The Missouri HIV Case Management Manual*. Please refer to the manual for guidance.
    a. Initial Contact
    b. Intake Standard
    c. Enrollment Standard
    d. MCMAT/Service Plan
    e. Supervision and Quality Reporting

2. Due to the specific needs of LRPN clients, LRPN case managers may be expected to follow additional policies and procedures to re-engage clients in HIV medical care. Please refer to the following subsections in this manual for guidance on LRPN policies and procedures.
    a. 2.0 Initial Contact
    b. 3.0 Enrollment Standard
    c. 4.0 Supervision and Quality Reporting

2.0: Initial Contact

2.0 Initial Contact

2.1 Referral Sources

1. Referral source refers to the entity notifying the LRPN program or staff of a person who needs LRPN services. Referral sources may include, but are not limited to:
    a. Local and State Surveillance
    b. Linkage to Care Program*****
    c. Intake Coordinator*
    d. Case Management
    e. Disease Intervention Specialists (includes DHSS EHE Coordinators)
    f. Epidemiology Specialists
    g. Local Agencies/Healthcare Providers
    h. Hospitals
    i. Self-referral
    j. Local and County Jails
    k. Medical Providers

2.2 Referral Process

1. LRPN CM will respond to referrals sources and/or clients **within two (2)** business days.
2. Once a client has been referred, an LRPN referral will be entered into the electronic client database. The LRPN referral status will remain in 1RFR until eligibility documents have been obtained.
3. If already enrolled in Ryan White Case Management, the LRPN referral can be placed in 8ENR status. LRPN staff will document under the specialty referral.
4. If not already enrolled in Ryan White Case Management, an Intake must be completed.

***NOTE**: Referral sites may vary by region.

3.0 Enrollment Standard

3.1 Enrollment

1. Complete all enrollment paperwork **within 30 days** of intake if the client is not active in case management. If the client does not enroll before the expiration of the Intake service referral, the referral may be extended for an additional thirty (30) days in accordance with the Intake Standard policy and procedures.
2. Assess client's access to health care coverage. If the client does not have active health insurance coverage, assist the client in accessing eligible health insurance coverage.
3. Discuss and provide the client with information on available facilities and providers for HIV medical care.
4. Establish where the client will receive HIV medical care.
5. Educate client on expectations at medical appointment and request approval to attend.
6. Schedule an HIV medical appointment and develop a plan for attendance with the LRPN case manager and/or peer navigator, if possible.
7. Provide HIV education, information on resources such as prevention for positives, and address client concerns.
8. Make additional community resource referrals as needed.
9. Clients Currently **Active** in Case Management
    a. Enter the LRPN Service Referral in 8ENR status with an end date that aligns with the CM service referral end date.
10. Clients **Not Active** in Case Management
    a. The LRPN Case Manager is responsible for completing enrollment into Ryan White Case Management in accordance with the Enrollment Standard policies and procedures.
    b. Change the LRPN Service Referral status to 8ENR with an end date that aligns with the CM service referral end date after enrollment.

3.2 MCMAT/Service Plan

1. For clients not enrolled in case management, the LRPN case manager will complete the MCMAT. If they are already enrolled, the LRPN case manager will review the MCMAT with the client.
2. The Case Manager and client will collaborate to develop an Individual Service Plan (ISP) that focuses on the client's engagement in care. The service plan must include either the HEALTH-Adherence (Medication and Treatment) and/or HEALTH- Health Status/Medical Care ISP item and identify actions and interventions that will be performed to address client-identified barriers.
3. Discuss Areas of Assessment and previous challenges that have led to difficulty maintaining care.

3.3 Transfers

1. Once a client is considered engaged in HIV medical care and is ready to transfer out of the LRPN program, the LRPN case manager will inform the client of the transfer process and options for where to receive HIV Case Management or other support services. Decisions for transfer should consider the client's input and needs, the type of facility the client prefers, and any challenges accessing care, including language.
2. Refer to regional transfer policies for transfer processes and expectations.

4.0: Timeline Objectives

4.0 Timeline Objectives

4.1 Timeline Objectives (After Intake and Case Assignment)

1. First 2 Days
    a. Attempt initial contact with the client.
    b. The Initial Contact will occur within 2 (two) days of the client's assignment to the CM, and the Initial Contact Encounter notes will include a description of the encounter type that occurred.

2. First 7 days
    a. New To Case Management
        i. Schedule an appointment with the client.
        ii. Enroll the client in the LRPN program.
        iii. Enter a Lost/Retention/Peer Navigation Program - DHSS referral.
    b. Transferring to LRPN from Case Management
        i. Schedule an appointment with the client.
        ii. Enter a Lost/Retention/Peer Navigation Program - DHSS referral.

3. First 30 days

    a. Ensure the client is enrolled in case management (if applicable).
    b. Make referrals to other programs and services as needed.
    c. Introduction to the Lost to Care team and Peer or Community Health Nurse (if applicable).
    d. Assist clients with scheduling medical appointments.
    e. Comprehensive HIV medication adherence counseling and education will be provided at enrollment and ongoing to reinforce and encourage medication adherence.
    f. Provide education on the following:
        i. HIV 101
        ii. Treatment Adherence
        iii. Undetectable equals Untransmittable (U=U)
        iv. CD 4 and Viral Loads
        v. Harm Reduction
            1. Modes of Transmission
    d. First 90 days (after initial contact is established)
        i. Attend HIV medical appointment(s) with client and schedule follow-up appointments.
        ii. Ensure CD4 and viral load labs are obtained and entered into the electronic client database.
    e. Prior to the end of the program, the following must be completed:

i. Education on levels of support and goals of the program with Missouri Ryan White System.
ii. Coordinate meetings to introduce the client to the new CM.
iii. Complete a transfer to medical case management or other programs as needed once engagement is established by the client. Clients are considered engaged in HIV medical care with the evidence of 2 labs and/or medical visits (at least 90 days apart) in the past year.

Section 5.0: Quality Management

5.0 Supervision and Quality Reporting

5.1 Quality Goals for LRPN Program

1. **Goal 1**: Link clients to verified medical care **<u>within 90 days</u>** of enrollment.
    a. Verified Medical Care Visit is defined as an HIV medical appointment attended by the client with a care provider with prescribing privileges or CD4 and Viral Load labs (Physician or Nurse Practitioner).
        1. Verified Medical Care visits within the first 90 days must be documented in the SCOUT database.
    b. Quality measures are in place to promote and track practices that will help retain clients in care by:
        i. Responding to referrals to the LRPN program
        ii. Attending HIV Medical Appointments with the client. LRPN Case Managers will document in SCOUT any medical appointments attended with the client under the J10.2M Medical Visit (Accompanied Client).

2. **Goal 2**: Engagement in HIV Medical Care
    a. Successful engagement in care will be evidenced by two (2) labs and/or medical visits (at least 90 days apart) within a 12-month time period.
    b. Verified Medical Care visits must be documented in the SCOUT database.