# State of Missouri
# HIV Linkage to Care Service Manual


Developed by Missouri Ryan White Part A, Part B, Part C, and Part D Statewide Managers Meeting Representative

Release Date: **October 1, 2023**

# Linkage to Care Service Manual

## Table of Contents

# Section 1.0 Program Overview

## 1.1 Linkage to Care Manual Purpose

The Linkage to Care Manual establishes the policies and procedures for Ryan White Linkage to Care Case Management services within the state of Missouri. The Linkage to Care Manual is an evolving document that works in conjunction with the Missouri HIV Case Management Manual and Statewide Services Manual. This manual will focus on performance standards for Linkage to Care Coordinators and the delivery of quality services provided to clients newly diagnosed with HIV. For the purpose of this manual, Linkage to Care Coordinator refers to designated staff working as an agent for the Linkage to Care Program.

## 1.2 Linkage to Care Model

Linkage to Care (LTC) is a strengths-based, intensive, short-term Medical Case Management program in the Ryan White HIV Care system of services. The purpose of LTC is to link clients who are newly diagnosed with HIV to medical care.

LTC Case Management is structured to be delivered through multiple face-to-face client interactions. LTC will provide coordination and linkage to support services for clients newly diagnosed with HIV for a minimum of 90 days prior to being transferred to general case management or a specialty program. The Linkage to Care Model may be utilized for clients who have never engaged in care or who need to reestablish care.

## 1.3 Program Description

LTC is an intensive case management program for clients who are newly diagnosed with HIV with the primary objective of *establishing medical care.*

1. The LTC program assists clients in overcoming initial barriers to engaging in medical care to achieve its primary objectives of linkage to and successful engagement in medical care.
2. The goal of the LTC Program is complete a minimum of one lab visit and one verified medical care visit with an HIV care provider with prescribing privileges (physician or nurse practitioner) within 90 days of diagnosis (see Section 5).
    a. The Missouri Part B standard is to complete this task within 30 days,
3. The LTC program utilizes a ‘gradual disengagement’ model in which LTC Coordinators provide frequent, in-depth, and supportive contact during the first half of the program, and gradually decrease frequency of contact and active assistance in the latter half of the program while assisting clients in building their self-management and self-advocacy skills. LTC Coordinators explain the program objective of establishing medical care and framework of gradual disengagement to clients routinely throughout the program.
4. The LTC program is designed to help clients accomplish the specific objective of engaging in HIV medical care. The following LTC medical case management interventions are in place to facilitate engagement in care by assisting the client with:
    a. Short-term acceptance of their HIV-positive status.

   b. Identifying personal strengths to facilitate engagement into HIV Medical Care
   c. Identifying both individual and system barriers that may impact engagement into HIV Medical Care.
   d. Develop and carry out a plan for overcoming barriers to engagement into HIV Medical Care.
5. The Linkage Coordinator will provide additional guidance to the client when it is time to transition into the next level of support. These range from:
   a. Independent engagement in care (No Ryan White services needed/client not eligible for Ryan White services)
   b. Limited support for engagement in care (Resource and Referral/Direct Enrollment Services)
   c. Medical/Specialty case management to maintain engagement and in care.

## 1.4 Eligibility

To be eligible for Linkage to Care clients must:

1. Be newly diagnosed with HIV (HIV Dx within the last 6 months)
2. Be a resident of the state of Missouri
3. Clients receiving additional Ryan White (RW) services other than initial counseling and Linkage to Care must have income less than or equal to 300% FPL.

Eligibility for Linkage to Care Programs vary by region. For the purpose of this manual, eligibility will refer only to clients newly diagnosed with HIV. If a client is not eligible for Ryan White services, the LTC coordinator must offer resources for other services, such as peer programs, copay assistance, and EHE.

## 1.5 MO Ryan White Case Management Expectations

In alignment with Missouri HIV case management standards, LTC coordinators are expected to abide by the following policies and procedures outlined in The Missouri HIV Case Management Manual.

1. Please refer to the manual for guidance on the following policies and procedures:
   a. Initial Contact
   b. Intake Standard
   c. Enrollment Standard
      i. Rapid Enrollment
   d. MCMAT/Service Plan
   e. Transfer Standard
   f. Supervision and Quality Reporting

2. Due to the specific needs of LTC clients, LTC coordinators will be expected to follow additional policies and procedures to engage clients in HIV medical care as outlined in this manual.

# Section 2.0 Initial Contact

## 2.1 LTC Referral Sources:

1. Referral source refers to the entity notifying the LTC program or staff of a person who needs LTC services. Referral sources may include, but are not limited to:
    a. Disease Intervention Specialists (includes DHSS EHE Coordinators)
    b. Local and State Surveillance
    c. HIV Testing Sites
    d. Intake Coordinator
    e. Case Management
    f. Local Public Health Agencies/Healthcare Providers
    g. Hospitals
    h. Self-referral
    i. Local and County Jails
    j. Medical Providers
2. Linkage to Care Coordinator will respond to referral source within 60 minutes to discuss a plan of action.

## 2.2 Initial Contact Standards

1. LTC Coordinators will initiate contact with client, in person, whenever possible and appropriate. Contact with client should be made as soon as possible but no later than the next business day. The LTC Coordinator will explain the LTC program and available RW services, as well as encourage enrollment into Case Management.
2. During the initial contact LTC will:
    a. Introduce client to LTC Coordinator.
    b. Provide client with opportunity to explore thoughts and feelings about being diagnosed with HIV.
    c. Evaluate need for crisis and/or safety intervention(s).
    d. Familiarize client with goals and timeframe of LTC Case Management, including transfer expectations.
    e. Assess client's understanding of diagnosis. Offer to review and answer questions about HIV test results.
    f. Begin identifying client's personal strengths, abilities, and skills.
    g. Help assess others' role in promoting or impeding access to services.
    h. Discuss options for HIV medical care and encourage engagement.

## Section 2.0 Initial Contact

i. Confirm correct contact information for the client and schedule a follow-up plan for future contact.

j. When appropriate, complete intake. Refer to Intake Policy and Procedure outlined in the Missouri HIV Case Management Manual**.**

k. Provide client with HIV education materials.

l. Collect any necessary documentation for release of client's Personal Health Information prior to enrollment.

m. Summarize/recap the major points of the encounter.

# Section 4.0 Timeline Objectives

## 3.1 Enrollment Standard

The LTC Coordinator will:

1. Discuss and provide client with information on available facilities and providers for HIV medical care.
2. Establish where client will receive HIV medical care.
3. Assist client with scheduling an HIV medical appointment and develop plan for attendance.
    a. The LTC Coordinator must attend the first medical appointment unless the client declines accompaniment.
    b. Provide HIV education and address client concerns to promote engagement in care.

## 3.2 Service Referrals

1. Upon completion of the enrollment, the LTC coordinator will enter the *IS-Linkage to Care* service referral in 8ENR status in addition to the regional Case Management referral.
2. The *IS-Linkage to Care referral* should be for a minimum of **ninety (90) days** in length.

## 3.3 Missouri Case Management Assessment Tool (MCMAT) and Individual Service Plans (ISP)

1. Linkage to Care Coordinator will complete MCMAT, including Linkage to Care specific questions, and Individual Service Plan (ISP) within 30 days of enrollment appointment.
2. The Case Manager and client will collaborate to develop an ISP that focuses on the client establishing medical care.
3. The service plan must include, at a minimum, the *HEALTH- Health Status/Medical Care* or an LTC Area of Assessment.

## 3.4 Transfer Procedure

1. Beginning one month prior to transfer:
    a. LTC Coordinator will inform client of transfer process and options for where to receive Case Management or other support services.
    b. Decisions for transfer should be based on and consider client's input and needs, type of facility client prefers, and any barriers to accessing care, including language.
2. Two-three weeks prior to transfer:
    a. Once an agency/location for Case Management or other support services has been decided, the LTC Coordinator will refer to regional transfer policies for transfer processes.

## Section 4.0 Timeline Objectives

3. The LTC Coordinators must initiate a warm handoff with the client and receiving case manager. The purpose of this handoff is to answer questions, review client progress, and discuss client goals and barriers with the receiving case manager.
    a. If "warm handoff" is not possible, LTC Coordinator and receiving case manager will case conference to confirm transfer is completed without issue.

## 4.0 Timeline Objectives

1. Once the LTC Coordinator is made aware of a person who needs to be linked to care, a minimum of three contact attempts are required.
2. At the time of the initial contact with the client (following HIV diagnosis and/or referral to LTC program), the LTC Coordinator will
    a. Complete intake and assess RW program eligibility.
    b. Assist with scheduling a confirmatory HIV test, if needed.
    c. Provide HIV education and answer HIV related questions from the client.
    d. Conduct preliminary crisis/risk assessment; namely, LTC Coordinators explore feelings about diagnosis; assess for clients' plans following contact with LTC Coordinator; explore support systems for client.
    e. Make a follow-up plan for contact.
3. Within the first 7 days from intake the LTC Coordinator will:
    a. Complete client enrollment visit for people who are RW eligible.
    b. Provide education and/or education materials (May include HIV 101, HIV Medication Adherence, understanding viral load and CD4s, pre-exposure prophylaxis (PrEP) for partners, etc.).
    c. Make referrals to other programs and services as needed/eligible (ex. Rapid Start, Patient Assistance Programs, Ryan White Outpatient Ambulatory Primary Care, Housing, Substance Use Counseling, Health Insurance Continuation, ADAP, Peer Support, etc.).
    d. Assist client with scheduling first medical appointment.
4. Within the first 30 days the LTC Coordinator will:
    a. Complete client assessment (MCMAT).
    b. Work with client on creation of ISP.
    c. Obtain confirmatory HIV test result and upload into the electronic database.
    d. Attend first medical appointment with client, when possible.
    e. Medication adherence check-in.
5. Within the first 90 days the LTC Coordinator will:

## Section 4.0 Timeline Objectives

a. Discuss Medical Case Management transfer options and expectations.

b. Make referrals to other programs and services as needed.

6. Prior to the program end the LTC Coordinator will:

a. Provide education on levels of support and goals of programs within Missouri RW System.

b. Coordinate meeting to introduce client to new Case Manager.

c. Complete transfer to Medical Case Management or other applicable programs.

d. Ensure second medical appointment is completed and/or scheduled.

e. Medication adherence check-in.

f. Ensure individuals who are **not** eligible for Ryan White Case Management are provided with appropriate referrals and resources.

# Section 5.0 Quality Management

## 5.1 Program Goals

**Goal 1:** Clients who are newly diagnosed are linked to HIV medical care in 30 days**.**

a. The National HIV/AIDS Strategy's objective for the Linkage to Care Program is to link clients to a verified medical care visit within 30 days from the date of a confirmatory test result showing client is HIV-positive.

b. Although this manual has defined successful linkage within a 90-day time frame, each of the Missouri regions' LTC programs will pursue quality improvement initiatives to align with the current National HIV/AIDS Strategy which sets a goal of 85% of newly diagnosed clients are linked to care in 30 days.

c. Verified Medical Care Visits must be documented in the electronic database. Linkage to Care will be evidenced by a minimum of one lab visit and one verified medical provider visit in the 30-day period.

**Goal 2:** Immediate response to reported incidents of client's who have a preliminary positive test result. (ex. HIV Rapid Test), when possible.

a. Immediate response is defined as initiating contact with newly diagnosed client within 24 hours.
b. LTC Coordinators will document their response in the electronic client database. The initial contact with the client will be documented using the *Initial Contact* encounter.

**Goal 3:** The LTC Coordinator will attend HIV Medical Appointments with the client when possible.

a. LTC Coordinators will document their attendance to client medical visits in the electronic database by utilizing the attended *Medical Visit (Accompanied Client)* encounter.