Linkage to Care:
Linking newly diagnosed HIV-infected Persons to Medical Providers through Linkage-to-Care Case Management (LTC)

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Linkage to Care: CDC ARTAS

CDC ARTAS:

- ARTAS = Antiretroviral Treatment Access Study
- Objective: link persons living with HIV to medical care
- Features: Strengths-based case management:
  - Empowerment & self efficacy
  - Clients identify internal strengths & assets

Findings:

- Compared to the standard of care group, people in the ARTAS case management were more likely to have visited their HIV provider:
  - At least once in 6 months (78% v. 60%)
  - At least twice in 12 months (64% v. 49%)

- Additional steps needed to improve linkage to HIV care

Source: Gardner et al. AIDS 2005;19:423-431
Objective is to increase the engagement in care among newly diagnosed HIV+ individuals from 43% to **60-80%** per year.

### Kansas City EMA Historical HIV Positivity Rates

<table>
<thead>
<tr>
<th>Year</th>
<th>Number dx HIV+</th>
<th>% Engaged in Medical Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>230</td>
<td>33</td>
</tr>
<tr>
<td>2002</td>
<td>161</td>
<td>32</td>
</tr>
<tr>
<td>2003</td>
<td>168</td>
<td>43</td>
</tr>
<tr>
<td>2004</td>
<td>167</td>
<td>60</td>
</tr>
<tr>
<td>2005</td>
<td>193</td>
<td>68</td>
</tr>
</tbody>
</table>

*(during ARTAS II study)*

**Source:** Kansas City Health Department. Percentages rounded to the nearest whole.
LTC: Eligibility Guidelines (adapted)

- HIV+ newly diagnosed
- Not more than 2 HIV medical appointments and never been on treatment (i.e. ARVs)
- Other HIV+ considered:
  - “Lost to Care” patients welcome (piloting)
  - Repeat clients (if lost) assessed for appropriateness
  - New to area clients (*in HIV care in other city and risk being lost to care*)
Today LTC: From Referrals to Active Handoff

Positive Result

**Outside Positive Result Referral:**
LTC paged before, at, or immediately after result. LTCs are mobile and respond within 20 min, starts partner elicitation, coordinates confirmatory result.

**General or Lost to Care Referral:**
LTC paged at contact w/ new-to-care client. Mobilizes to meet or contact, confirms HIV+, collaborates w/ D.I.S. and RW to confirm not in care or services.

90 day LTC service, beyond "linked" date; support w/ partner notification; attends medical appointments; orients to HIV system, confirm HIV payer source; initiates RW services; weekly case conference on progress toward care goals & graduation

90 Days & Engaged in Care = Active handoff: 
graduate to -> RW Case Manager or self management
Results: Kansas City ARTAS II Project

199 referred, 91 participated

94% linked to care* within 90 days

89% retained in care* at 6 months

84% engaged in care* at 12 months

*“care” = attended appointment with a prescribing provider MD, DO, NP et al
HIV Diagnosis

Page Linkage to Care – 20m response

Initial Response – meet with patient and diagnosing provider

Intervention - Enrollment or Referrals

Linkage to Care - 90 Day, intensive intervention of LTC Case Management (continuation w/ referral to CM services)

87% COMPLETE: Graduate to long term HIV Case Management Services, continue engagement in care

8% COMPLETE: Graduate to self-sufficiency, continued HIV care with own resources

5% NOT COMPLETE: Lost to Care, Unable to Contact, Disengaged from Program; cont’d attempts re-engagement

84% of graduates still in care after 12 months.

Referring Sites
• Hospitals
• Health Depts (KC, Jx, Jo, Wy, MO)
• Publicly Funded Testing Sites
• Free Clinic (KCFHC)
• Med Offices/Other
• Self Referral
Terms Important to Our LTC Program

- “passive referrals” vs. “active referrals”
- “linked to care” vs. “engaged in care”
- On call (incoming referrals)
- Graduated disengagement
- Strengths Perspective (SBCM)
- LTC Coordinator vs. Case Manager (ALCM)
- First & second medical appointment
- Active handoff (strict standard)
KC ARTAS Referral Sources

Who's Referring?

Referrals include ALL referrals screened by ALCMs regardless of eligibility form completed or enrollment status.

In the beginning (first 2 years)
Recruiting, Retaining, Sustainability

Administrative Set up for LTC

- Setting the Stage
- Preparing your System
- Accountability to LTC Standards
Incoming (referrals in to LTC)

Setting the stage
- Commitment of System Supervisors
- Buy-in from Testing sites

Preparing the system
- Integrating DSH/HC systems
- Communication: Reminders of Program/LTC staff present at referral meetings

Strong standards & results!
- Commitment to opt-out referrals
- 20 minute pager response
- Reinforce “active referrals”
- ALCM gives available at delivery of positive results

Pre-intervention recruitment
Outgoing (referrals out of LTC)

Setting the stage
- Commitment of Supervisors
- Buy-in from Case Management sites
- Integrating into CM system standards
- Perform “intake” tasks/documentation
- Reinforce “active referrals” to long term CM system
- Continuum of care goals

Preparing the system
- Coaching Case Managers
- Clear, deliberate documentation standards
- LTC presence at system meetings

Strong standards & results!
Success Checklist:
Implementing a Linkage to Care Program

- **Existing**, strong working relationships with:
  - City/State Health Departments
  - Disease Intervention and C & T Services
  - HIV Case Management Systems
  - Medical Care facilities

- Continuum of Programs - as much onsite as possible
- Experienced staff, strong in Case Management
- Demonstrated leadership in HIV services
- Major networking skills!
- Customer Service *(view professionals as secondary client)*
Checklist: Defining Your Program’s Linkage to Care

- Branding the service for entire system
- Outreach to C & T referral sources
- Outreach to medical referral destinations
- Know points of entry of HIV+ individuals
- Broad outreach to potential clients
- Targeted outreach to potential clients
- Market using client and system outcomes publically
Checklist: Active Referrals Activity

- Client readiness to accept or act on a referral
- Highlight motivator – attuned to what client wants (*motivational interviewing*)
- Preparing, using both didactic and experiential education
- Visualizing goals and outcomes
- Attending appointment with client
- Active “hand off” and follow up
Checklist: Active Referrals Tools

- Hotline or pager number for referrals
- “Where can I find you” form/tool
- Material without the word “HIV” or “AIDS”
- Maps, pictures, forms of care sites/services
- Offer to train HIV testing staff throughout service area
- Report back on outcomes of referral
- Act as “sales representative” touching base w/ referral sites monthly
LTC Staff: An Advanced Skill Set

- Previous experience in RW or hospital case management
- Previous experience with homeless, SA, youth populations
- STRONG expertise in HIV/AIDS
- BSW or MSW (strengths model experience or understanding)

(continued)
LTC Staff: An Advanced Skill-Set

- Harm Reduction understanding and practice application
- Flexible hours to meet client needs (whatever it takes spirit)
- Outcome focused (involved in all areas of project)
- Customer service attitude with both clients and referring professionals
Commitment to the LTC Process

Using LTC short-term Case Management model (ARTAS adapted)

- **graduated disengagement** (90 day)
- **active referrals** (into program & in service coordination)
- **cross training staff**
- **LTC staff as trainers** (outreach to professionals)
- **active hand-off** (graduating program)
- **case conference** (weekly)


Questions: Amber Rossman, LMSW

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