

Lessons Learned During and After Implementation of CDC's ARTAS Linkage to HIV Care Demonstration Project: Kansas City

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Kansas City: Linkage to Care

- I. **Introduction** to project & results
- II. **Referrals In:** Challenges, Lessons, Future
- III. **Linkage Service:** Continued and Expanded
- IV. **Referrals Out:** Challenges, Lessons, Future

Kansas City Project Area

Kansas City Project Area include:



- 2 States (KS & MO)
- 11 counties in MO
- 3 counties in KS
- Missouri Dept of Health and Senior Services
- Wyandotte Co. Health Dept.
- Kansas City Health Dept

Review of Results : Kansas City ARTAS II Project

199 referred, 46% (91/199) participated in the study

87% "linked to care" within 90 days

(attended at least 1 appointment to generate a medical record with a primary care provider)

89% "participated" in care in 6 months

(attended appointment with a M.D., D.O., N.P. et al)

84% still "engaged" in care at 12 months

(attended appointments, including follow up for labs or medications consultation with a M.D., D.O., N.P. et al)

Formerly known as...ARTAS II Linkage to Care, Missouri Continuation

2006 - "Title II" funded LTC services in KCMO

- 2 positions in western Missouri

2007 - Part A/B expanded LTC to St. Louis, Kansas City and Springfield/Joplin

- 10 positions in Missouri

2008 - All LTCs attended Part B funded training WITH their site supervisors

- Contracted with Wright State University - trainers for ARTAS II

2008 - LTC service incorporated into statewide RW Case Management Standards, Policies and Procedures Manual

Formerly known as...ARTAS II Linkage to Care, Missouri Continuation

- LTC integrated in HIV Case Managers and Counseling/Testing systems

- Statewide workgroup made up of regional managers drive service standards

- Liaisons generate referral and collaborate on challenges

Client Perspectives: Why Linkage?

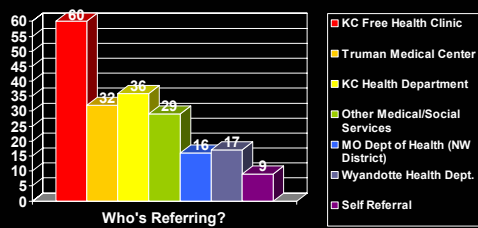
96% in the KC site study had no personal help dealing with their HIV diagnosis and care.*



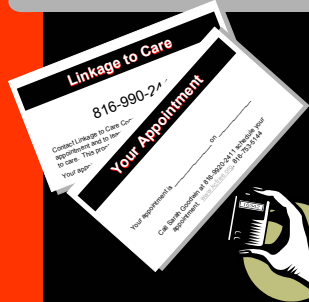
The Status Quo: Traditional Referral to Care

- **Late diagnosis is frequent**, especially of socio-economically disadvantaged persons, immediate care is vital
- **“Passive” referrals do not support** vulnerable population to navigate complicated systems, intimidating disease concepts, and face numerous barriers to care
- **Numerous missed opportunities** for earlier engagement in care, treatment, and prevention

Referrals In: Kansas City Sources



Generating Referrals: Integrating into the Ryan White System of Care



Setting the stage

- Commitment of Grantees and Supervisors

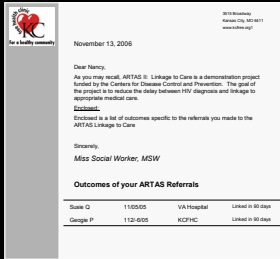
Preparing the system

- Buy-in from Testing sites
- Training D.I.S. & C.T.S. staff
- Developing tools for easy LTC prescribers at meetings of all levels

- LTC respond to incoming referrals and outgoing referral system needs

- Personalizing incoming referral to source (i.e. Emergency Dept, Disease Intervention, Intake Staff)

Generating Referrals: Customer Service (D.I.S., CTS, Providers)



Responding to "referrals in" with outcomes says:

"Your referral is important and you can trust LTC to see it through"

"You are a part of this client's success in care"

"Our projects collaborate for public health outcomes"

Service: Linkage to Care

- Meet w/ client immediately after HIV diagnosis
- Integrated into Ryan White CM system
- Provide 90 day service, plan for continuum of care:

BEGINNINGS:

- HIV 101
- health literacy
- partner elicitation (as needed)
- establish primary care
- identify strengths/resources
- access community/Ryan White
- anticipate barriers to care
- RW intake requirements

LINKAGE TO CARE:

- launch plan of care
- reinforce strengths/resources
- orient to – attend – debrief medical appointments
- Review Strengths & Barriers to care
- prepare for graduation into
 - a) Medical Case Mgt.
 - b) Independence

Client Perspectives: Why Linkage?

LTC Clients, regardless of their attitude toward diagnosis or medical care stated that

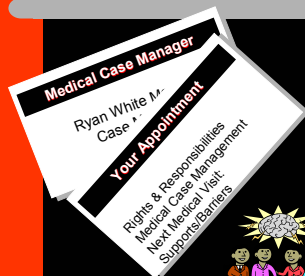
LTCs had common characteristics:



Referral Out: "Disengagement"

- 87% "graduated" to enroll in long term Ryan White Case Management
- 8% "graduated" to self-management (i.e. self-sufficient, had sufficient supports/resources, declined service)
- 5% were closed before linkage process or when time to "graduate" to long term Case Management (i.e. unable to locate, moved, etc)

Referrals Out: "Graduated Disengagement" & "Active Handoff" for successful continuum



Setting the stage

- Commitment of Supervisors
- Buy-in from Case Management Sites
- Coaching Case Managers
- Integrating into CM system
- Goals of service made clear
- LTC presence at meetings

Strong standards results!

- Perform "intake" or "pre-CM" tasks/documentation
- "graduated disengagement" to support independence & self-management
- Reinforce "active handoff"

KCMO – Linkage reaches new heights!

- **2007 ACROSS THE STATE**
St. Louis (MO); Kansas City (MO/KS); Springfield/Joplin
- **2008 COLLABORATION** - Surveillance/Disease Intervention Services "Lost to Care" 1/1/2008
- **2009 NEXT STATE**
Kansas reports launch of Linkage to Care programming – MO is prepared to support across state lines (share experiences, support, collaboration)

*....and Opt-Out Testing collaborations
(St. Louis & Kansas City)*

...and KCMO – Linkage reaches new heights!

- **2008 COLLABORATION** - Opt-Out Testing
 - Truman Medical Center, major indigent care hospital Emergency Department
 - 24/7 referral acceptance and response
 - Individualized training for ED staff (during OraQuick Rapid Test training)

LTC offers reliable follow-up to new HIV diagnosis

- Survey of 154 Emergency Department providers
- Reasons for not testing for HIV:
 - 51% concerned about follow up after an HIV positive test, therefore don't routinely provide HIV testing
 - 45% not a "certified" counselor
 - 27% HIV testing not available
 - 19% too time-consuming

-Fincher-Merigi et al, 2002: AIDS Pat Care STDs

Missouri: using thought-leaders from across the state to address threats

Significant barriers would threaten affective Linkage to Care service:

- Inadequate referrals through LTC
- Blurring of primary purpose of "linkage" (i.e. additional roles, requirements from Outreach or Care funders)
- System supervision needed by leaders who understands LTC program, Strengths Model and are clear on the implementation process

Success Checklist:

Lessons Learned: To implement 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 – co-located, as possible
- ✓ Experienced staff, strong in Case Management
- ✓ Lead site has demonstrated leadership in system
- ✓ Major networking skills, customer service!!!
 - ✓ Referrals in = professionals as secondary client
 - ✓ Referrals out = professionals as secondary client

Missouri – Linkage to Care

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