Linkage To Care

Linkage To Care (LTC), a short-term Early Intervention Service (EIS), includes a range of client-centered activities focused on improving health outcomes in support of providing HIV care. LTC is a service provided for people newly diagnosed with HIV, people who have fallen out of care, people at risk of falling out of care, people who are new to the city or state, or people who were recently released from incarceration. LTC is not provided alongside Medical Case Management (MCM). However, LTC can be provided alongside Registered Nurse Case Management and Non-Medical Case Management. This service is provided by Linkage To Care Specialists (LTCS).

LTC includes all types of case management encounters (for example, face-to-face, phone contact, and any other forms of communication).

Key service components and activities for LTC include:

- Initial assessment of service needs.
- Development of a comprehensive, individualized care plan.
- Timely and coordinated access to medically appropriate levels of health and support services and continuity of care.
- Continuous client monitoring to assess the efficacy of the care plan.
- Re-evaluation of the service plan based on acuity, with adaptations as necessary.
- Ongoing assessment of the client's and other key family members' needs and personal support systems.
- Treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments.
- Client-specific advocacy and/or review of utilization of services.
- Assist client in attending medical appointments with consistency.
- Transition to self-management or a less intensive care service as clinically appropriate, generally within 9–12 months of intake.
- Benefits navigation and health insurance.
- Outreach and engagement.
- Care coordination with other services, like public health.
- Education and counseling to support positive adjustment and address possible diagnosis grief.

LTC also includes benefits counseling by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible (for example, Medicaid, Medicare Part D, AIDS Drug Assistance Program (ADAP), pharmaceutical manufacturer's patient assistance programs, other state or local health care and supportive services, and insurance plans through the health insurance marketplaces or exchanges).

Subrecipients providing LTC services are expected to comply with the Universal Standards of Care, EIS Standards of Care, as well as these additional standards:

Standard 1: LTC services must be delivered in accordance with the Wisconsin Ryan White Part B Eligibility and Recertification Policy and Procedures.

Providers are responsible for determining eligibility at enrollment and confirming eligibility annually.

Documentation

Client records must document that the client is living with HIV, resides in Wisconsin, and has household income under 500% FPL at initial enrollment in accordance with the Wisconsin Ryan White Part B Eligibility Policy, linked above.

Standard 2: During initial contact, key information about the client must be collected or verified in the Electronic Medical Record (EMR).

Providers must attempt to collect or confirm the following client information:

- Contact and identifying information.
- Emergency contact, if available.
- Insurance status.
- Documentation of income and status of residing in Wisconsin.
- Demographic information.
- Contact information for other service providers and corresponding Release of Information (ROI) forms.
- Proof of HIV diagnosis.

Documentation

Documentation of all elements outlined above must be completed within 30 days of first medical visit, initial referral, or contact. Documentation must show any corresponding ROIs, as needed and applicable.

Standard 3: Immediate referrals must be made for clients with most needs.

Immediate referrals, internal and external, to the appropriate services are required for clients who:

- Are not engaged in medical care.
- Are taking medication but will run out prior to first medical appointment.
- Are a danger to themselves or others.
- Are under the age of 18.
- Are pregnant.

Documentation

Documentation of immediate referrals made and outcomes for needs listed in this standard must be included in the client record.

Standard 4: Intakes may be performed by providers, non-service provider staff, or interns.

Intake may be performed by subrecipient staff or interns who are not LTCS, provided they meet all the following criteria:

- Are an employee or intern of the subrecipient.
- Received proper onsite training and signed the agency confidentiality agreement.
- Completed the HIV Basics Online Course offered through the University of Wisconsin-Madison, HIV Training System.

Documentation

The client record must show that intake is performed by a LTCS. If performed by someone who is not a LTCS, the required criteria must be documented in their personnel file or somewhere easily accessible for chart audits.

Standard 5: The Wisconsin Acuity Index Tool (WAI) must be used to assess the appropriateness of LTC for client's needs.

The WAI must be completed within 30 days of intake and evaluates client level of needs.

Documentation

A completed WAI form or WAI built into an electronic medical record is available for review.

The client record must document that the initial WAI was completed within 30 days of intake.

Standard 6: A client that scores a 0 or 1 after initially completing the Wisconsin Acuity Index (WAI) can be transferred to Medical Case Management (MCM).

If the client's initial WAI score is 1, the client can be transferred to a medical case manager within 30 days if LTCS and supervisor agree that MCM better fits the client's needs. All transitions must be reasonable and intentional. A warm hand off, sharing of client record, and provider-to-provider direct contact, are considered best practice. All three should be completed whenever possible.

If the client's initial WAI score is 0 and they are not newly diagnosed the client can be enrolled in Brief Services or referred to self-management. Either route should be discussed with the client.

Clients who are newly diagnosed with an initial WAI score of 0 must be enrolled in LTC or MCM for at least 90 days.

Documentation

Client record shows score of WAI and date of result, steps made to transfer services, and supervisor approval of the transfer.

Standard 7: Within 30 days of the WAI completion, clients with an acuity score above 0 must receive an initial comprehensive assessment.

A comprehensive assessment describes the client's medical and psychosocial needs in detail. It identifies service needs being addressed and by whom; services that have not been provided; barriers to service access;

and services not being appropriately coordinated. This assessment also evaluates the client's resources and strengths, including family and other supports, which may be utilized during service planning.

The assessment may include gathering information from existing client record(s), as well as meeting with the client face-to-face, when possible. The assessment should include all the client information gathered at intake, and address client need(s) in the following areas:

- Education
- Financial information
- Medical care team
- Adherence to HIV medications
- Substance use
- Housing
- Social support and relationships
- Overall health
- Employment
- Health insurance
- Retention in HIV medical care
- Mental health
- Harm reduction methods
- Transportation
- Oral health
- Nutrition
- Vision care
- Activities of daily living
- Domestic violence screening
- Dependents
- Alternative therapies and/or medicines
- Legal
- Language and culture

Documentation

The client record must document that all required information in each area was collected through the comprehensive assessment. If the record is missing some information, there must be a clear record of what is missing and a plan to revisit with the client when appropriate.

LTCS are encouraged to use the comprehensive assessment form developed by the Wisconsin Communicable Disease Harm Reduction (CDHR) Section to ensure they are gathering all the required information listed above.

Subrecipients may revise the state form or develop their own assessment tool as long as all of the elements on the comprehensive assessment form are covered. Any assessment tools developed must be strengths-based and easily accessible.

Standard 8: The LTCS is responsible for the completion of a comprehensive assessment.

The LTCS must attempt to meet face-to-face, with the client at least once during the assessment process. Face-to-face can be in-person or virtual. If catastrophic events should cause this to be impossible, and thus requiring face-to-face meetings would delay service delivery, a LTCS can complete the assessment process without an in-person or virtual face-to-face meeting.

Documentation

The client record must document actions taken by LTCS that are consistent with this requirement.

Standard 9: Based on the findings of an initial comprehensive assessment, the LTCS and client must collaboratively develop an initial service plan.

Developing a service plan is a central component of LTC and provides the client and care team with a proactive, concrete, and step-by-step approach to addressing client needs.

Client needs identified during the WAI and comprehensive assessment are prioritized and translated into a service plan, which defines specific goals, action steps needed to meet goals, and who will be the responsible party for each action step.

The LTCS has primary responsibility for the development of the service plan. Active client involvement—defined by client participation, input, and agreement in each aspect of the service plan development—is required. Goals, objectives, and activities of the service plan are determined with the participation of the client and, if appropriate, family, close support persons, and other providers.

At minimum, the initial service plan includes:

- Goal(s).
- Action steps [to be taken towards goal(s)].
- Individual responsible for the action step.
- Anticipated timeframe for each action step, when known.
- Client signature and date, or documentation of verbal approval.

When applicable, supervisory review of the service plan occurs at intervals stated on WAI form.

Documentation

A service plan, with all required elements, must be available for review by the Wisconsin CDHR Section upon request.

Standard 10: Action steps begin immediately after development of the service plan.

Specific activities performed during the service plan use will vary based on the unique needs of each client. However, at least one of the activities must promote and support client engagement in HIV medical care and overall health.

Documentation

The client record must document specific activities and promotion or support of client engagement in HIV medical care and overall health.

Standard 11: Communication and coordination with the client's HIV medical care team is essential for effective LTC to occur.

Frequent care consultation will happen with other members of the client's medical care team.

Documentation

The client record should contain evidence of regular and ongoing contact with key members of the client's HIV medical care team.

Standard 12: The type and frequency of contact with the client must be based on client needs.

Expectations for type and frequency of client contact are based on WAI score and listed on the WAI form.

Documentation

The client record must document a frequency of contact consistent with the most recent WAI score. LTCS can contact clients more frequently. If the contact continues to be more frequent than a WAI score of 1 or 2 would warrant, the LTCS should consider re-administering the WAI or manually increasing the score.

Standard 13: Client acuity must be reassessed periodically, based on acuity level.

Due to the short-term nature of LTC, the WAI must be re-administered at least twice a year for all LTC clients. Expectations for more frequent reassessment are based on WAI score and listed on the WAI form.

Documentation

The client record documents that the client's acuity was reassessed at the appropriate frequency based on the most recent WAI score, and/or if significant changes in life circumstances occur.

Standard 14: The client must receive a comprehensive assessment periodically, based on the acuity level.

A comprehensive assessment must be re-administered annually at minimum for all LTC clients. Expectations for re-administering a comprehensive assessment are listed on the WAI document.

A comprehensive assessment does not need to be re-administered for clients who have significant life changes. Instead, a new WAI is to be administered and the timing of other required documents will be determined by that score.

Documentation

The client record documents that the client received a new comprehensive assessment at the appropriate frequency based on the most recent WAI score.

The client record should also include progress notes outlining any reason for missing information, documentation of referral(s) made, and outcome of referral.

Standard 15: The client's service plan must be reviewed based on acuity level.

Service plan review includes updating the status of existing action steps and identifying new goals and action steps to work towards meeting goals.

The LTCS has primary responsibility for the updated service plan. Client input and approval of the plan is required each time when reviewing the plan. Expectations for frequency of service plan review are based on WAI score and listed on the WAI form. Supervisory review of the service plan occurs as needed.

Documentation

The client record must document that the service plan was reviewed at the required frequency by the client and the LTCS. When applicable, the client record documents supervisory review of the service plan at intervals stated on WAI form.

Changes in the service plan must be documented in the client record.

Standard 16: Upon completion of LTC services, the client must transition to self-management, a less intensive case management service, or be discharged.

Reasons for client completion include:

- Client completed LTC goals.
- Client WAI score reaches 0–1.
- Client is no longer eligible for services.
- Client is no longer in need of service.
- Client is considered "lost to follow-up" or does not engage in service.*
- Client is referred to another case management or LTC program.
- Client incarceration is greater than six months.
- Client relocates outside of service area.

Reasons for client discharge include:

- Agency initiated discharge due to behavioral violations (this should be a last resort)*.
- Client chooses to discharge service.
- Client death.*

*See Universal Standards for guidance.

Documentation

The client record must document which reason(s) for completion or discharge were met.

A brief transition or discharge narrative must be included in the client record.

If transitioning to other care services, documentation must include, at minimum, the client's service plan and evidence of communication between LTCS and the care services provider taking over client's care.

The LTCS should inform the care services provider taking over client's care of plans to discharge no later than three weeks prior to discharge. A warm hand off should take place whenever possible.