Dimension: Age	Optimal Linkage and Referral (Active Referral Intervention)
This Intervention is Lined to the Following Secondary Drivers: • Process for engaging clients to take advantage of linkages and promote offered age-related services • Processes in place for making customized referrals (after vetting potential referrals), following-up on referrals, and ensuring successful linkages • Geriatric and pediatric health providers are integrated into the HIV care team and participate in case conferences	
Level of Evidence: Well-Defined Interventions with an evidence-base	

Summary:

Active Referral involves successful linkage of people with HIV to primary care as well as other services and supports. This may include newly diagnosed individuals, persons previously diagnosed who have never been linked to care, or persons who have fallen out of care and are being re-linked.

Core Components

Active Referral[6] addresses several key areas that have been found to improve linkage and re-engagement in care, including:

- removal of structural barriers
- increased social support services
- use of peers, client navigation, and care coordination
- a culturally responsive approach
- appointment scheduling and follow up
- timely and active referrals post-diagnosis
- integrated one-stop-shop care delivery

One study[7] looked at 16 barriers to successful linkages and proposed evidence-informed methods for mitigating their effects. One strategy associated with increased linkage to care is active referral. Many studies have shown that referral by a tester who makes the treatment appointment or accompanies the patient to an appointment increases the likelihood of linkage, compared with passive referral (e.g., only

[6] Active Referral Intervention. (2017, June). Retrieved May 17, 2020, from https://targethiv.org/sites/default/files/file-upload/resources/ihip-linkage-to-Care-Active-Referral-Case-Study-and-Intervention.pdf

[7] Carter, M. W., Wu, H., Cohen, S., Hightow-Weidman, L., Lecher, S. L., & Peters, P. J. (2016). Linkage and Referral to HIV and Other Medical and Social Services: A Focused Literature Review for Sexually Transmitted Disease Prevention and Control Programs. *Sexually transmitted diseases*, *43*(2

Suppl 1), S76–S82. https://doi.org/10.1097/OLQ.0000000000000290

providing written material).

The table below outlines the barriers and potential strategies for mitigating them.

TABLE 1.

Common Barriers to Linking or Retaining HIV-Infected Patients in HIV Medical Care

Barriers (Reference Number)	Examples of Potential Means of Mitigating Barriers
Psychosocial	
Low self-efficacy[19]	Strength-based case management
Health illiteracy[19]	HIV counseling and education, appropriate and varied educational materials
Concerns for confidentiality[20]	Explain and post confidentiality protections, provide private spaces for triage and examination
Concerns for stigma[21]	Nonjudgmental and inclusive approach and clinic environment
Language barriers[19,22]	Access to translation services through staff on site or by phone
Cultural barriers[16,22]	Cultural competency training, hiring cultural concordant staif
Substance use[23]	Screening for, and access or referrals to, substance-abuse programs
Mental illness[16]	Screening for, and access or referrals to, mental health services
Isolation[20]	Peer patient navigation, support group, case management
Socioeconomic	
Homeless[17]	Access to HIV/AIDS housing resources
Poverty[16,17]	Access to jobs training, social security disability benefits, or poverty reduction programs.
Lack of transportation[18]	Providing HIV care appointments at locations convenient to the patient; directly providing transportation assistance
Lack of insurance[16,18]	Providing health insurance enrollment service at the clinic or referrals to such
Health care system Complexity of health care systems[17,18]	Colocating HIV care and STD clinics; strong referral or linkage systems
Complexity of insurance systems[18,19]	Providing health insurance enrollment service at the clinic or referrals to such; ongoing support and education for using benefits

Tips and Tricks:

- Active referral programs often include peer navigators.
- While formal linkage and referral agreements between providers may be useful, they cannot replace active referrals.
- Implementing a successful active referral system at an HIV clinic takes time, testing and refining before going to scale, using continuous improvement methods.

Additional Resources (Existing Guides, Case Studies, etc.):

- HRSA HIV/AIDS Bureau (HAB) - **Active Referral Intervention: Case Study, Overview, and Replication Tips**

- **Linkage and Referral to HIV and Other Medical and Social Services**: A Focused Literature Review for Sexually Transmitted Disease Prevention and Control Programs

- Target HIV's **Using Community Health Workers to Improve Linkage and Retention in Care**

Suggested Measures:

Process Measures

- Number of referrals made
- % of referrals made that result in a successful linkage
- % of patients who agree or strongly agree that (Name of Clinic) provides culturally responsive referrals
- % of patients who agree or strongly agree that (Name of Clinic) provides active follow up to help ensure that referrals are successful and meet my unique needs

Outcome Measures

- % of patients that report successful linkages with improved viral suppression rates within 6 months
- % of patients that report successful linkages that achieve viral suppression (Percentage of patients with a HIV viral load less than 200 copies/ml at last viral load test during the measurement year)

Citations and Acknowledgements:

1. Active Referral Intervention. (2017, June). Retrieved May 17, 2020, from https://targethiv.org/sites/default/files/file-upload/resources/ihip-linkage-to-Care-Active-Referral-Case-Study-and-Intervention.pdf
2. Carter, M. W., Wu, H., Cohen, S., Hightow-Weidman, L., Lecher, S. L., & Peters, P. J. (2016). Linkage and Referral to HIV and Other Medical and Social Services: A Focused Literature Review for Sexually Transmitted Disease Prevention and Control Programs. *Sexually transmitted diseases*, *43*(2 Suppl 1), S76–S82. https://doi.org/10.1097/OLQ.0000000000000290