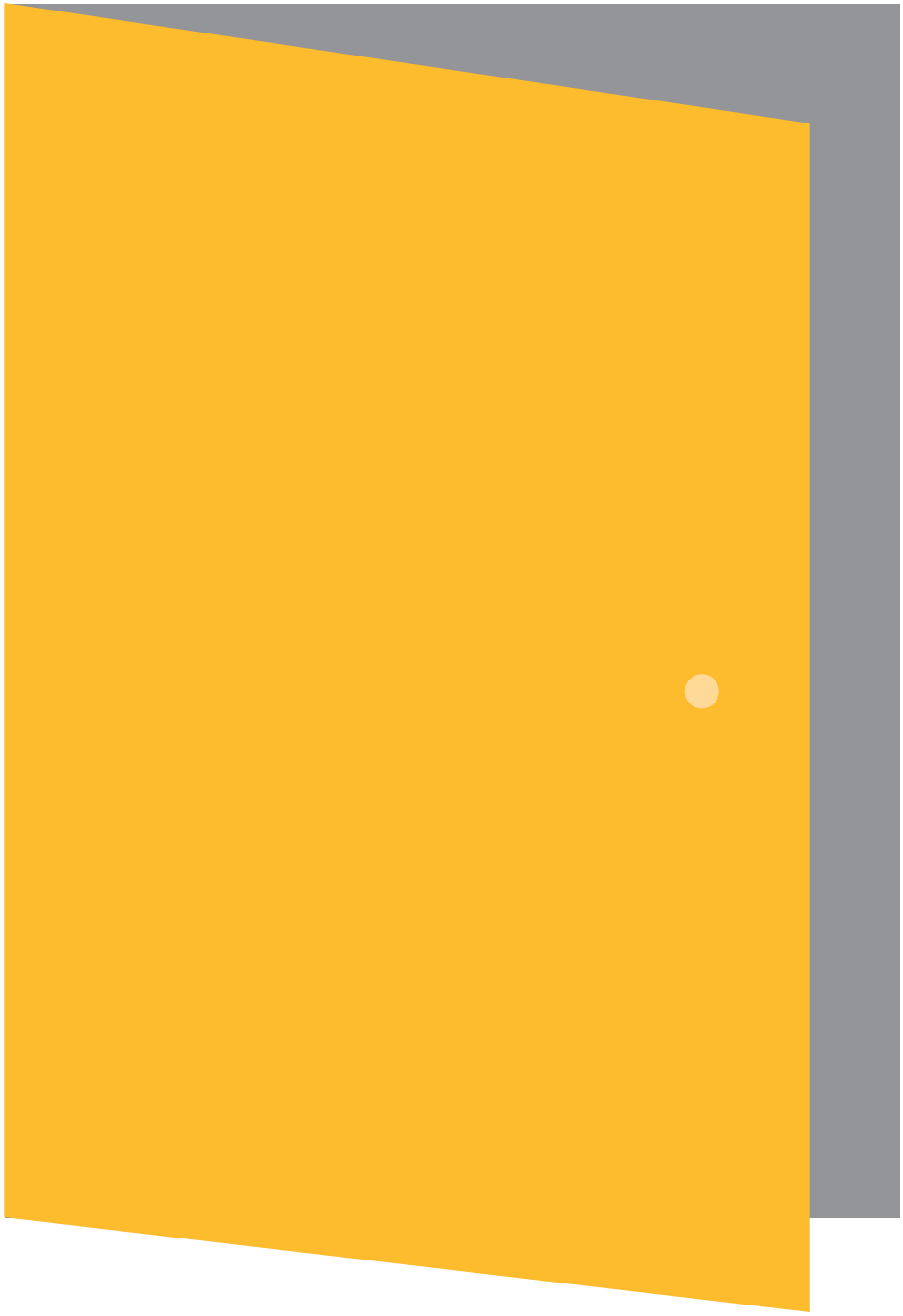

COMMUNITIES ADVOCATING EMERGENCY AIDS RELIEF

CAEAR COALITION FOUNDATION

Opening Doors

A Guide for Building Effective Linkages between CARE Act-Funded Providers and Key Points of Entry to Health Care

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I. Executive Summary

In response to the HIV/AIDS epidemic, communities have created broad continua of services for people living with the disease. For the most part, the services provided by these networks of care are funded by the federal Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, which pays for primary health care and support services that address the unmet health needs of people living with HIV disease.

Community networks have made a significant impact on the health of Americans living with HIV, but more remains to be done. While thousands have benefited from the CARE Act, many still do not have access to these life-saving programs. These individuals are unable to take advantage of care, treatment and services that could improve their health and help them lead longer, fuller lives.

When Congress reauthorized the CARE Act in 2000, it included new requirements intended to expand the number of people receiving services through certain sections of the law. The new language requires agencies funded under Title I and Title II of the CARE Act to maintain relationships and linkages with "key points of entry" to the local health care system. The goal: to reach individuals who are either newly diagnosed with HIV or who know their HIV status but are not in care.

This publication was created to help all CARE Act-funded agencies assess and broaden their current linkages. Many of the ideas in this guide come from the experiences of CARE Act grantees, planning councils and funded agencies. Representatives of these groups participated in a series of focus groups and key informant interviews with the CAEAR Coalition Foundation. The foundation extends its deep appreciation to all who took part in these meetings—both for their guidance in shaping this document and for their continued commitment to helping those living with HIV disease.

II. About This Guide

This guide is designed to help nurture linkages between organizations that are already part of the local continuum of HIV care and key points of entry into the health care system for people living with HIV. It will be useful for CARE Act-funded providers who are interested in developing, implementing or monitoring such linkages. It also will be useful for staff and leaders at the key point-of-entry agencies that may or may not be funded under the CARE Act.

The first half of this guide provides an overview of the linkages required by the Health Resources and Services Administration (HRSA) and of the steps to creating effective linkage agreements in your state or community. The second half of the guide describes how to create an ideal Memorandum of Understanding (MOU) for your agency and its partners, walks you through the steps for implementing an MOU, and provides an overview of how best to monitor linkages once they are established.

This publication:

- Provides an overview of WHY LINKAGES ARE IMPORTANT to an effective continuum of care;
- Gives background of THE SPECIFIC LINKAGES MANDATED BY THE CARE ACT;
- Explains HOW EFFECTIVE LINKAGES CAN BE DEVELOPED and offers guidelines for achieving useful linkage agreements; and
- Addresses COMMON BARRIERS TO LINKAGES and possible strategies for overcoming them.

The guide is designed to be used, not merely read. It includes worksheets as well as space for you to take notes and jot down ideas for your agency. It was developed by the CAEAR Coalition Foundation as a tool for improving your effectiveness, and we hope that the information in these pages will help your organization bring enhanced care to people in your community and state.

III. Why Linkages Matter

A Strong Continuum of Care Helps People Living with HIV

The U.S. communities hit hardest by HIV and AIDS have responded to the epidemic by building continua of care and services for people living with the disease. These networks include a broad array of health care providers largely funded by the federal Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. The CARE Act pays for primary health care and support services that address the unmet health needs of people living with HIV disease. The networks built with CARE Act funding have made a significant and positive impact on the health of their clients (see **Box 1**).[1]

Each year, CARE Act services reach an estimated 500,000 individuals through the following programs:

- *Title I* provides funds to localities (also known as Eligible Metropolitan Areas, or EMAs) that have been most affected by the HIV/AIDS epidemic.
- *Title II* provides grants to states and territories for primary health care to improve the quality, availability and organization of care services for people living with HIV and their families.
- *Title III* provides funds for outpatient primary medical care and early intervention services for people living with HIV through grants to public

BOX 1

The Impact of CARE Act Services on Quality of HIV Care

A study by researchers at Columbia University found that CARE Act services have a significant impact on the health outcomes of people living with HIV/AIDS. The researchers examined the impact of services funded through all CARE Act Titles in New York City and found that, among people living with HIV /AIDS:

- Those receiving primary medical care from a CARE Act-funded provider were 60-70 percent more likely to report appropriate medical care, and 40-50 percent more likely to report being on Highly Active Antiretroviral Therapy (HAART), than those who received their primary medical care from a non-CARE-Act-funded provider.
- Those receiving case management and/or client advocacy from a CARE Act-funded provider were 80-90 percent more likely to report receiving appropriate medical care, and 70 percent more likely to be on antiretroviral therapy, than those who received case management and/or client advocacy from a non-CARE-Act-funded provider.

Those who received primary medical care from a non-CARE-Act-funded provider were half as likely as clients of CARE Act providers to report care that meets minimum HIV practice guidelines.

1 Abramson, D., et al., "Assessing the Impact of the Ryan White CARE Act on Health Outcomes in New York City: Executive Summary," 2001, unpublished.

and private nonprofit organizations. Title III also funds capacity development and planning grants to help organizations improve their programming.

- *Title IV* funds private and public nonprofit agencies to provide demonstration programs offering comprehensive HIV care (including medical, social and support services) to women, children, youth and families with HIV. Title IV also funds coordination between care providers and clinical research programs.
- *Part F* funds the AIDS Education Training Centers (AETCs), the HIV/AIDS Dental Reimbursement Program and Special Projects of National Significance (SPNS).

Yet, while thousands of people living with HIV disease have benefited from CARE Act services, many still are not taking part in these life-saving programs. Between 180,000 and 240,000 Americans living with HIV are unaware that they carry the virus. An additional 300,000 people know that they have HIV but are not receiving appropriate HIV-related care,[2] and an estimated 40 percent of HIV-infected people begin antiretroviral treatment later than recommended by the U.S. Public Health Service.[3] When people living with HIV do not access HIV-related services, they are unable to take advantage of care, treatment and services that can improve their health and help them lead longer, fuller lives.

The Benefits of Effective Linkages

For people living with HIV

The ultimate goal of forming referral linkages is to connect people living with HIV to the services they need. It is estimated that as many as half a million people living with HIV in the United States do not get the care that is necessary to treat and manage the disease.

Referrals between point-of-entry agencies and CARE Act providers can help people living with HIV/AIDS to:

- Receive critical health and social services;
- Improve their health;
- Enhance quality of life; and
- Lengthen their lives.

For CARE Act providers

Linkages are vital to creating a coordinated system of care and making sure clients get the services they need. Linkages increase the number of people living with HIV/AIDS who have

2 Fleming, P.L. et al. HIV Prevalence in the United States, 2000, 9th Conference on Retroviruses and Opportunistic Infections, Oral Abstract, 2002.

3 McNaughten, A., et al., "Factors Associated with Immunologic Stage at which Patients Initiate Antiretroviral Therapy," 9th Conference on Retroviruses and Opportunistic Infections, Poster Abstract 473 M, 2002

access to specialized and appropriate treatment and related services. It is essential that CARE Act providers link with appropriate organizations—even those that are not funded by the CARE Act—in order to ensure system coordination and address consumers' needs.

Formal linkages can:

- Clarify responsibility among CARE Act providers and other service agencies;
- Foster successful, system-wide service coordination;
- Ensure that the referral process endures through staff turnover;
- Generate new relationships within the linked organizations;
- Help the monitoring system for both providers and their partners;
- Facilitate continuity of care among multiple providers for the individual client; and
- Maximize CARE Act funds by identifying primary payers.

In addition, the federal government hopes that expanding communication and cooperation among service providers will make HIV screening and referrals a standard activity in a range of social service and health care settings. This, in turn, will help reduce barriers to care and eliminate the unfortunate stigma that is still carried by HIV/AIDS testing, counseling and treatment.

"Overall, I think our mandate from HRSA is that we need to get people into primary care; and, secondarily to that, we need to look at the larger picture. It's one thing to link [our clients]; it's another to retain them once they've been linked up. That's a challenge." -GRANTEE

For key points of entry

Point-of-entry agencies may be overwhelmed by their clients' needs related to HIV and AIDS. For an organization such as a homeless shelter or detention center whose primary mission is not health care, providing treatment and other services for those living with HIV may drain both staff time and resources. Meanwhile, for an organization whose mission is health care-related but not focused on HIV—such as a family planning clinic, a migrant health center or an emergency room—the demands associated with adequately treating the disease can be staggering.

Formal linkages with CARE Act providers enable point-of-entry agencies to:

- Remain focused on their primary mission while still ensuring that people living with HIV/AIDS get the services they need; and
- Create partnerships and collaborations that broaden the agencies' ability to serve their communities and their clients while enhancing their profile in the community.

The New Linkage Requirements Explained

What are the linkage requirements?

When Congress reauthorized the CARE Act in 2000, it included new language aimed at expanding the number of people who receive HIV-related services. The law now requires recipients of Title I and Title II funds to "maintain appropriate relationships with entities in the eligible area served that constitute key points of access to the health care system for individuals with HIV disease…for the purpose of facilitating early intervention for individuals newly diagnosed with HIV disease and individuals knowledgeable of their HIV status but not in care."[4] (See **Appendix A**.)

In other words, entities funded by Titles I and II of the CARE Act now are required to develop referral relationships with organizations through which people living with HIV are likely to access the health care system. These entities—from emergency rooms to homeless shelters and mental health programs—are known as "key points of entry" because they are the first (and sometimes the only) means by which many people seek and receive health care.

BOX 2

What are the "Key Points of Entry"?

The key points of entry listed in the CARE Act are:

- Adult and juvenile detention facilities
- Detoxification programs
- Emergency rooms
- HIV counseling and testing sites
- Homeless shelters
- Mental health programs
- Sexually transmitted disease clinics
- Substance abuse treatment programs

In addition to these key points of entry, the legislation also requires linkages with other entities. Those facilities are:

- Community health and family planning centers (grantees under Section 330 of the PHSA)
- Comprehensive hemophilia diagnostic and treatment centers
- Family planning centers (grantees under PHSA Section 1001)
- Federally qualified health centers
- Health services for the homeless (grantees under PHSA Section 340)
- Migrant health centers (grantees under PHSA Section 329)
- Private, nonprofit entities that provide comprehensive primary care services to populations at risk of HIV disease
- Public health departments
- Other health care points of entry specified by the eligible areas

Congress's goal was to connect more people living with HIV/AIDS with essential HIV-related medical and support services. The hope is that CARE Act providers can reach not only individuals who are newly diagnosed with HIV, but also those who know their HIV status but are not in care. **Box 2** lists the types of health care providers with which CARE Act-funded entities must form linkages.

What are HRSA's expectations regarding linkages?

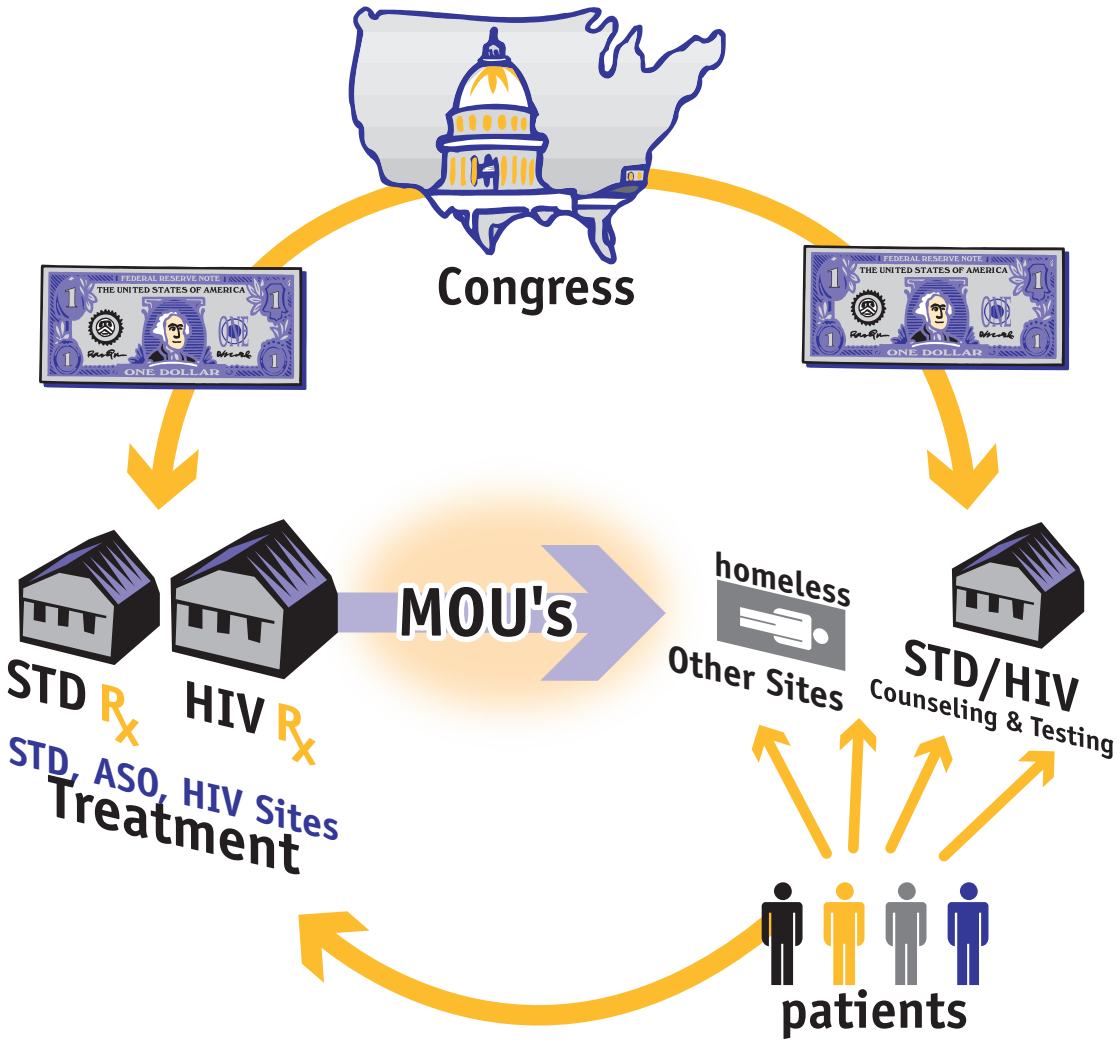
The federal Health Resources and Services Administration (HRSA) is responsible for implementing the CARE Act. HRSA outlined its expectations regarding linkages in a

4 Section 2605 (a)(3) of the CARE Act.

guidance letter issued in 2001 (See **Appendix B**.) In that letter, HRSA directs Title I and Title II grantees and planning councils to "engage in discussions regarding the nature of appropriate relationships between funded HIV service providers." HRSA also directs grantees to develop referral relationships and linkages between funded providers and key points of entry.

HRSA requires that the relationships be "documented through contract language requiring providers to establish ongoing relationships with the local points of entry." HRSA also suggests that these relationships can be supported by funding local points of entry, or by holding regular meetings between CARE Act-funded providers and point-of-entry programs. HRSA uses grantee progress reports, monthly monitoring calls and site visits to monitor grantee compliance with these requirements.

HRSA does not expect organizations to form linkages with every agency. The worksheets in this book are designed to help your organization make the right decisions about which of the many possible partners to reach out to first. (Also see CAEAR's recommendations in Step III, page 16, for suggestions on the number and type of linkages to form.)



What is the Relationship between Early Intervention Services (EIS) and the New Linkage Requirements for Title I grantees?

In the CARE Act of 2000, Congress also authorized Title I grantees to fund Early Intervention Services (EIS), which are defined as counseling, testing and referral activities designed to bring people living with HIV into the local continuum of care.

According to HRSA, "Funding EIS should be considered primarily as a mechanism to establish critical and key relationships and linkages between the local Ryan White system of care and points of entry within the EMA. Through contractual relationships between the EMA and community-based access points, HIV-positive clients [who are] not in care may be identified and referred into the health care system."

By including EIS in Title I services, Congress sought to increase the availability of key counseling, testing and referral services at the points of entry within an EMA. The planning council can play a crucial role in expanding the availability of these essential services and in bringing the points of entry into the local CARE Act-funded services network. This can be achieved in two ways: by allocating a certain portion of the EMA's Title I funds to EIS; and by directing funded entities to locate and form linkages with key points of entry.

IV. Building Relationships: Linking CARE Act Providers with Key Points of Entry

Establishing working, formal relationships between CARE Act providers and points of entry can be a challenging process. Many CARE Act providers have long-established and effective relationships with some points of entry in their communities. For others, however, the relationships either do not exist or exist in informal and haphazard ways that limit their effectiveness and reach. Often, referral relationships are based on personal connections among staff and have not been institutionalized through monitoring mechanisms. One good source for information about your local epidemic is your local health department. Information on Title I and Title II can be found at www.hab.hrsa.gov/programs.htm.

Informal relationships are a useful beginning. But a strong continuum of HIV care that provides easier access to early intervention services requires formal links between CARE Act-funded providers and key points of entry. The following steps—together with the accompanying worksheets—will help your organization begin the linkage process.

STEP ONE — Assess the epidemic in your community and state.

Before your organization can develop formal relationships with other providers, you need a better understanding of the populations in your community or state who are most at-risk of living with HIV disease but who are not yet in care. As part of this assessment, you should examine your EMA's Comprehensive Plan, which is likely to contain useful demographic information, as well as strategies for reaching affected populations.

The HIV/AIDS epidemic can be a very local phenomenon. Each community looks different in terms of its particular risk factors and the groups that are disproportionately affected by the disease, as well as the resources available for responding to the needs of those living with HIV. CARE Act providers will therefore want to form linkages with different kinds of agencies, based on their unique local needs.

Those providers that are effectively reaching their community's affected populations already will have a good idea about the groups that are most at-risk, most disconnected from AIDS care and most in need of services. CARE Act providers are likely to be serving many of these individuals already. At the same time, however, providers should acknowledge that their current clients may not be a complete reflection of those who are most at-risk within their service areas. It is possible that some groups are not being reached by CARE Act providers; many in the community may not even know their HIV status. See Box 3 for a list of demographic and other factors that can influence whether or not an individual or group needs greater access to care. **Worksheet 1** will help you to assess this issue as well.

BOX 3

Factors Affecting Those Living with HIV/AIDS

- Age
- Gender
- Race/Ethnicity
- Housing Status
- Alcohol and other drug use
- Poverty
- Income
- Language
- Health Status
- Family Status

STEP TWO — Assess the local service community.

The next thing to do after assessing the nature of the epidemic in your community or state is to examine the key points of entry to the health care system and to determine which are most likely to serve people living with HIV/AIDS. Whether they (or their clients) know it or not, many organizations in your community or state are currently serving people living with HIV/AIDS. These agencies together form the pool of potential linkage partners. They include:

Social Service Agencies—Agencies that help people with services that are not usually related to health care, such as housing or food.

Health Care Providers—Agencies that help people with health care, but that do not focus on HIV/AIDS issues, such as family planning clinics or migrant health centers.

Writing down your community's social service and health care providers will help your agency assess where linkages will be most useful to you and your clients. **Box 4** contains a list of social service and health care agencies that are likely operate throughout your EMA, assisting individuals with issues other than care related to HIV/AIDS.

In addition to these organizations, your agency may have other ideas for linkages based on your experience with other organizations in the community or the state. Here are a few of the ways in which CARE Act providers can be sure to identify a broad range of potential linkages:

Worksheet 1

ASSESS THE EPIDEMIC IN YOUR COMMUNITY

Using the following demographics factors, develop a narrative assessment of the HIV/AIDS epidemic in your community. Pay particular attention to the factors that disproportionately affect people living with HIV in your community. Taking these factors together—along with your experience working in the field—think about where the epidemic is currently focused in your community and where it is moving. Keep in mind these questions:

- **Age:** Are there certain age ranges that are more affected than others? In your community, it may be teenagers and young adults who are the group most frequently being newly infected, while AIDS itself is largely found in adults. Increasingly, older adults are becoming infected with HIV/AIDS. What age ranges are most likely to experience HIV and AIDS in your community?

Age Ranges

- Pediatric (children under 13)
- Adolescent (13-24)
- Adult (25 – 49)
- Older Adults/Geriatric (50 and over)

Notes:

- **Gender:** Nationally, men are more likely to become infected than women are. Are men, women, or trans-gender individuals at-risk in your community?

Notes:

Gender

- Men
- Women
- Transgender

ASSESS THE EPIDEMIC IN YOUR COMMUNITY

- **Racial/Ethnic Background:** Are there racial groups, or ethnic groups, that are disproportion-ately affected by HIV/AIDS? Nationally, African Americans and Hispanics experience higher rates of infection than other groups. What is the situation in your community?

Racial/Ethnic Groups

- African American/ Black (non-Hispanic)
- American Indian/ Alaska Native
- Asian
- Caucasian/White (non-Hispanic)
- Native Hawaiian/ Pacific Islander
- Hispanic/Latino (a)
- More than one of the above
- Other

Notes:

- **Poverty:** The lack of advantages and opportunities that come from low income has been clearly connected with increased risk of many health problems, including HIV infection, and reduced access to health care. Are there particular groups in your community who are likely to experience poverty?

Notes:

- **Drug Use:** Injection drug use is correlated to increased risk of HIV/AIDS infection. Other substances—such as alcohol or Ecstasy—may play a role too, as they impair decision making and can lead to risky and unprotected sexual behavior. What is the situation connected to drug and alcohol consumption in your community?

Notes:

ASSESS THE EPIDEMIC IN YOUR COMMUNITY

- **Housing Status:** HIV/AIDS is found at alarming rates among the homeless, whose infection rates may be ten times higher than the rate among the general population. How many homeless people are in your community, and what is the state of their health?

Notes:

- **STD Infection:** Having a sexually transmitted disease increases a person's chances of contracting HIV/AIDS. Are there connections between STDs and HIV/AIDS in your community? If so, which STDs are most a factor?

Notes:

STD's

- Gonorrhea
- Herpes
- Syphillis
- Chlamydia

- **Sexual Behavior:** In some communities, men who have sex with men (MSM) are the fastest growing group of newly infected individuals. In others, the risk is greatest among heterosexuals who inject drugs or have sex with injection drug users. Are there groups in your community who are at risk of infection because of their sexual activities or partners?

Notes:

ASSESS THE EPIDEMIC IN YOUR COMMUNITY

What other factors affect people who are at-risk of HIV/AIDS in your community?
It may be that certain groups—such as people who are deaf or those who work as migrant laborers—have high infection rates in your state and/or community. List out other characteristics you may be aware of here:

Taking these factors together—along with your experience working in the field—think about where the epidemic is currently focused in your community

Where is the epidemic centered in your community?

The population that is most at risk may be young, homeless kids who engage in survival sex. It may be older adults who don't realize that they are at-risk for infection. List out what you know about the main groups at risk of HIV infection:

Where is it heading?

HIV/AIDS is a moving target. The disease often shifts where it is centered—from gay, white males to African American heterosexual girls, for example. You'll want to think about where your community is starting to see the epidemic, and form linkages with organizations that can help meet the need of newly infected people as the disease evolves. List out what you know about groups that appear to be increasingly at-risk of HIV infection:

These lists will help you think about the service providers that will make good linkage partners. We'll come back to them lists later on.

- *Consumer-Identified Linkages*—Consumers often are well versed in navigating the service delivery system. Engaging CARE Act clients in the linkage process helps ensure success and consumer agreement with the process.
- *Site Visits*—Useful linkages can be identified during program coordinators' site visits, when agencies discuss their needs and coordinators can help establish connections with other agencies.
- *Title I Neighborhood Networks*—Monthly HIV network meetings for providers and consumers can generate even more ideas about potential linkages.

Worksheet 2 will help your agency generate a list of places that offer health care and social services in your community and state. We have filled out one section as an example. But remember: Your list will be very localized. There may be several homeless shelters and STD clinics in your community, or only one of each. Similarly, your community may have a well-established network of neighborhood health centers, or there may be only one public hospital. Developing a detailed list of these points of entry is a necessary step toward identifying those providers with which your agency can establish productive linkages.

STEP THREE – Prioritize service providers for linkages.

On **Worksheet 2**, you have listed all of the potential partners with which you could form linkages. It is a long list, but remember:

- This is *not* the list of agencies with which you must form linkages.
- The list simply helps to prioritize the most appropriate organizations for linkages.

Looking across all of the organizations on this list, the next step is to decide which ones would be the best partners for your agency. This will give you a manageable list to target for creating new memoranda of understanding (MOUs) on referral to care. Your target list should include agencies that serve clients who are most likely to be:

- Underserved;
- Living with HIV; and
- Not receiving CARE Act services.

BOX 4

Potential Linkage Partners

Social service providers

- Adult and juvenile detention facilities
- HIV counseling and testing sites
- Homeless shelters
- Substance abuse treatment programs
- Local nonprofit HIV prevention agencies
- Public health departments

Health care providers

- Community health centers
- Detoxification programs
- Family planning centers
- Comprehensive hemophilia diagnostic and treatment centers
- Federally qualified health centers
- Health services for the homeless
- Migrant health centers
- Mental health programs
- Sexually transmitted disease clinics
- Emergency rooms

Which service organizations are most likely to see people living with HIV/AIDS in your community? It may be that there are many people with HIV who are served at the local homeless shelter. However, if research shows that few homeless people in your community are living with the disease, the shelter is not the best place to form a new linkage. In the same way, if research and your experience indicate that most of those who are living with HIV and who are not yet in care are drug-addicted teens, then one of the best places to begin forming linkages is with agencies serving that population.

Your agency's priority list should include several categories of groups. You may already have informal agreements with some of these groups, and others may already be funded to conduct EIS. The goal here, however, is to move toward more formal, working relationships. **Worksheet 3** will help you identify these groups so you can begin to work with them to broaden access to HIV/AIDS services in your community or state.

CAEAR Recommendations — Start Small and Expand

HRSA has not specified a required number of linkages that CARE Act providers must form with their point-of-entry agencies. The HRSA guidance letter states only that CARE Act providers must maintain "appropriate relationships" with these entities. Moreover, while Congress described the entities with which CARE Act providers are *likely* to seek linkages, it, too, did not mandate a set number—or type—of linkages.

Based on focus group feedback and research among its members, the CAEAR Coalition Foundation believes that providers should begin by seeking **three to five** formal linkages in their communities. Of these formal linkages, the Foundation believes that:

1. The first should be with *the most relevant* of the counseling and testing (C&T) facilities in your community—i.e., the C&T agency that serves those who are most likely to need CARE Act services but who are not receiving them. This may be a C&T facility that serves a particular racial/ethnic, age or other group. An immediate linkage to a CARE Act provider will help the facility ensure that its clients have rapid access to anti-retroviral therapy and other life-enhancing services.
2. A second MOU should be established with the community's main sexually transmitted disease (STD) clinic serving the population most in need of CARE Act services. As with C&T facilities, the community's primary STD clinic is likely to diagnose a fair number of cases of HIV, and a system for immediate referrals will help clients begin to get care in a timely fashion.

ASSESSING LOCAL PROVIDERS

Directions: Using the list below, generate a list of places that offer health care and social services in your community. Writing down the services that exist in your community will help you to assess where linkages will be most useful for you and your clients. For each type of organization, list the agency name, contact information, agency mission, and clientele served (including HIV risk factors), and any agency-specific information that is relevant to assessing the agency's appropriateness to serve as a referral partner. Also, include any specific notes or comments about each organization. An example is provided.

Likely agencies:

- Adult detention facilities
- Juvenile detention facilities
- Detoxification programs
- HIV counseling and testing programs
- Substance abuse and treatment programs
- Local non-profit HIV prevention agencies
- Public health departments
- Community health centers
- Family planning centers
- Comprehensive hemophilia diagnostic and treatment centers
- Federally qualified health centers
- Health services for the homeless
- Migrant health centers
- Mental health programs
- Sexually transmitted disease clinics
- Emergency rooms

ASSESSING LOCAL PROVIDERS

Agency	Contact	Mission	Clientele	Notes
Gotham Family and Medical Services	*Sandy Joe*	*Provides primary medical care*	*Varied*	*Receptive to linkages in past*

IDENTIFYING NATURAL ALLIANCES AND SELECTING POTENTIAL PARTNERS

Generate a list of agencies with whom you currently work or agencies that would be logical choices as partners. For each, list the agency name, contact information, current relationship (if any), and who in your organization works with that agency. Circle the three to five that you want to start with, leaving the rest for later.

Priority A: Current Relationships

Many CARE Act providers already have informal linkages or collaborative arrangements with non-CARE-Act-funded organizations in their areas. Your agency may already have robust relationships with some area points of entry—i.e., agencies from which you receive referrals and with whom you regularly communicate. Often, these informal agreements grew out of personal relationships between staff members.

While collaborations of this nature can be very effective, they rarely withstand staffing changes without considerable effort, since they are based on personal—rather than organizational—connections. These organizations are, however, appropriate places to begin creating formal linkage MOUs. This is particularly true of agencies with less bureaucracy and fewer territorial concerns.

Agency	Contact	Current Relationship	Staff
(Example) *Gotham City Counseling*	*Mary Joe*	*Clients that need pre- and post-testing counseling are referred to them*	*Sandy*

IDENTIFYING NATURAL ALLIANCES AND SELECTING POTENTIAL PARTNERS

Priority B: Counseling and Testing Facilities

List the names of the most relevant of the counseling and testing (C&T) facilities in your community—those that serve individuals who are most likely to need CARE Act services, but who are not receiving them.

Agency	Contact	Current Relationship	Staff

Priority C: STD Clinics

List the community's main sexually transmitted disease (STD) clinics. These clinics are also likely to identify and serve people living with HIV who will need CARE Act services.

Agency	Contact	Current Relationship	Staff

IDENTIFYING NATURAL ALLIANCES AND SELECTING POTENTIAL PARTNERS

Priority D: Your Community's Needs

You probably are well aware of the services and supports that your agency's clients need but are not currently getting. For example counseling and testing, housing etc. List these services as well as the names of any agencies that work on these issues in your community.

Agency	Contact	Current Relationship	Staff

Priority E: EIS Agencies

New federal EIS funds offer opportunities for enhanced linkages between outreach and care providers. EIS providers offer counseling, testing and referral services that clearly dovetail with CARE Act providers' mission and services. HRSA's guidance letter notes that "funding EIS should be considered primarily as a mechanism to establish critical and key relationships and linkages between the local Ryan White system of care and points of entry within the EMA."

Agency	Contact	Current Relationship	Staff

IDENTIFYING NATURAL ALLIANCES AND SELECTING POTENTIAL PARTNERS

3. The remaining MOUs should be made with points of entry that best meet your community's particular circumstances and demographics. As noted, the HIV/AIDS epidemic may disproportionately affect one group more than another—e.g., teenagers, the homeless, substance abusers, or a particular racial/ethnic population. Based on your particular circumstances, use at least one MOU to ensure that at-risk groups get increased access to care.

> *"We are a small EMA and so our linkages occur naturally with our system of services. Those connections to points of entry also occur naturally because, very often, we have one service provider in each category."*
>
> *—PLANNING COUNCIL SUPPORT STAFF*

STEP FOUR — Begin reaching out to potential partners.

In **Worksheet 3**, you circled three to five agencies with which to form linkages. Now it is time to start reaching out to these agencies. Here are some suggestions for moving from establishing initial contacts to developing formal linkage agreements:

- *Contact staff at the other agency.* You or one of your staff may have a personal relationship that can provide the basis for discussing a formal linkage. You may decide to reach out to the direct service staff, or to go straight to the administrative side. Every organization is different, and you should take the approach that is most comfortable for you.
- *Meet with staff and discuss the benefits of collaboration.* A one-on-one meeting is best for describing why a linkage agreement would benefit both parties. You will want to discuss the benefits of CARE Act services for people living with HIV; how these services can help the agency's clients; and why linkages make sense for the point-of-entry provider. You may need to hold several meetings with staff at different levels before gaining approval for an MOU.
- *Develop an MOU.* If the other agency is interested, an MOU is the next step. The two organizations can write the MOU together, or you can present a draft MOU to the agency for its comment and review. (See the following sections for more information on drafting MOUs.)
- *Review and sign the agreement.* Formalizing the agreement by signing paperwork is just the beginning of a relationship between two parties. The next step is to create ways to make the

> *"In our EMA, we're dealing with a system where there are no agreements formalized. All of them are based on personal relationships."*
>
> *—GRANTEE*

partnership real and effective. For the partnership to truly thrive, agencies must find ways to build communication, share information and assess the collaboration on an ongoing basis. (See the following sections for more on how to make linkage relationships work.)

Common Barriers to Developing Linkages

Sadly, barriers exist to developing strong referral networks for HIV/AIDS services (see Box 5). While you are exploring the possibility of establishing formal linkage agreements with other agencies, you will want to consider ways to overcome these barriers, which include:

BOX 5

Potential barriers to linkages:

- Competition for scarce funds
- Institutional bureaucracy
- Lack of time, staff and resources
- Shortage of needed services
- Prejudice against people living with HIV
- Lack of representation on planning councils
- Confusion about how the CARE Act works and what the different Titles' services are

Competition:

Linkages are likely to be affected by competition for increasingly scarce funding. In some areas, the CARE Act is the primary funding source for community organizations. Flat or decreasing funding from the CARE Act and philanthropic sources may create competition and lead to tension between community agencies. This may affect agencies' willingness to form linkages with organizations that are perceived to be competitors for available dollars.

Hard-to-reach agencies:

For a variety of reasons, CARE Act providers traditionally have found it hard to form alliances with schools, private physicians, hospitals, mental health and substance abuse providers, and correctional and/or detention institutions. These agencies often are not funded under the CARE Act, although they tend to serve individuals who are at increased risk for HIV infection—such as young people and those in the corrections system.

Burdensome paperwork:

Point-of-entry organizations may be concerned that formal agreements with CARE Act providers will result in additional paperwork and administrative duties. Potential collaborators may be reluctant to form linkages with CARE Act providers because of the CARE Act's reporting requirements, which can prove an insurmountable barrier to collaboration when passed along to referral agencies.

Demand for services:

Social service providers often are overwhelmed by the desperate need for services in many

"Linkages only work when there are services there to link them with."

—PLANNING COUNCIL SUPPORT STAFF

communities. This is particularly true for substance abuse, homeless, housing and translation services. Where resources are scarce and where service providers struggle to keep up with need, the time and energy that collaboration requires may be in short supply.

HIV stigma:

There is still a stigma associated not only with HIV/AIDS but also with providing services to people living with the disease. This may make it hard for non-CARE-Act-funded providers to understand the vital importance of partnering to serve their clients who are living with HIV. Some point-of-entry providers may also believe that they do not have enough clients living with HIV/AIDS to warrant greater service coordination.

Lack of planning council representation:

Too often, non-CARE-Act-funded providers do not sit on planning councils. It has been particularly difficult, for example, to involve Medicaid representatives in the councils. What's more, in some cases the representatives of non-funded agencies do not have decision-making power or authority and cannot engage their organizations in collaborative programs and projects.

Confusion among non-CARE-Act-funded providers:

Providers and the public often do not understand the difference between the various CARE Act Titles, and how the CARE Act differs from Medicaid. This lack of clarity makes it hard for people (particularly those who are unfamiliar with CARE Act providers) to know which entities they should join with in referral arrangements.

Suggestions for Overcoming Barriers

While a strong planning council can help address some of the barriers to formal linkages, many of these problems can only be overcome with time, energy and commitment. Sometimes the best strategy is to wait, build relationships with other agencies and come back to the more challenging organizations later on. Some useful strategies for building connections are noted below.

Build partnerships

Bringing more people to the table helps to increase collaboration. Publicly funded organizations and other hard-to-reach agencies should be engaged in CARE Act activities (such as the work of Title I planning councils and Title II planning consortia) even if they do not receive CARE Act funding. Potential partners include faith-based organizations, school boards, hospitals and correctional facilities.

Educate

Other organizations may not realize that their clients have needs connected to HIV/AIDS; or they may be confused about CARE Act services. Training and education can help these agencies understand the CARE Act and the benefits of formal linkages. Agencies need to understand that linkages can help them help their clients while remaining focused on the agency's mission.

Protect confidentiality

Overcoming concerns about disclosure requires confidentiality to be protected throughout service coordination systems. Clients must be actively informed about their rights and told how their confidentiality will be protected.

Create protocols

Protocols help to establish a standard way for referrals to work while guiding newcomers though the process. Systemization may help to encourage agencies that have not traditionally used referrals to create referral protocols and become more collaborative.

Build trust and confidence

Involving familiar and/or well-connected individuals in attempts to develop linkages can build confidence among agencies. When an agency's board member suggests linkages, or when a longtime colleague raises the issue, it helps to build trust between the two entities.

Prioritize linkages

As noted above, it is inherently difficult to form linkages with certain types of agencies. As a result, it is important to be realistic that these arrangements may take awhile to get off the ground. CARE Act providers may want to form a second tier of linkage partners; these are agencies to pursue for linkages only after other agreements are in place. In particular, larger institutions that have to involve their legal departments in negotiating MOU agreements should be placed on a second tier for outreach.

Worksheet 4 can help you assess the barriers that may exist between your agency and others in your community and state, and begin listing strategies that can be used to overcome them.

OVERCOMING BARRIERS TO LINKAGES

Directions: Think about organizations with which it has been hard traditionally to form partnerships. List each agency and describe barriers that exist between it and your agency. Consider strategies that can be used to bridge the gaps between the agencies. Begin with the agencies that would produce the most beneficial linkages. As noted, these strategies might include educating agency staff on HIV-related service needs of their clients; developing a model confidentiality policy for agencies that provide limited or no HIV-related services; creating a standard referral form that other agencies can use to refer their clients to you; and enlisting the leadership of your agency to work with their peers at other organizations on forming relationships. An example is provided.

Agency	Barrier	Strategy
Gotham Family and Medical Services	*Case managers are not responsive to requests for coordination*	*Schedule a meeting with the executive director to establish a relationship*

OVERCOMING BARRIERS TO LINKAGES

V. Making Linkages Work: The Memorandum of Understanding

Once your organization has identified agencies to form linkages with, and has worked to overcome any barriers to doing so, the next step is to form agreements to broaden services for people living with HIV/AIDS in your community.

What is a Memorandum of Understanding?

A Memorandum of Understanding can also be called a Memorandum of Agreement; for the sake of simplicity, this document uses the term "Memorandum of Understanding," or "MOU." Like a contract, an MOU outlines an agreement between two parties and delineates actions and deadlines to which all parties agree to adhere. An MOU, however, is not binding in the same way that a contract is, because a contract includes legal components such as indemnification, risk-sharing and other representations. An MOU primarily outlines a shared project or set of activities, but does not include penalties for any violations of the agreement. See **Appendix C**.

> *"Any one of our gatekeeper agencies that allows access to our continuum of care must have a formal relationship with at least two out of three government entities."* —GRANTEE

Many organizations cannot enter contracts without the involvement of their legal representation and/or the approval of their board of directors. This makes MOUs all the more appealing because they are simpler for agencies to implement and do not to require the same level of oversight or administrative approval.

MOUs will be different depending on the agencies involved and the scope of the partnership. Nevertheless, every MOU should be written according to the following principles:

- The goal of the MOU should be to help the agencies' clients;

- The agreement should lay out a feasible scope of work (e.g., it should not necessitate an overwhelming amount of paperwork or require unrealistic staff efforts);
- The MOU should be designed to survive any personnel changes at the agencies;
- It should include a process for assessment after a specified period of time; and
- It should include monitoring provisions to help the agencies determine how the agreement is working.

Potential Components of an MOU

MOUs are variable and can include many components, which are described below. Nevertheless, every agreement should include:

- Names of the agencies signing the MOU;
- Specific details about the activities occurring under the linkage agreement;
- A clear timeline for the agreement; and
- Executive signatures.

Some CARE Act providers have one standard MOU that they use with all referral partners. An MOU template is very useful and ensures that all relevant and important information is captured in the agreement. Creating one "boilerplate" agreement, however, may reduce flexibility and ultimately weaken potential partnerships, so proceed cautiously.

Following are the main components of an MOU (not all of these sections will be necessary for every agreement):

- *Names of the parties entering the agreement:* The names of the agencies involved, and a description of each agency's mission.
- *Overview of the project or activities to which the parties are agreeing:* A summary of the activities to be governed by the agreement; the specific name of the project (if any); the authorization granted by the MOU; and the project's goals, intended outcomes and target clientele.
- *Responsibilities:* An outline of each party's roles and obligations under the agreement, and a description of what each party will do. This is an appropriate place to note that each organization will comply with all appropriate local, state, or federal laws and regulations.

> *"My problem is figuring out what to include in the MOUs. Do I need one that everyone signs with everyone identified? Or do I want to do individual agreements between agencies? Do I need one or a dozen?* —*TITLE I ADMINISTRATOR*

- *Timeline:* A description of when the MOU activities will start, and the date by which they will be completed. This section may also include a timeline for reassessing or renegotiating the MOU.
- *Duration (or term) of the MOU:* A description of the overall length of the agreement. Some MOUs have a one-year duration, with a provision that the agreement can be extended upon mutual consent. If the MOU is an extension of a previous agreement, that fact would be noted in this section.
- *Termination of the MOU:* Conditions under which the MOU may be terminated, other than the end of the project timeline. This section might address what happens to the MOU if funding is curtailed or if one agency cuts its programs in the area covered by the MOU. This section also may list the mechanism for terminating the MOU (e.g., "Termination will occur 30 days after written notice is submitted to the executive director of the other agency").
- *Personnel involved in the activities or projects:* A list of the staff who are affected by the agreement. Note staff titles rather than individual names, so that future staffing changes do not affect the intent of the agreement.
- *Reporting requirements:* The reporting requirements that govern the MOU. Reports might be required to detail the number of clients referred by the point of entry, the number of clients served by the CARE Act provider, the meetings or training sessions conducted between the two entities, etc. Note the schedule for submitting reports (e.g., monthly or quarterly). Copies of required tracking, evaluation or other forms may be appended to the MOU.
- *Financial matters:* Although many MOUs do not include any financial relationships, it should be noted in the MOU if money is changing hands. This includes any revenue sharing, compensation or reimbursement related to staff time, number of referred clients or other costs. Also, clarify the schedule and means by which funds will be exchanged (e.g., on a monthly basis by invoice, quarterly reimbursement claims, semi-annual grants, etc.).
- *Confidentiality:* Privacy is a paramount concern for many people living with HIV/AIDS. Therefore, the MOU should describe mechanisms to protect client confidentiality within the referral system and in the agencies' reporting.
- *Other communication requirements:* The MOU may set out mechanisms to ensure compliance, cooperation and communication between the two parties. Describe any regularly scheduled meetings, monthly reports, record-keeping functions and other such responsibilities.
- *Signatures:* The executive director or the chief executive officer of each agency should sign the MOU.

Sample MOU

Below is a sample Memorandum of Understanding that illustrates how an agreement might look. Each section is highlighted, with notes about what the sections contain.

MEMORANDUM OF UNDERSTANDING BETWEEN The XYZ CARE Act Provider and City-Wide STD Testing Facility

This agreement is entered between the **XYZ CARE Act Provider** & **City-wide STD Testing Facility**. The XYZ CARE Act Provider serves the Anywhere City EMA and provides treatment, care and other needed support services for people living with HIV. The City-Wide STD Testing Facility is the primary STD counseling and testing facility for Anywhere City.

Summary (or Overview)

XYZ CARE Act Provider & City-Wide STD Testing Facility agree to jointly collaborate on the *Referral Project*, an effort to increase linkages between testing sites and AIDS service organizations in Anywhere City. As partners, XYZ CARE Act Provider and City-Wide STD Testing Facility will refer clients diagnosed with HIV/AIDS, encourage service delivery to people living with HIV, and facilitate secondary referrals between agencies. The parties propose to serve 200 adults living with HIV/AIDS each year, primarily the homeless and Latino populations in Anywhere City.

This MOU authorizes City-Wide STD Testing Facility to provide XYZ CARE Act Provider with the names and other demographic information of people newly diagnosed with HIV to facilitate their referral to care.

Responsibilities (or Scope of Services)

City-Wide STD Testing Facility will:

- Provide a referral to XYZ CARE Act Provider to all clients newly diagnosed with HIV/AIDS;
- Provide each client with materials explaining the benefits of XYZ CARE Act Provider services;
- Contact XYZ CARE Act Provider to make an appointment for clients newly diagnosed with HIV;
- Provide required reports on all referrals to XYZ CARE Act Provider; and
- Comply with all appropriate local, state, or federal laws and regulations.

XYZ CARE Act Provider will:

- Accept referrals from City-Wide STD Testing Facility of all clients newly diagnosed with HIV/AIDS;
- Agree to make an appointment with clients within three days of the referral;
- Facilitate secondary referrals back to City-Wide STD Testing Facility;
- Provide required reports on all clients referred by City-Wide STD Testing Facility; and
- Comply with all appropriate local, state, or federal laws and regulations.

Timeline and Duration

This MOU shall remain in place from May 1, 2003, until May 1, 2004, unless modified in writing before that date. Clients will be referred on a continual basis throughout the year. This MOU may be extended for additional months or years at the end of the agreement period.

Termination

This MOU may be terminated in whole or in part by either party without cause. The MOU will be deemed to be terminated 30 days after written notice of the first party's intent to terminate has been received by the second party. This notification must include the reason for termination of the MOU. This MOU will terminate automatically if either party ceases to provide HIV/AIDS testing, counseling or care services due to lack of funding. In the event of termination, all required reports will be completed until the end of the agreement.

Personnel

Staff governed by this MOU include all counseling and testing workers, administrative staff accepting appointments, and case managers. Points of contact for communication on this MOU will be the Testing Manager, City-Wide STD Testing Facility; and Coordinator of Case Management, XYZ CARE Act Provider.

Reporting

Reports will be submitted to each agency on a monthly basis, no later than the 15th of each month. City-Wide STD Testing Facility will provide a monthly report on the number of clients referred to the XYZ CARE Act Provider, including the age, gender and race/ethnicity of each client. XYZ CARE Act Provider will provide City-Wide STD Testing Facility with a monthly report on the number of clients seen for care, including the age, gender and race/ethnicity of each client.

Finances

There are no financial arrangements governed by this MOU. Neither agency will bill, reimburse or charge the other for services provided to clients.

Confidentiality

Clients' names shall remain confidential as required by state and local law. Upon successful referral to XYZ CARE Act Provider, City-Wide STD Testing Facility will destroy all identifying information connected to the client. XYZ CARE Act Provider will maintain case records in locked and secure areas that are accessible only to case managers.

Communication

City-Wide STD Testing Facility and XYZ CARE Act Provider agree to participate in quarterly meetings of case managers and administrators. These meetings will provide an opportunity to assess the referral linkages, review referral data and suggest necessary improvements. Other parties may also be invited to participate in these meetings, as needed.

Belinda Caring, M.S.W.	James Extendlife, MD
Executive Director	Chief Executive Officer
City-Wide STD Testing Facility	XYZ CARE Act Provider

Your Ideal MOU

Agency MOUs are unique documents. What works for one organization may not be effective for another. Some of the components noted above may be essential for you, while others may not be useful in your particular situation. Use the worksheets below to think about what components you want your MOUs to contain, and to sketch out an initial agreement. **Worksheet 5** will help you determine the MOU components that you believe are appropriate and necessary for your agency to include in its agreements. In **Worksheet 6**, you will use our template to draft a sample MOU between your agency and another collaborating partner.

What HRSA Requires from CARE Act Providers

According to HRSA's guidance letter, the existence of linkage relationships should be documented through contract language that requires providers to establish ongoing relationships with local points of entry. As noted above, HRSA also suggests that these relationships be supported either through funding or by regularly scheduled meetings between staff of CARE Act providers and points of entry (see **Appendix B**). To demonstrate the formal linkages, CARE Act providers can provide HRSA with copies of their MOUs, monthly reports, meeting minutes and project evaluation data. It is important to demonstrate, in your CARE Act application, that linkages with key points of entry exist and are being monitored.

YOUR IDEAL MEMORANDUM OF UNDERSTANDING (MOU)

Use the worksheet below to think about what components you want your MOUs to contain.

COMPONENT	**Names of parties entering agreement**
WHAT IT IS	List the agencies that are entering the agreement and describe their mission
DO YOU NEED IT?	Always
BE SURE TO INCLUDE	Your agency name
	Your agency mission
	Partner's agency name
	Partner's mission

COMPONENT	**Overview of the project or activities**
WHAT IT IS	Summarize activities, authorization, goals, outcomes and target clientele
DO YOU NEED IT?	Always
BE SURE TO INCLUDE	Linkage activities
	What the MOU authorizes the agencies to do
	Goals of the linkage agreement
	Intended outcomes of the project
	Target clientele for linkages

YOUR IDEAL MEMORANDUM OF UNDERSTANDING (MOU)

COMPONENT	**Responsibilities of each agency**
WHAT IT IS	Summarize responsibilities by agency
DO YOU NEED IT?	Always
BE SURE TO INCLUDE	What your agency will do as part of the MOU
	What the other agency will do as part of the MOU
	Statement that each agency will comply with all appropriate local, state, or federal laws and regulations

COMPONENT	**Signature of executive from each agency**
WHAT IT IS	Indicates official authorization for the agreement
DO YOU NEED IT?	Always
BE SURE TO INCLUDE	Executive director or CEO signing for your agency
	Executive director or CEO signing for partner agency

COMPONENT	**Timeline of project activities**
WHAT IT IS	Describes when activities will start, be assessed, and stop.
DO YOU NEED IT?	Usually
BE SURE TO INCLUDE	Date project will start
	Date activities will occur (or be started) by
	Date activities will be assessed
	Date activities to end

COMPONENT	**Duration (or term) of the MOU**
WHAT IT IS	Overall length of the MOU
DO YOU NEED IT?	Usually
BE SURE TO INCLUDE	This MOU will remain in place until:
	This MOU may be extended upon agreement of the parties.

YOUR IDEAL MEMORANDUM OF UNDERSTANDING (MOU)

COMPONENT	**Termination**
WHAT IT IS	Conditions under which the MOU may be terminated
DO YOU NEED IT?	Usually
BE SURE TO INCLUDE	Under what conditions would MOU end
	What happens if either party loses funding for program
	How termination is conveyed to the other party

COMPONENT	**Personnel involved**
WHAT IT IS	Staff members involved in the agreement by title
DO YOU NEED IT?	Usually
BE SURE TO INCLUDE	Your staff involved in the agreement
	Other party's staff involved in the agreement

COMPONENT	**Confidentiality**
WHAT IT IS	Overview of mechanisms for protecting patient confidentiality
DO YOU NEED IT?	Usually
BE SURE TO INCLUDE	How names will be stored
	How confidentiality will be protected in the reporting process
	How confidentiality be protected in making referrals

YOUR IDEAL MEMORANDUM OF UNDERSTANDING (MOU)

COMPONENT	**Reporting requirements**
WHAT IT IS	What information the agencies will share with each other as part of the MOU
DO YOU NEED IT?	Sometimes
BE SURE TO INCLUDE	Any reports required from either agency
	Frequency of reports (monthly, quarterly, annually)
	Information that must be contained in reports

COMPONENT	**Financial Matters**
WHAT IT IS	Describes financial relationships controlled by the MOU
DO YOU NEED IT?	Sometimes
BE SURE TO INCLUDE	Describe any financial arrangements that exist under the MOU
	Describe any revenue sharing plans
	Describe any compensation plans
	Describe any reimbursement plans
	Frequency of payments
	Schedule for billing or invoices
	Reports/paperwork required

COMPONENT	**Communication**
WHAT IT IS	Describes communication responsibilities
DO YOU NEED IT?	Sometimes
BE SURE TO INCLUDE	Regularly scheduled meetings

YOUR SAMPLE MOU

Use this worksheet as a template for what an MOU could look like between your agency and another collaborating partner.

Memorandum of Understanding

between

Crestview HIV Care Center (YOUR AGENCY) and Creekside Nutrition Center (REFERRAL AGENCY)

This agreement is entered between

Crestview HIV Care Center (YOUR AGENCY) and Creekside Nutrition Center (REFERRAL AGENCY)

Describe your mission:

Crestview HIV Care Center provides medical care and case management services for people in all stages of HIV disease.

Describe the other agency's mission:

Creekside Nutrition Center distributes food and cooked meals to people with limited financial resources and those who are too ill to prepare their own meals.

Summary

Crestview HIV Care Center (YOUR AGENCY) and Creekside Nutrition Center (REFERRAL AGENCY)

Agree to jointly collaborate on the HIV nutrition project (NAME OF PROJECT) an effort to increase linkages between

HIV care providers and providers of food in Mountain Valley. (FACILITIES/LOCATION)

As partners,

Crestview HIV Care Center (YOUR AGENCY) and Creekside Nutrition Center (REFERRAL AGENCY) agree to

work together to provide people with HIV/AIDS who can not afford food or are unable to cook for themselves with food and prepared meals.

YOUR SAMPLE MOU

The parties propose to serve

People with HIV/AIDS in Mountain Valley whose nutritional needs are not being met.
DESCRIBE NATURE OF COLLABORATION

Responsibilities

Crestview HIV Care Center will YOUR AGENCY	Assess all clients nutritional needs and their resources to meet those needs Identify clients whose nutritional needs are not being met and provide them with information about the services of Creekside Nutrition Center Contact Creekside Nutrition Center's intake coordinator and schedule an intake appointment for each referred client Comply with all appropriate local, state, or Federal laws and regulations (Always include the compliance responsibility.)
Creekside Nutrition Center will REFERRAL PARTNER	Conduct intake sessions for all clients referred from Crestview HIV Care Center Develop a nutrition plan for each client and begin providing appropriate food and meal services Provide appropriate Crestview HIV Care Center case manager with information on services provided to each client. Refer clients with HIV who need medical and support services to Crestview HIV Care Center's intake coordinator and schedule an appointment for them as necessary Comply with all appropriate local, state, or Federal laws and regulations (Always include the compliance responsibility.)

YOUR SAMPLE MOU

Time-line & Duration

This MOU shall remain in place from January 1, 2003 (STARTING DATE) until December 31, 2003 (ENDING DATE) unless modified in writing before that date. The MOU may be extended for Six months (LIST TIME PERIOD IN MONTHS OR YEARS)

Termination

This MOU may be terminated in whole or in part by either party without cause. The MOU will be deemed to be terminated 30 days after written notice of intent to terminate has been received by the other party. This notification must include the reason for termination. This MOU will terminate automatically if (LIST CONTINGENCIES)

Either agency ceases operations

In the event of termination, all required reports will be completed through the end of the agreement period.

Personnel

Staff governed by this MOU include (LIST STAFF TITLES/POSITIONS)

Crestview HIV Care Center	Case managers
	Intake coordinator
Creekside Nutrition Center	Intake coordinator

Points of contact for communication on this MOU will be

John Smith, case management director
CONTACT FOR YOUR AGENCY

Susan Wilson, intake coordinator
CONTACT FOR COLLABORATING AGENCY

YOUR SAMPLE MOU

Reporting

Report will be submitted to each agency on a quarterly basis.
FREQUENCY

Crestview HIV Care Center will provide
YOUR AGENCY

the total number of clients referred to Creekside Nutrition Center's intake coordinator

Creekside Nutrition Center will provide
OTHER AGENCY

the number of intakes it performed for Crestview HIV Care Center clients, the number deemed eligible for services, and the number that enrolled.

Finances

LIST FINANCIAL ARRANGEMENTS, IF ANY. IF NONE, STATE SO.

Neither party will compensate the other for services performed

Confidentiality

DESCRIBE HOW CONFIDENTIALITY WILL BE PROTECTED BY EACH PARTY.

Both Crestview HIV Care Center and Creekside Nutrition Center have confidentiality policies (attached) governing client-related information and client files and both will adhere to their policies. Referrals will be made via telephone, but no names will be left on voicemails or sent via email. Quarterly reports will only contain aggregate numbers and no names.

Crestview HIV Care Center's case management director and Creekside Nutrition Center's intake coordinator will meet quarterly.

Clients names shall remain confidential as required by state and local law.

YOUR SAMPLE MOU

Communication

Andre Jackson, Executive Director, Crestview HIV Care Center and
YOUR AGENCY

Tammy Mills, Executive Director, Creekside Nutrition Center
COLLABORATING AGENCY

will participate in meetings on a quarterly basis.
FREQUENCY

These meetings will provide an opportunity to assess the referral linkages, review referral data and suggest necessary improvements. Other parties are also invited to participate in these meetings, as needed.

Signatures

YOUR AGENCY'S EXECUTIVE DIRECTOR	OTHER AGENCY'S EXECUTIVE DIRECTOR
LIST EXACT TITLE	LIST EXACT TITLE
YOUR AGENCY NAME	OTHER AGENCY NAME

YOUR SAMPLE MOU

VI. Happily Ever After: Monitoring Linkages

Agreeing on an MOU, of course, is just the start of the linkage relationship, and agencies should plan to assess their MOUs on a regular basis, such as every six months. Are both parties meeting their obligations under the agreement? What gaps in service remain, and how they can be bridged? Based on the information gathered during the monitoring process, assess whether you and your partner agency need to make any changes to the MOU.

If a linkage is not working as well as it could, the agencies can refine the system, the MOU agreement or both. On the other hand, if everything is going smoothly, the agencies may decide to increase their level of collaboration and reflect that in an expanded MOU.

Some common ways to determine whether the MOU is working include:

- *Data collection:* Keeping track of the number of consumer referrals is a very important part of measuring the system's effectiveness. Data collection can track how many referrals have been made and what their outcomes were.
- *Feedback from consumers and referral agencies:* Consumer satisfaction is another way to determine success. Clients who have had notable interactions (either good or bad) are often willing to share their experiences and make recommendations for improvements or changes.
- *Meetings:* Meetings are an important way for providers to discuss and monitor how the referral process is going, share information and resources, and effectively coordinate care. Meetings may be most effective when they take place among individuals in similar service category or staff positions, such as case managers.

> *"We go out and we re-evaluate what's an effective linkage. We're not just talking about partnerships, we're talking about what makes sense to increase access."* —GRANTEE

Worksheet 7 lays out different ways to monitor agreements and provides space for you to start thinking about what will work best for you.

Worksheet 7

MONITOR THE LINKAGE

Examine each MOU from as many different perspectives as possible. Use this worksheet to help decide how you want to assess the agreements that are negotiated with various partnering organizations. Assess your agency's MOUs on a regular basis, such as every six months. If a linkage isn't working as well as it could, the agencies can refine the system, the MOU agreement or both.

AGENCY: (fill in name of linkage partner)

Agreement: (note the type of agreement that is in place):

Monitoring Mechanism	What It Is	Do You Want It?	Who Does It?	How Often?
Data collection	Measurements of the number of consumer referrals and their outcome	0 Yes 0 No	(staff name)	0 Monthly 0 Quarterly
Feedback from consumers and referral agencies	Assessment of consumer and client satisfaction	0 Yes 0 No	(staff name)	
Meetings	Face-to-face meetings between key staff	0 Yes 0 No	(staff name)	0 Monthly 0 Quarterly
Other			(staff name)	

MONITOR THE LINKAGE

AGENCY: (fill in name of linkage partner)

Agreement: (note the type of agreement that is in place):

Monitoring Mechanism	What It Is	Do You Want It?	Who Does It?	How Often?
Data collection	Measurements of the number of consumer referrals and their outcome	O Yes O No	(staff name)	O Monthly O Quarterly
Feedback from consumers and referral agencies	Assessment of consumer and client satisfaction	O Yes O No	(staff name)	
Meetings	Face-to-face meetings between key staff	O Yes O No	(staff name)	O Monthly O Quarterly
Other			(staff name)	

MONITOR THE LINKAGE

AGENCY: (fill in name of linkage partner)

Agreement: (note the type of agreement that is in place):

Monitoring Mechanism	What It Is	Do You Want It?	Who Does It?	How Often?
Data collection	Measurements of the number of consumer referrals and their outcome	0 Yes 0 No	(staff name)	0 Monthly 0 Quarterly
Feedback from consumers and referral agencies	Assessment of consumer and client satisfaction	0 Yes 0 No	(staff name)	
Meetings	Face-to-face meetings between key staff	0 Yes 0 No	(staff name)	0 Monthly 0 Quarterly
Other			(staff name)	

MONITOR THE LINKAGE

AGENCY: (fill in name of linkage partner)

Agreement: (note the type of agreement that is in place):

Monitoring Mechanism	What It Is	Do You Want It?	Who Does It?	How Often?
Data collection	Measurements of the number of consumer referrals and their outcome	0 Yes 0 No	(staff name)	0 Monthly 0 Quarterly
Feedback from consumers and referral agencies	Assessment of consumer and client satisfaction	0 Yes 0 No	(staff name)	
Meetings	Face-to-face meetings between key staff	0 Yes 0 No	(staff name)	0 Monthly 0 Quarterly
Other			(staff name)	

VII. Expanding Care Throughout the EMA

This document mainly concerns how individual CARE Act providers can form linkages with points of entry to the health care system in their communities. At the same time, broad and comprehensive efforts on the part of the entire community are also needed to ensure that everyone living with HIV/AIDS receives the care needed to live a better, longer life.

CARE Act providers, planning councils, grantees and others must work together to make sure that people living with HIV/AIDS receive the best possible services. The following section describes steps that can be taken within the EMA—chiefly by planning councils—to help CARE Act providers and other entities fulfill their missions and create effective pathways to services for people living with HIV/AIDS.

Provide clear requirements on linkages

Planning councils can do more than just encourage CARE Act providers to form linkages with key points of entry. Some planning councils now require providers responding to RFPs to demonstrate that they have established referral mechanisms in the community; some specifically require a minimum number of linkage agreements. Planning councils also fund community programs to create collaborations between CARE Act providers and others that link people living with HIV with care. Councils also can require or encourage linkages and coordination among providers in different EMAs, since consumers often migrate between areas.

Offer technical assistance

Many CARE Act providers and points of entry need technical assistance on linkages, referrals and partnerships. Sponsoring regularly scheduled meetings among an EMA's local providers and key points of entry provides an opportunity for these groups to establish relationships and discuss improvements in service coordination. Planning councils also can work to build relationships with hard-to-reach agencies, such as the educational, correctional, hospital and mental health systems.

On a broader level, the planning council can help CARE Act providers address the political implications of the allocation and reallocation process. They also can work with providers to help them understand what the local needs are and to avoid duplication of services.

Assess current linkages

Planning councils can evaluate funded organizations' linkage agreements to ensure that they are effective. The New York City EMA, for example, makes this assessment part of its standard site visit activities. By standardizing reporting requirements, the planning council can encourage linkages, especially with non-CARE-Act-funded providers.

Provide training and education

Planning councils can conduct training and educational sessions on how to form effective partnerships. In addition to educating its own members, the planning council should reach out to the broader provider community with messages about the importance of linkages with the local CARE Act service network. By setting up regularly scheduled meetings of members, planning councils provide an essential forum in which providers can share best practices.

Bring in new participants

A Florida EMA is coordinating a statewide faith-based conference to engage participation, develop linkages, educate faith institutions and develop the foundation for future service coordination.

Planning councils can engage new agencies and involve them in HIV/AIDS programs and efforts. Public agencies, hospitals, faith-based communities and school boards are important entities to involve in the planning council, regardless of whether or not they receive CARE Act funding. Planning councils and grantees also can help to foster communication between state and federal health departments.

Offer networking opportunities

When provider representatives get together, the absence of decision-makers or other key personnel may hamper efforts to collaborate. Some planning councils hold separate, clearly defined meetings within their EMAs for different staffing levels. For example, there may need to be specific (and separate) meetings for executive directors, outreach/case management workers and housing and/or other service provider staff to address specific issues about coordination. Face-to-face contact of key staff from provider organizations improves service coordination.

Develop standardized referral systems

Standardized referral systems help clients who are not already in the CARE Act system to easily access CARE Act-funded services while reducing service duplication and paperwork. Several EMAs currently use "CAREWare" and "Provide" systems. Before a universal system can be implemented, however, providers must come to consensus on how confidentiality will be protected — for example, through the development of an EMA-wide universal consent form that can be used when referring clients to other agencies.

Consider innovative structures

Some communities have combined their Title I planning council and Title II consortium as a way to avoid duplication of effort and increase service provision. One EMA has a combined planning body that sets priorities for allocation processes, establishes eligibility criteria, develops the comprehensive plan and conducts other planning activities. Another successful model, used by a different EMA, is to have a separate consortium and planning council, along with a combined planning body that serves as a mechanism to ensure compliance, discuss service needs and develop collaborative plans.

Additionally, referral agreements can be used to build more complex relationships between CARE Act providers and key points of entry. Some communities are creating collaborations that integrate CARE Act providers into service agencies such as homeless shelters, community health centers or prisons. Whether the provider staff is available on a continuous basis or on a more restricted schedule, co-locating offers many benefits to collaboration.

Use **Worksheet 8** to think about how to expand linkages and services in your EMA.

Here are some additional examples of how other EMAs have addressed the issue of linkages.

In the **New York City** (NY) EMA, organizations funded in the "Outpatient Medical Care" and "Case Management" categories provide the majority of Title I-funded case management and care coordination services. In order to increase the number of people living with HIV who are in care, the EMA requires these organizations to maintain referral relationships with point-of-entry agencies. The Title I-funded agencies are mandated to establish formal referral agreements with HIV testing and counseling centers and STD clinics. In addition, they are required to establish formal linkages with other key points of entry, "based on the specific considerations of their target population."[5] The EMA suggests that the funded agencies establish as many of these referral agreements as possible.

5 New York EMA. *Policy on Early Intervention Services/Maintaining Appropriate Referral Relationships*. April 2002

Further, the EMA mandates that these agreements must include the names of the parties, the time frame of the agreement, a clearly defined referral process, and a description of the follow-up mechanism to ensure that referrals are occurring. The EMA requires that documentation of these agreements be kept at the CARE Act provider's offices and be available for inspection by health department and HRSA staff. The EMA monitors compliance and the effectiveness of these agreements as part of agency site visits.

The **Hartford** (CT) EMA requires all of its Title I service providers to maintain "appropriate referral relationships with HRSA-defined key points of entry for early intervention."[6] Providers must maintain documentation of these agreements in the form of letters of agreement, memoranda of understanding or other formalized documents.

These collaborations are furthered by several other means as well. First, the EMA has created a model of HIV Care Coordination for case managers that links hospital-based, behavioral health, prevention and CARE Act-funded case managers together. Service agreements among the entities allow case workers to share information with the client's approval. Case managers get together at semi-monthly meetings to share information and ideas.

Helping EMAs Build Capacity

Here are some ideas, generated by the CAEAR Coalition Foundation focus groups, on how HRSA can help providers serve their communities:

- Hold routinely scheduled meetings between EMAs to discuss ways to improve service coordination and establish linkages.
- Develop uniformity in referral systems and reporting requirements for EMAs (state and/or area-wide.)
- Train EMAs on developing MOUs and other best practices.
- Involve CARE Act providers in federal decisions on referral requirements and linkage expectations.
- Increase funding for EMAs to help CARE Act providers formalize linkages. EMAs now have more responsibilities and providers may be unwilling to engage in linkages without additional resources.

"There is no way possible that we can develop linkage agreements with all of the points of entry that HRSA requires, without some assistance from the feds." —GRANTEE

Second, the EMA has formalized client referrals between organizations funded by Title I and Title II. Referral forms include the client's authorization to release information, allowing a uniform intake and certification for every client.

Third, CARE Act services are co-located in the EMA's homeless shelters, two federally qualified health centers and the local children's medical center. EMA protocols help HIV testing counselors link newly diagnosed individuals to CARE Act providers and encourage reciprocal referral from case managers to test counselors for secondary prevention.

Finally, the EMA funds CARE Act providers to link with non-CARE-Act-funded prevention outreach workers, needle exchange programs, homeless shelters and HIV clinics. The providers agree to follow up on "no-show" clients and to re-engage them with medical and support services.

6 Communication between Ann Levie, Director of the Hartford EMA Title I, to HRSA. March 15, 2002.

BROADER EFFORTS TO EXPAND CARE

Broad and comprehensive efforts on the part of the entire community are necessary to make sure that everyone living with HIV receives the care they need to live healthier and longer lives. Use the worksheet below to think about ways that agencies in the EMA, and the planning council as a whole, can help grantees and others to form linkages.

LINKAGE REQUIREMENTS	Planning councils can encourage or require CARE Act providers to form linkages with key points of entry.
What requirements has your agency made about forming linkages?	
What areas exist where you need clarification?	
Who could provide this for you?	

TECHNICAL ASSISTANCE (TA)	Many CARE Act providers and points of entry need technical assistance on linkages, referrals and partnerships.
What kind of TA have you found helpful in creating relationships and linkages?	
What types of TA would be useful that you haven't yet received?	
Who could provide this for you?	

BROADER EFFORTS TO EXPAND CARE

HELP ASSESS CURRENT LINKAGES	Planning councils can evaluate funded organizations' linkage agreements to ensure that they are effective and review the agreements during site visits..
Does your planning council help assess the linkages you already have?	
Would this be helpful to you?	
Who could perform assessments for you?	

TRAINING AND EDUCATION	Planning councils can conduct training and educational sessions about the importance of linkages with the local CARE Act service network, both to council members and the broader provider community.
What kind of training would be helpful for your agency?	
Who could provide this for you?	
What training would be helpful for your colleague organizations?	
Who could provide this for them?	
What education does your community need?	
Who could provide this for the community?	
Who could provide this for you?	

BROADER EFFORTS TO EXPAND CARE

ENGAGING NEW PARTICIPANTS	Planning councils can engage new agencies and build relationships with hard-to-reach agencies such as the educational, correctional, hospital and mental health systems.
What agencies are missing from planning council and other EMA activities?	
What agencies would be useful that are not involved?	
Who could provide this for you?	

NETWORKING OPPORTUNITIES	Planning councils can hold meetings, conferences and other events to build relationships among community agencies that will lead to collaboration.
What organizations would you like to connect with?	
What is the best way to reach out to these agencies?	
Who could help create this connection for you?	

BROADER EFFORTS TO EXPAND CARE

STANDARDIZE REFERRAL SYSTEMS	Standardizing referral systems help those who are not already in the CARE Act system to access CARE Act-funded services, provide a consistent referral system, and reduce both paperwork and duplication of services.
How could a standardized referral system help your community?	
What agencies should adopt a standardized referral system?	
Who could help set this up for?	

INNOVATIVE STRUCTURES FOR COMMUNITY GROUPS	Some communities have combined their Title II consortia and planning councils as a way to address duplication of efforts and increase service provision.
What agencies or groups could the planning council work more intensively with?	
How would this help patients in your community?	
Who is the best person to help with new structures?	

VIII. Conclusion

The research is clear: people living with HIV do better when they receive specialized and expert health and social services. Compared to those without care, people living with HIV who receive CARE Act services are more likely to receive appropriate care and therapies and, most importantly, live longer, fuller lives.

Although we know how to help people living with HIV, many who would greatly benefit from services are not yet in care. While they may visit a health care or social service agency for assistance, these individuals are not linked with a CARE Act-funded provider who can give them the specialized treatment they need.

To address this service gap, Congress and HRSA are encouraging linkages between CARE Act providers and other community agencies. These linkages are effective ways to:

- Ensure continuity of service for people living with HIV;
- Increase the number of people who have access to appropriate treatment and related services;
- Create effective coordination systems;
- Clarify responsibilities among agencies; and
- Help the monitoring system for both providers and their partners.

The CAEAR Coalition Foundation hopes that the materials and samples provided in this guide will be helpful as you work to improve service coordination in your community so that more people living with HIV/AIDS can get the care they need.

Appendix A: Congressional Language from the Ryan White CARE Act Reauthorization, 2000

Section 2605 (a)(3) of the CARE Act

(3) ...that entities within the eligible area that receive funds under a grant under this part will maintain appropriate relationships with entities in the eligible area served that constitute key points of access to the health care system for individuals with HIV disease (including emergency rooms, substance abuse treatment programs, detoxification centers, adult and juvenile detention facilities, sexually transmitted disease clinics, HIV counseling and testing sites, mental health programs, homeless shelters), and other entities under section 2604 (b)(3) and 2652(a), for the purpose of facilitating early intervention for individuals newly diagnosed with HIV disease and individuals knowledgeable of their HIV status but not in care;

Appendix B: HRSA Guidance Letter: Early Intervention Services – Maintaining Appropriate Referral Relationships

HIV/AIDS Bureau

Issue: Early Intervention Services
Maintaining Appropriate Referral Relationships

Dear Title I Colleagues:

This is the seventh letter in the series of communications from the HIV/AIDS Bureau (HAB), Division of Services Systems (DSS), that addresses changes in the Title I and Title II programs funded under the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. On October 20, 2000, former President Clinton signed P.L.106-345, a law to reauthorize the CARE Act, containing provisions that affect all CARE Act programs. Some new requirements will become effective immediately, while others will require longer implementation periods. HAB/DSS will communicate our expectations to you through this series of letters focused on specific issues, as well as through future guidance documents, technical assistance calls, and reports.

This letter provides specific information regarding new requirements described in Section 2604 "Use of Amounts" and Section 2605 "Application." These sections describe the way Ryan White funds can facilitate access to individuals with HIV disease into treatment, by: 1) funding Early Intervention Services (EIS) under Titles I and II, and 2) requiring appropriate linkage relationships with key points of entry. The new EIS service category supports efforts to identify and create linkages with key points of entry for individuals newly diagnosed with HIV or those knowledgeable of their HIV status but not in care. The long term impact will be to normalize screening for HIV in diverse social service and health care settings and to help reduce barriers to care for the traditionally underserved by expanding the network of referrals.

Planning activities will be required to make the option available to integrate EIS into the service delivery plan for fiscal year (FY) 2002. The new requirements are explained below, beginning with legislative citations for each, followed by descriptions of HAB/DSS implementation expectations for EIS and for maintaining appropriate referral relationships.

Legislative Citations –
Section 2604 (42 USC 300ff-14). USE OF AMOUNTS
(b)(3) EARLY INTERVENTION SERVICES -- (A) IN GENERAL -- *The purpose for which a grant under section 2601 may be used include providing to individuals with HIV disease early intervention services described in section 2651(b)(2), with follow-up referral provided for the purpose of facilitating the access of individuals receiving the services of HIV related health services. The entities through which such services may be provided under the grant include public health departments, emergency rooms, substance abuse and mental health treatment programs, detoxification centers, detention facilities, clinics regarding sexually transmitted diseases, homeless shelters, HIV disease and counseling and testing sites, health care points of entry specified by eligible areas, federally qualified health centers, and entities described in section 2652(a) that constitute a point of access to services by maintaining referral relationships."*

"(B) CONDITIONS – With respect to an entity that proposes to provide early intervention services under subparagraph (A), such subparagraph applies only if the entity demonstrates to the satisfaction of the chief elected official for the eligible area involved that - -

(i) Federal, State, or local funds are otherwise inadequate for the early intervention services the entity proposes to provide; and
(ii) the entity will expend funds pursuant to such subparagraph to supplement and not supplant other funds available to the entity for the provision of early intervention services for the fiscal year involved."

"Section 2605 [300ff-15]. APPLICATION"
"(a) IN GENERAL To be eligible to receive a grant under section 2601, an eligible area shall prepare and submit to the Secretary an application containing such information as the Secretary shall require, including assurances adequate to ensure-

"(3) that entities within the eligible area that receive funds under a grant under this part will maintain appropriate relationships with entities in the eligible area served that constitute key points of access to the health care system for individuals with HIV disease (including emergency rooms, substance abuse treatment programs, detoxification programs, adult and juvenile detentions facilities, sexually transmitted disease clinics, HIV disease counseling and testing sites, mental health programs, and homeless shelters) and other entities under section 2604(b)(3) and 2652(a) for the purpose of facilitating early intervention for individuals newly diagnosed with HIV disease and individuals knowledgeable of their HIV status but not in care."

HAB/DSS Expectations :

As of FY 2001, EIS is a fundable service category for Title I CARE Act grantees, under certain conditions outlined in the planning process in Section 102, Duties of Councils of the CARE Act. The reauthorized legislation specifies the entities and the conditions under which they may provide EIS. In addition, as of FY 2001, a new Chief Elected Official (CEO) assurance has been added which requires that appropriate relationships be maintained by service providers with points of entry for the purpose of facilitating early intervention. All these requirements are detailed in the following sections.

I. Early Intervention Services (EIS)

A. Purpose of Title I EIS

The HAB relied on the Congressional Managers Statement which defines EIS as counseling, testing, and referral activities designed to bring HIV positive individuals into the local HIV continuum of care. This definition is similar to that for Title III in Section 2651 of the CARE Act. The goals are to decrease the number of underserved individuals with HIV/AIDS while increasing their access to the local continuum of care by providing:

- Test results that identify HIV status earlier in the progression of the disease;
- Information on living with HIV disease and managing therapeutic regimens;
- Counseling on modifying behaviors that compromise own or other's health status;
- Referrals to appropriate prevention and risk reduction programs and to primary care or case management for those testing positive; and,
- Referrals to prevention programs for high risk individuals who test negative.

B. Conditions for Providing Title I EIS

Since several State and Federal programs currently fund an array of EIS, the reauthorized CARE Act is very specific about the conditions under which counseling, testing, and referral activities should take place under Title I. In contracting for Title I EIS, the HAB/DSS expects that those services will be:

- Included in annual Eligible Metropolitan Area (EMA) planning activities;
- Consistent with Centers for Disease Control guidelines for HIV counseling, testing, and referral;
- Consistent with the requirement that post-test counseling place an emphasis on the individual's responsibility to inform their sex and/or injection drug equipment sharing partners about their status in order to reduce transmission; and
- Inclusive of established referral relationships to be maintained by EIS providers including a mechanism for receiving feedback from health and social support service providers to which clients are referred.

C. Entities That Are Eligible to Provide Title I EIS

Title I EIS should be designed to expand the settings in which HIV positive individuals are brought into care. Funding EIS should be considered primarily as a mechanism to establish critical and key relationships and linkages between the local Ryan White system of care and points of entry within the EMA. Through contractual relationships between the EMA and community based access points, HIV positive clients not in care may be identified and referred into the health care system. These points of entry locations, include, but are not limited to:

- emergency rooms,
- substance abuse treatment programs,
- detoxification programs,
- adult and juvenile detentions facilities,
- STD clinics,
- Federally qualified health centers,
- HIV disease counseling and testing sites,
- mental health programs, and
- homeless shelters.

These entities, along with others referenced in section 2604(b)(3) and 2652(a) should be considered among the pool of applicants for all, or some components of, an EMA's EIS counseling, testing, and referral funding. These include public health departments, Titles I, II, and III providers, hemophilia diagnostic and treatment centers, migrant health centers, community health and family planning centers, and non-profit private entities that provide comprehensive primary care services to populations at risk of HIV disease.

D. Planning for Early Intervention Services

All EMAs should ident ify local key points of entry for persons who know their status and are not in care. These are the likely health care access points for traditionally underserved HIV positive individuals. This information should be part of the EMAs Comprehensive Plan to be submitted with the FY 2003 application and should guide the EMA in strategically planning for optimal location and composition of EIS.

Due to the new emphasis on increasing access to care using EIS, the FY 2002 application guidance will require EMAs to discuss the process for considering EIS as a service category as part of their regular planning process for setting priorities and allocations for FY 2002. All EMAs should collect information on current EIS providers in their communities, including those funded by other CARE Act Titles and State and local governments. Using this resource inventory and the points of entry referral information, Planning Councils can identify gaps in services for those not in care and determine how to best fill those gaps, which may include funding an EIS service category. If EIS funding is needed to increase

access to care, it should then be integrated into the EMA service delivery implementation plan for FY 2002. Future year funding of Title I EIS should only take place after these planning steps have taken place.

In the coming months, HAB/DSS will provide more specific information regarding Title I EIS, including a conceptual model for EIS. HAB/DSS also will provide further written, telephone communications, and technical assistance to help grantees with EIS planning.

II. Maintaining Appropriate Referral Relationships

A. The CEO of each EMA must provide assurances with the grant application to the Health Resources and Services Administration in September 2001 related to the maintenance of appropriate relationships by funded entities with key points of entry to facilitate early intervention. Grantees and Planning Councils should engage in discussions regarding the nature of appropriate relationships between funded HIV service providers and should develop referral relationships and linkages between funded providers and the nine key points of entry listed in the legislation, as well as others identified locally.

B. HAB/DSS will ask for information on how the EMA defines and maintains these relationships as part of the FY 2002 grant application, and in subsequent applications. Relationships should be documented through contract language requiring providers to establish ongoing relationships with the local points of entry. They can be further supported through expansion of the provider network to include funded relationships with local points of entry or regular joint meetings between CARE Act providers and points of entry administrators.

To assist EMAs in determining appropriate relationships, HAB/DSS will provide information on best practices for establishing and maintaining referral linkages based on models currently under development by the Special Projects of National Significance projects. HAB/DSS will monitor grantees to ensure compliance in maintaining appropriate relationship requirements through progress reports, monthly monitoring calls, and site visits.

If you have additional questions, please contact your Project Officer.

Sincerely,

Joseph F. O'Neill, M.D., M.P.H.
Associate Administrator

Appendix C: Fact Sheets

MOU Basics

What is a Memorandum of Understanding?

Like a contract, a Memorandum of Understanding (MOU)––also known as a Memorandum of Agreement (MOA)––outlines an agreement between two parties, delineating actions and deadlines to which all parties agree to adhere. An MOU, however, is not binding in the same way that a contract is. A contract includes legal components such as indemnification, risk-sharing, and other representations and an MOU does not. An MOU primarily outlines a shared project or set of activities, but does not include penalties for any violations of the agreement.

What to look for in an MOU

An MOU should:

- Help the agencies' clients access services they need
- Be feasible––not create an overwhelming amount of paperwork or require unrealistic staff efforts
- Be for a specific period of time
- Be reassessed at a specific time
- Withstand personnel changes
- Include provisions to help the agencies determine if the agreement is working

Potential components of an MOU

Your MOU may contain some or all the following sections:

- **Names of the agencies** entering the agreement and their missions.
- **Overview of the project or activities** governed by the agreement, including the name of the project (if any), authorization granted by the MOU, the project's goals, its intended outcomes, and target clientele.
- **Each party's responsibilities.** Also, the appropriate place to note that each party will comply with all appropriate local, state, or federal laws and regulations.

- **A timeline** of when activities will start and end. May also include a timeline for reassessing or renegotiating the MOU.
- **Duration (or Term) of the MOU.** Some MOUs have a one-year duration, with a provision that the agreement can be extended upon mutual consent. If the MOU is an extension of a previous agreement, it would be noted in this section.
- **Conditions for termination** other than the end of the project timeline noted above. Might address what happens if funding stops or if one agency cuts its relevant programs and list the mechanism for termination of the MOU (e.g. "termination will occur 30 days after written notice is submitted to the executive director of the other agency").
- **Personnel involved in the activities or projects,** including staff titles rather than individual names so that future staffing changes do not affect the agreement.
- **Reporting requirements.** Reports might detail the number of clients referred by the point of entry, the number of clients served, the meetings or training sessions conducted between the two entities, etc. Should include schedule for reports (e.g. monthly or quarterly). Copies of required tracking, evaluation or other forms may be appended to the MOU.
- **Financial matters.** Although most MOUs do not include any financial relationships, it should be noted if money is changing hands. This would include revenue sharing, compensation, or reimbursement related to staff time, number of referred clients or other costs. Also clarify the schedule and means by which funds will be exchanged (e.g. on a monthly basis by invoice, quarterly reimbursement claims, semi-annual grants, etc).
- **Mechanisms to protect client confidentiality** within the referral system, addressing requests for information and reporting requirements.
- **Other requirements** to ensure compliance, cooperation and communication between the parties, such as regularly scheduled meetings, monthly reports, and record-keeping functions.
- **Signatures** of the executive directors or the chief executive officers of both agencies.

Not all of these sections will be necessary for every MOU. **At minimum, an MOU should include:**

- Names of the agencies signing the MOU
- Specific details about the activities occurring under the linkage agreement
- Clear timeline for the agreement
- Executive signatures

Barriers

Identifying obstacles to linkages and developing strategies to eliminate them is a key step to enhancing continuity of care. Barriers can be agency-specific or EMA-wide issues that hamper or prevent coordinated service and effective, integrated delivery. Examples of barriers can include:

Competition Among Agencies: Some agencies fear losing clients and funding if they link with other agencies that they perceive to be competitors.

HIV Stigma/Prejudice Against PLWH: Some agencies are associated with serving people with HIV, which may make other agencies less willing to link with them and clients less willing to go there for services.

Confidentiality Concerns: If an agency does not have a strong confidentiality policy then others may be unwilling to link to them, even if their services are needed. In addition, all providers do not have a uniform confidentiality policy, which may impact the ability of the agencies to exchange appropriate information after consumers have been referred.

CARE Act Reporting Requirements: Some organizations not funded by the CARE Act are reluctant to participate in lengthy CARE Act reporting requirements.

Shortage of Needed Services: Services that agencies identify as ones they need to link to are not always available or accessible in the EMA, creating a void in the integration of services.

Lack of Representation on Planning Councils: Planning councils may lack representatives from particular categories of agencies or institutions, such as hospitals, Medicaid, prisons, private physicians, etc. that agencies in the care system need to link to.

Staff Turnover: Changes in personnel may limit the development of key relationships and weaken existing linkages.

Bureaucracy of Large Institutions: In order to enter into linkage agreements, many large institutions must go through a lengthy process involving several layers of management and legal review.

Limited Guidance: Agencies and grantees do not have all of the information and resources they need regarding how to determine which linkages to make and how to make them.

Lack of a Uniform Referral Rystem: A centralized CARE Act referral system that allows providers to track referral and other case management-related services does not exist.

Lack of Resources: Providers may not be as willing to engage in linkages without the necessary resources to support the additional work.

Strategies for Overcoming Barriers

Identify Missing Partners: Review local CARE Act network to determine the types of agencies and organizations with whom existing providers need to link but which are not currently engaged in the system or not engaged at the level needed. In some communities, these missing partners include faith-based institutions, hospitals, public school systems, and substance abuse providers.

Educate Potential Partners: Hold trainings or conferences directed at specific communities or groups of potential partners to educate them about the need for their involvement and determine what type of information, resources, and support they need to be involved. Such trainings could be local, state or regional depending on location.

Involve Potential Partners in Planning Councils: Recruit key representatives of institutions and agencies to sit on the local HIV services planning council.

Train Local Providers in Linkages: Educate existing CARE Act providers on strategies for coordinating and linking with fellow agencies inside and outside of the existing network.

Hold Regular Networking Meetings: Convene EMA-wide meetings of agency staff to facilitate development of personal relationships among key personnel.

Reduce Stigma and Raise Profile of Need: Well-connected and visible public figures can help remove the stigma that some agencies and institutions associate with providing HIV services and call attention to the need for more agencies and communities to become involved.

Develop Standardized or Model Tools: Provide MOUs and confidentiality policies that providers can use or adapt to facilitate their linkages.

Develop Standarized Referral Policy: A standardized referral system streamlines the referral process and reduces the need for each agency to develop their own process.