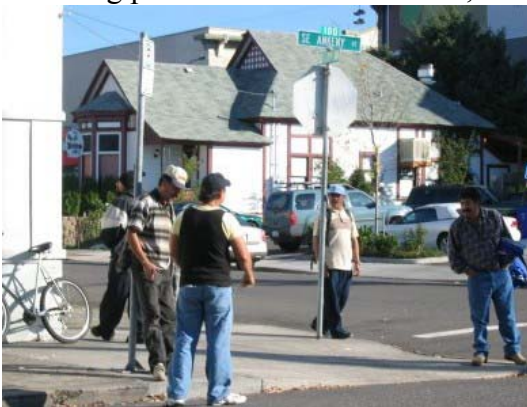


SPNS Outreach Initiative Program Descriptions

Overview

The HIV/AIDS Bureau of the Health Resources and Services Administration (HRSA) launched the Targeted HIV Outreach and Intervention initiative in October, 2001. The purpose of the Outreach Initiative, funded through the Special Projects of National Significance (SPNS) program, was to implement and evaluate interventions designed to connect underserved vulnerable populations living with HIV who knew their HIV status with HIV primary care. The initiative was funded in two phases; during Phase 1 programs received funding to evaluate their existing interventions to connect people with care and plan for service enhancements that would improve engagement and/or retention in care. In Phase 2, programs received additional funding to both enhance their interventions and continue their evaluations. Ten programs were funded to participate in Phase 2, representing diverse service provider organizations including community-based organizations, health clinics and medical centers, and organizational partnerships. The programs used different types of personnel to deliver the interventions - peer outreach workers and advocates, social workers, case managers, or nurses – and subscribed to a variety of theoretical models. Finally, the programs also varied in their program objectives – while some focused solely on retention in care, others sought to find and connect with people who had recently tested positive for HIV or who had been lost to follow up for six months or more. Below we provide an overview of each of these HIV outreach and intervention programs.

CareLink is a program of Cascades AIDS Project (CAP), one of the oldest community-based AIDS service organizations in the United States, located in Portland, Oregon. Outreach workers from the CareLink program identify HIV-infected people who are not receiving medical care or who are at risk for falling out of medical care and work with them to reduce or eliminate barriers to engaging and remaining in medical care. Operating within CAP, which provides a wide range of support services including intake to case management, housing and employment, allows the CareLink program to most efficiently and effectively help clients access the information and services they need in order to be able to focus on their health. The CareLink program specifically focuses on the Latino population (roughly one-third of clients) and other underserved populations including persons who are homeless, addicted to drugs, or have mental illness.



The CareLink Program ascribes to the Transtheoretical Stages of Change Model by training outreach workers to develop rapport and foster clients' sense of empowerment. Outreach workers conduct outreach to high risk populations in the community (i.e., on the streets, bars, parks, etc.), use a peer referral program to bring in out-of-care HIV-infected individuals, and conduct group and individual interventions to sub-populations (e.g., migrant farm workers). The CareLink model

emphasizes the importance of continually assessing a client's needs through determining existing service use and gauging barriers and readiness to receive these services. The outreach workers use motivational interviewing techniques to promote engagement and retention in medical care and case management. Outreach workers also educate clients about HIV, the service system, self-advocacy, and risk reduction.



In Phase 2 of the Outreach Initiative, CareLink has developed stronger relationships with external case management providers to help the case managers reconnect with clients who are out of care. The program has increased its staff and expanded its focus to serve more women, youth, and people being released from prison and has implemented a life skills and health literacy intervention to promote engagement and retention in care.

Caring Connections is a theory-based, scripted intervention designed to improve the retention of HIV-infected women and their infants in medical care at the Miami Family Care Program of the University of Miami/Jackson Memorial Medical Center in Miami, FL. Over 90% of the women enrolled in the intervention are African American and nearly one quarter are pregnant when they enter the program.

The Phase 1 evaluation identified that standard clinic procedures such as phone calls and postcards were insufficient to keep all women in medical care, particularly those who often missed appointments. The major barriers to care were unsatisfying relationships with caregivers and unmet concrete case management needs. The Phase 2 intervention is designed to address these problems. All HIV-infected women who have missed two or more clinic visits in the past six months (including primary care, obstetrics, newborn infant HIV screening and pediatric immunology) are identified by a hospital-generated list. When these women come back to the clinic, they are approached to enroll in Caring Connections, a four-session scripted intervention that targets health-care behavior change. The theoretical basis of Caring Connections is Transtheoretical Stages of Change plus Women in Relations theory.

Three intervention sessions occur in advance of an upcoming clinic appointment, and one afterwards, and all are delivered by a mental health clinician. The first two sessions last an hour each and are face-to-face. Using Motivational Interviewing techniques, they focus on identifying discrepancy between the participant's current behavior (missing medical appointments, poor self care) and what she wants for herself and her health outcomes. The third session is a 15-minute phone contact just prior to the clinic appointment, to mentally walk the woman through the day of her clinic appointment to plan her preparedness. The final session, also a brief phone contact, is a follow-up to review her experience at the clinic or, if the appointment was missed, to repeat session 3 in anticipation of the rescheduled appointment. During the course of the

intervention, women with concrete needs that create barriers to keeping appointments are linked to case management services.



The Drew University Mobile Outreach Project has provided outreach and HIV counseling, testing and referral services to at risk populations in Los Angeles County since 1992. The project uses a mobile van which travels throughout the County, with primary target areas of West

Hollywood and South Central Los Angeles. Outreach workers and other staff on the van provide HIV antibody screening and primary care services to low income minority populations as well as the homeless, sex workers, runaway youths, and transgender/transsexual persons of color.

Outreach workers who are hired from the affected communities go to designated locations such as drug treatment facilities, shelters, and methadone treatment clinics to offer HIV and STD screening services. Outreach program staff is trained in the Transtheoretical Stages of Change Model and the project as a whole embraces community mobilization and empowerment. They seek to engage the community in problem-solving, and empowering clients to develop knowledge and skills to reduce their risk for infection with HIV and other STDs.

While the main role of outreach workers is to engage people in HIV counseling and testing, they also make it a priority to refer HIV positive individuals to primary medical care following a positive test result. However, these referrals are made to clinics all over Los Angeles County, based on convenience and where the client prefers to receive care. One of the challenges identified during Phase 1 was the inability to provide adequate follow-up on these referrals, since the primary function of the outreach workers was to work out of the mobile van and bring people in for counseling and testing. Another program limitation was the lack of resources to meet many of the social needs of clients who tested positive for HIV. To address these issues, the Phase 2 intervention added a case manager to the mobile van team in order to follow-up on health care referrals and provide support services that facilitate access to care for HIV-infected clients. This is the first time that the outreach program has had the resources to develop stronger relationships with their HIV-infected clients and spend the time to make sure they are connected to comprehensive services.

The Fenway Institute of Fenway Community Health partners with six community based organizations to provide outreach and Health System Navigation (HSN) in Boston, MA. In Phase 1 Fenway partnered with three community-based organizations to engage and retain their clients living with HIV in HIV medical care. They found that many participants were already connected to HIV medical care, but that their care was unstable over time. In Phase 2, the HSN program focuses more explicitly

on identifying individuals who are not stable in care using a screening instrument. Their target populations include people of color, transgender individuals, active drug users or those in recent recovery, ex-offenders, homeless individuals, and women.

The theoretical underpinnings of the HSN program are the Popular Opinion Leader model, Diffusion of Innovations, and Transtheoretical Stages of Change. Working from a strengths-based perspective, Health Systems Navigators conduct brief assessments, develop client-driven action plans, and work with clients to achieve their goals. HSNs are not based within a single organization, but conduct outreach and provide services in the community itself, meeting their clients at home or service agencies, and accompanying them to appointments. The skill sets of an HSN can either stand alone as an HSN job description or be incorporated into the job descriptions of a peer advocate, transitional case manager, or outreach worker. The HSN intervention is designed to be time limited and focused on helping people become stable in care through the establishment of more permanent relationships with culturally competent medical providers and case managers. Thus, the HSN, working to complement case management services, may overlap with case management to a limited degree – such as making referrals - but only until such time as the client is receiving consistent case management.

One challenge for the program is training HSN staff who work for different organizations to achieve a common understanding of the project goals, program model, practical aspects of their job, and reasons for project evaluation. In Phase 2 the Fenway Institute convened a Training Academy for staff and their supervisors from programs throughout Boston with responsibilities similar to those of HSNs to learn about the intervention. Collaborative efforts are underway to create a sustainable HSN program, where staff of multiple agencies citywide work together to address the varied needs of people who are not receiving consistent HIV-related medical care.

The Horizons Project is an AIDS Service Organization affiliated with Wayne State University and the Detroit Medical Center that provides prevention, outreach and care to young people aged 13-24. The majority of youth are low-income African Americans, half male and half female. About ¼ of the young women are mothers, and 40% of the young men self-identify as MSM. The goals of the program are to increase the number of HIV-infected youth who receive case management and support, and who enter and stay in HIV medical care and treatment.

The program draws upon Social Network Theory, the Continuous Relationship Model, and Transtheoretical Stages of Change Model by employing peers as staff. This builds the relationships necessary to connect with HIV-infected youth and combat the stigma associated with HIV and homosexuality among young people. HIV-infected youth arrive at Horizons through many channels including the local health department, the two main HIV care clinics in Detroit, case management agencies, and peer networks. The Horizons staff is organized into teams: an MSM prevention team, a high-risk heterosexual prevention team, a care team and an evaluation and research team. Each team conducts outreach as part of their work. The prevention teams do street outreach to encourage high-risk youth to receive HIV counseling and testing. The clinical care team, consisting of a peer advocate, care coordinator, social worker, psychologist, doctor and nurse, conducts outreach to find HIV-infected youth who are lost follow-up. Peer

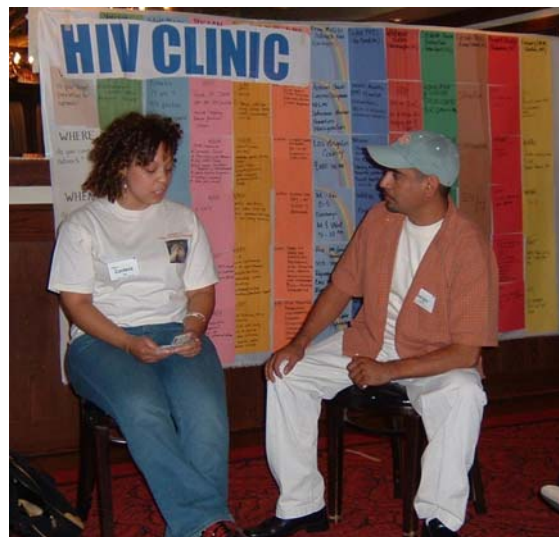
advocates link clients to services including transportation and housing, attend medical appointments, make home visits, and offer support groups (“Jam Sessions”). The evaluation team focuses on youth who are newly diagnosed or lost to the care system, and works with the other teams to bring young people back into care. Clients rarely go more than two weeks without receiving some kind of contact from someone at Horizons.

Horizons’ clients face many challenges such as lack of transportation, stable housing, and financial support; HIV stigma and homophobia; and the developmental and emotional issues that young people face along with their HIV. For Phase 2 of the Outreach Initiative, Horizons added a motivational interviewing and values clarification intervention, with the hope that these interactions will contribute to retention in care. They are testing these two different types of interventions and examining the role of professionals vs. peer staff in administering the intervention.

Konnect II is a peer support and advocacy program operated by the People of Color Against AIDS Network (POCAAN), an AIDS Service Organization in Seattle, Washington. The target population is HIV-infected adults of color who are not enrolled in primary care, or are sporadic users of care. Over half of the clients are African-American and 40% identify as Latino or Hispanic. Approximately two-thirds of the clients are male, and just over half identify as heterosexual.

Services provided by Konnect II include outreach, prevention education, counseling and testing, advocacy, and peer support. The program conducts weekly support groups, host social events and dinners, and convenes a monthly educational program. Project staff includes peer outreach workers and advocates, client volunteers, and program managers. As Konnect II does not provide medical care directly, and as clients go to multiple medical and social service providers, Konnect II staff spends much of their time accompanying clients to medical appointments and advocating for clients with other service providers. Most of the outreach conducted by Konnect II is outreach to other AIDS Service Organizations and care providers. Konnect II plays a unique role in the community as one of the very few organizations that is run and staffed by people of color with a specific mission to provide culturally relevant education, care and support to minority populations at risk of or living with HIV. Thirty-nine percent of the clients report that they speak Spanish most of the time, and Konnect II is one of the few HIV/AIDS service providers in the community with Spanish-speaking staff. Thus, many referrals to the program come from other organizations in the community that do not have the same cultural capacity as Konnect II.

One of the challenges faced by Konnect II clients is the dearth of culturally or linguistically competent mental health and substance abuse treatment services in the



community. Therefore, Konnect II's Phase 2 enhancement is the addition of a part-time mental health and part-time chemical dependency counselor to the staff in order to provide intensive and culturally appropriate behavioral health services to clients who are hesitant to seek care elsewhere.

Montefiore Medical Center partners with CitiWide Harm Reduction, a community-based organization that was founded as a syringe exchange program, to provide outreach services to homeless individuals living with HIV in New York City, many of whom have a history of cocaine or heroine use. Ninety-five percent of the clients are people of color (60% African American, 35% Latino), the vast majority self-identify



as heterosexual, and approximately 1/3 are women. Montefiore physicians and nurse practitioners work as a team with CitiWide peer outreach workers to conduct door-to-door outreach in 15 single room occupancy hotels (SROs) in the Bronx and Upper Manhattan. The purpose of this outreach is to provide support, inform people of services, offer harm reduction supplies, provide limited home-based medical care, and engage people in care, services, housing and prevention.

CitiWide Harm Reduction offers support and education groups, including for Hepatitis C coinfection. They also provide case management, mental health counseling and care, housing placement, syringe exchange, peer education, transportation to and from the center and the clinic, and other support services. Although Montefiore Medical Center has its own HIV clinic, individuals engaged through outreach access HIV primary care at multiple clinics throughout the city, when they obtain care at all. Both CitiWide and their Montefiore clinical partners practice a harm reduction approach with clients, encouraging program involvement regardless of current substance use or risk behaviors. The program also draws from the Popular Opinion Leader model, using peers in a team approach with clinicians.

Over time, one of the challenges for clients who live in SROs is that they may have to move from one SRO to another every 28 days, and thus may end up moving miles from their previous health care provider. In order to minimize gaps in care, during Phase 2 the partnership established an HIV clinic on-site at the CitiWide drop-in center, staffed by Montefiore clinicians. Because many clients attend the drop-in center to receive other support services, the hope is that locating a clinic on-site will increase access to high-quality HIV medical care. In addition, Phase 2 will establish an enhanced clinical intervention to



focus on care and treatment for Hepatitis C coinfection.

Project Bridge of the Immunology Clinic at Miriam Hospital in Providence, Rhode Island provides community re-entry services for HIV-positive ex-offenders. Services include prison outreach, intensive case management, and mental health services for HIV-infected individuals who are released from the Rhode Island corrections system. Rhode Island has mandatory HIV testing for individuals who are sentenced, and Miriam Hospital physicians provide HIV medical care in the prisons. Project Bridge's objectives are to ensure continuity of medical care as clients transition from prison to the community and promote retention in community-based health care. Nearly 40% of their clients are women, about half of all clients are white and half are African-American. All of the clients have a history of alcohol or drug use to varying extents. Following a harm reduction model, being in recovery is not a condition of program enrollment.



Project Bridge staff work as two-person teams consisting of a non-peer outreach worker and a licensed clinical social worker. In addition to visiting clients in correctional settings prior to release, the teams meet with clients at their homes and other community locations,

coordinate referrals, accompany clients to appointments for medical care and social services, and provide transportation assistance. Participants are enrolled for an 18-month period following release from prison, and then are transitioned to long-term service providers in the community. Project Bridge's approach to serving clients is based on the Eco-behavioral model, where staff members work with clients to address their needs in their environment and address issues across systems, including medical care, mental health care, housing, and substance use treatment. Staff employs techniques from the Transtheoretical Stages of Change Model, working with clients step-by-step to increase periods of stability and decrease periods of relapse. Another theoretical aspect of the program is the Continuous Relationship Model that stresses the importance of building the client-provider relationship to promote health and positive behavior change.

During Phase 1, Project Bridge staff found that many of their clients lacked basic life survival skills in their communities and had limited health literacy, making it difficult for them to obtain benefits, employment, and housing or to meet their health care needs. In Phase 2 Project Bridge is offering life skills and health literacy training to improve clients' help-seeking behaviors and understanding of their health care needs.

The Well-Being Institute in Detroit, MI, is an AIDS Service Organization that provides outreach, nursing case management, and support services to low-income, HIV-infected women in Detroit. Most of their clients are heterosexual African American

women, and many are dually or triply diagnosed with mental health and substance abuse disorders. The Well-Being program is designed to increase recruitment of women into services, improve their mental health, decrease substance abuse, increase retention in medical care and improve overall well being.

The primary strategy for achieving these goals is to establish and maintain relationships with HIV-infected women through the Personalized Nursing LIGHT theoretical model, a nursing intervention that assists clients to improve their sense of well-being with the goal of achieving their maximum potential. All Well-Being staff is trained in this model, and in turn teaches it to clients. Medical providers, counseling and testing programs, and other AIDS Service Organizations all refer women to the Well-Being program. Well-Being has established partnerships with the two main clinics that provide HIV care in Detroit, and the clinics identify female patients who have been out of care for the past six months or sporadically use medical services. The clinics refer these women to Well-Being staff for support services and nursing follow up. Well-Being operates its own mobile van counseling and testing services, another source of client referrals.

The Well-Being outreach teams consist of a peer or nonprofessional outreach worker and a nurse. They make home visits, attend medical appointments with clients, and spend a lot of their time in the community looking for people who have been lost to follow-up. In addition to outreach, other services provided directly by Well-Being include counseling and testing, transportation, and mental health services. Well-Being also offers a drop-in service and hosts many support groups.

One of the biggest challenges Well-Being encountered in Phase 1 was maintaining its services in the face of serious budget cuts and reduced staff time. For Phase 2 they now triage all new clients, based on criteria that were developed from the Phase 1 evaluation. Women are then assigned to an “intensive” intervention or a “brief” intervention, based largely on the existence and severity of mental health and substance abuse co-morbidities. Thus, all women continue to receive services, but not at the same level of intensity.

Whitman-Walker Clinic in the Washington DC area is a multi-service AIDS Service Organization and HIV Clinic that has provided social services and medical care for individuals with HIV since the early 1980’s. Originally a clinic that primarily served gay men, Whitman Walker’s current patients vary widely in race, ethnicity, drug-use history, sexual orientation, and gender.

The clinic has developed special services for Latinos, African Americans, the LGBT community, and individuals with drug addiction. However, the clinic has a higher than desired no-show rate for appointments. During Phase 1 the outreach to follow up on missed appointments was conducted primarily by telephone or mail, as is standard in many clinics.



During Phase 1 Whitman Walker conducted chart reviews of all new clinic patients during a one-year period to examine the characteristics of individuals who were later lost to follow up or sporadic users of care. Based on this analysis, they developed a screening algorithm for new patients to determine their risk for sporadic or non-use of care. In Phase 2, new clinic patients who identified as being at-risk are referred to a new program staffed by Retention Care Coordinators (RCCs). The goal of the RCC program is to facilitate retention in care by providing ancillary services, support and referrals to other support services.

The theoretical underpinnings of the RCC program are the Health Beliefs and Self-care Deficit Models for behavior change. RCCs are trained to meet the clients “where they are at” through a harm reduction approach, and work with clients for either a 6 or 12 month period. RCCs are not case managers, but will help their clients learn to navigate and access the health care system. The RCCs also make courtesy calls before appointments and for all no shows. To eliminate potential barriers to accessing medical care, they provide vouchers for babysitting and transportation, accompany clients to appointments both inside and outside the clinic, and make referrals to other programs at Whitman Walker such as support groups, transportation assistance, mental health services, and substance abuse treatment.