CURRICULUM

Innovative Approaches to Engaging Hard-to-Reach Populations Living with HIV/AIDS into Care

January 2013

Curriculum:
Innovative Approaches to Engaging Hard-to-Reach
Populations Living with HIV/AIDS into Care

U.S. Department of Health and Human Services
Health Resources and Services Administration
HIV/AIDS Bureau
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INTRODUCTION

PURPOSE AND BACKGROUND

This Integrating HIV Innovative Practices (IHIP) curriculum provides clinic staff and other stakeholders with guidance on how to replicate models of care developed to engage and retain hard-to-reach populations into HIV medical care. These best practices stem from the wealth of research produced by participants in the Special Projects of National Significance (SPNS) Program.

SPNS is the research arm of the Ryan White HIV/AIDS Program, facilitated by the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB), which supports the demonstration of cutting-edge approaches to HIV care that otherwise would not be funded or evaluated.

This IHIP curriculum can serve as a quality improvement initiative geared to helping agencies build their capacity to reach and serve people living with HIV/AIDS (PLWHA) from marginalized and underserved populations that are not engaged in care, are unstable in or sporadic to care, and/or have fallen out of care.[1]

By leveraging the guided discussions, activities, resources, and other materials in these trainings, participants will build their knowledge, skills, and abilities related to:

- The impact of HIV on these populations, and the barriers known to prevent them from accessing lifesaving HIV prevention, testing, treatment, care, and ancillary services;

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1. The phrases "engagement in care," "retained in care," "unstable in care," and "lost to care" are defined in the Models of Care Terms and Definitions Handout.

- How SPNS models of care help clinics reach these populations and mitigate HIV in their communities;
- Guidance concerning replication of these best practices into one's clinical operations; and
- Information about the way this work aligns clinic operations with the goals of the National HIV/AIDS Strategy.

TARGET AUDIENCE

Health professionals and advocates working with vulnerable PLWHA, including marginalized and underserved populations—ethnic and racial minorities, sexual minorities, currently and formerly incarcerated persons, people with substance use disorders (SUDs), injection drug users (IDUs), and others—would benefit from this curriculum. Those in particular who would benefit are:

- Clinical personnel, including medical doctors, nurse practitioners, registered nurses, other nursing staff, care coordinators, case managers, health service navigators, and front desk staff, and
- Stakeholders, namely consumers, local HIV Planning Council or clinic advisory board members, and representatives from HIV/AIDS providers and other partnering agencies.

TRAINING DESIGN

The training modules in this curriculum have been set up to accommodate the busy schedules of HIV clinics and agencies. Each module may be taught as a stand-alone session, which takes between 20 and 60 minutes to complete (although 60-minute sessions may be broken into two 30-minute modules to meet clinic needs and time constraints; where this break could occur is indicated), and includes teacher instruction, guided group discussion, group activities, and group evaluation components. When longer periods of time are available, sessions may be combined.

Although specialized training is not required, it is highly recommended that facilitators familiarize themselves with the information in this curriculum and the related IHIP training manual, "Innovative Approaches to Engaging Hard-to-Reach Populations Living with HIV/AIDS into Care." A series of complementary IHIP online webinars are available online at www.careacttarget. org/library/integrating-hiv-innovative-practices-ihip.

INSTRUCTIONAL APPROACH

This curriculum is set up as a series of trainings, activities, and handouts[2] designed to teach, engage, and guide staff discussion around the implementation of one or more SPNS models of care.

The staff person(s) heading the implementation process within the clinic ideally should facilitate the trainings. Group Discussions and Group Activities also may include input from other speakers, including (but not limited to) other clinic staff, partnering agency representatives, or other HIV/AIDS-related personnel.

The material covered in the curriculum is reflected in the related training manual. Its success depends on the willingness of the trainer—referred to as the Facilitator throughout this curriculum—to leverage all of the materials provided herein.
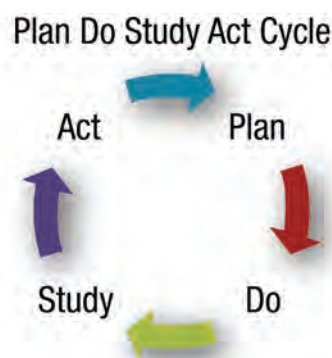
The quality improvement plan aspect of the training is framed by the Plan-Do-Study-Act (PDSA) cycle, which involves:

1. **Plan:** Nearly all of the modules are geared to "planning." In these, clinics examine different models of care and discuss what they want the clinic to achieve in implementing them.
2. **Do:** The one "do" module in this training curriculum helps clinics jumpstart the implementation of their selected model(s) of care.
3. **Study:** The "study" phase of the PDSA cycle involves evaluating the results of the planned and conducted action. Modules 1 through 8 include a Group Evaluation component that allows participants to assess the pros and cons of different models of care and informs their decisions concerning next steps for the clinic.

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2. Handouts can be printed as well as placed on flash drives and handed out to participants.

4. **Act:** The curriculum is designed to help agencies reach the "act" stage of the PDSA cycle, when the clinic has incorporated the selected model(s) of care into its operations permanently.

Like the PDSA cycle itself, the modules are designed to be iterative, and can be repeated as necessary.

The activities described in the curricula accommodate up to 20 participants easily and can be modified as needed. The activities encourage learning through interactive discussion, rather than just lecture, in order to familiarize participants with proven approaches to engaging and retaining PLWHA in care.

MATERIALS AND EQUIPMENT

Each module comes with an associated PowerPoint presentation, as well as detailed discussion and activity guides. Handouts are also provided for most of the modules.

These presentations and other IHIP materials are available from the TARGET Center Web site at www.careacttarget.org/ihip.

Throughout this curriculum, the Facilitator will require the following materials for each training session:

- A computer and compatible LCD projector that can readily play the training sessions' PowerPoint presentations
- Screen or blank wall on which to project each training
- Handouts of the material to be reviewed in that day's training session
- Paper and easel(s)
- Colorful markers
- Tape for affixing paper to the wall as necessary
- A bowl or hat for group activities
- Invited guest speaker(s), as needed.

Note: The Facilitator should neatly log thoughts and questions on the paper during each session, since participants may want to refer to notes from previous sessions. The Facilitator may want to transcribe (or facilitate the transcription of) these notes into a Word document to permit production of future reports, work plans, and guidance related to the selected model(s) of care.

MANUAL FORMAT

Throughout the manual are detailed slides with talking points, guided discussions, and group activities to facilitate the learning process. At the start of each module is a breakdown of the training's components, which are marked by the following symbols:

Session Length

PDSA Cycle

Teaching Presentation

PowerPoint Slide

Group Discussion

Activity

Evaluation

Trainer's Note

Handout

MODULE 1:
The HIV/AIDS Epidemic in the United States:
The Scope of the Problem
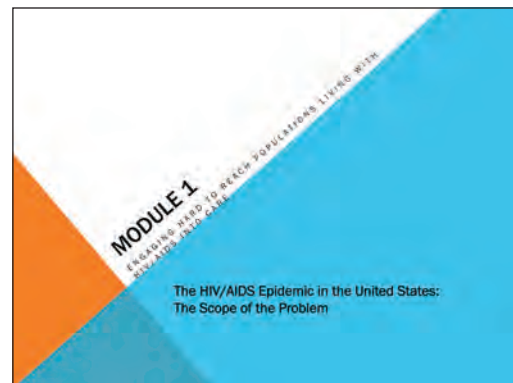
60 minutes

Module 1 can be done in full within 60 minutes or broken into two 30-minute sessions (with slides 1–9 conducted in a single session and 10–14, case study, and handout conducted in the subsequent session).

PLAN module

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SUMMARY

The goal of this module is to provide participants an overview of the HIV/AIDS epidemic in the United States, particularly within marginalized and underserved populations. It highlights how the National HIV/AIDS Strategy and HRSA's SPNS Program are helping to end HIV/AIDS through the coordinated development and implementation of innovative approaches to HIV care. It also serves as a springboard to help clinics initiate important discussions about the how to better engage vulnerable PLWHA within their communities into care.

MATERIALS NEEDED

- Computer and compatible LCD projector to play the PowerPoint presentation
- Paper and easel(s) for taking notes
- Colorful markers
- Tape for affixing paper to the wall as necessary
- Copies of the Module 1 handout to distribute.

Module 1 features presentation material, group discussions, and a group activity.

The Facilitator or other appointed person should write key thoughts voiced by participants throughout the presentation and subsequent discussions on the paper/easel.

Below are key points for the Facilitator to stress during the presentation and discussion topics to explore with the group.

SLIDE #2:
ADDRESSING THE UNITED STATES EPIDEMIC

Start with a discussion of the National HIV/AIDS Strategy (NHAS).

The NHAS, launched by the White House in July 2012, is geared to mitigating and ultimately ending the HIV/AIDS epidemic in the United States.

This national roadmap is crystallized into three overarching goals:

- *Reducing the number of people who become infected with HIV,*
- *Increasing access to care and improving health outcomes for PLWHA,* and
- *Reducing HIV-related health disparities.*

How do you think the National HIV/AIDS Strategy is connected to the work we do at the clinic?

What impact have you noticed so far?

SLIDE #3: NHAS: MORE IMPORTANT THAN EVER

NHAS is more important than ever in light of how many PLWHA are not receiving HIV/AIDS services.

The CDC estimates that 20 percent of the 1.2 million people estimated to be living with HIV in the United States are not in care.

SLIDE #4: WHAT POPULATIONS OF PLWHA
ARE NOT IN CARE?

Marginalized and underserved populations are overrepresented among PLWHA in the United States.

Populations that have the least access to care or resources to meet their basic needs bear the greatest burden of HIV.

These groups have been disproportionately impacted by HIV/AIDS since the start of the epidemic in 1981.

SLIDE #5: SNAPSHOT OF THE DOMESTIC HIV EPIDEMIC

Here are some statistics that highlight the immense impact of HIV in marginalized communities:

- Though African-Americans represent approximately 14 percent of the United States population, they constitute nearly one-half of all PLWHA in the United States.
- Young African-Americans, especially men who have sex with men (MSM), are hardest hit.
- African-American women represent 63 percent of HIV diagnoses among women in the United States.
- In 2010, Hispanics represented only 16 percent of the United States population, but accounted for over 20 percent of new HIV diagnoses and 20 percent of AIDS diagnoses.
- Asians and Native Hawaiians or Other Pacific Islanders (NH/PIs) had the third largest burden of HIV in the United States (after African-Americans and Hispanics) in 2010.
- AIDS rates are 40 percent higher among American Indians/ Alaska Natives than Whites.

SLIDE #6: OTHER VULNERABLE PLWHA POPULATIONS NOT IN CARE

Continue the discussion with these statistics:

Other groups that have been disproportionately impacted by HIV nationwide include:

- Sexual minorities, particularly MSM and transgender women
- PLWHA with SUDs
- PLWHA engaged in injection drug use (IDU)
- Women, particularly women of color
- Youth, particularly young MSM of color
- Currently and formerly incarcerated PLWHA
- Vulnerable and highly mobile groups, such as migrant workers, sex workers, and homeless persons

Who are the vulnerable populations served by our clinic?

- What populations of PLWHA within the community does the clinic serve? Who are not served?
- Why do you think some populations of PLWHA are engaged in care at the clinic and others are not? Is it related to the clinic's operations? To the populations of PLWHA themselves?
- What populations of PLWHA does the clinic wish to target more effectively?

SLIDE #7: WHAT ARE THE BARRIERS PREVENTING PLWHA FROM ACCESSING HIV/AIDS CARE?

Here we have a list of economic, psychosocial, and systemic barriers that often prevent PLWHA from accessing care:
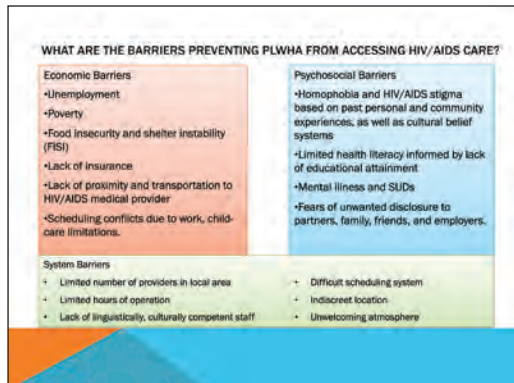
- Is there anything listed here as a barrier to care that you find surprising?
- What barriers do you think are missing from each category? Why?
- Have you worked with patients who were reluctant to get tested for HIV due to any of these barriers? If so, which barriers? Are patients testing late for HIV?
- What do you do to help these PLWHA overcome their barriers to care?

SLIDE #8: LATE HIV TESTING AND ENTRY INTO CARE

After the discussion, talk about the health ramifications of late HIV testing.
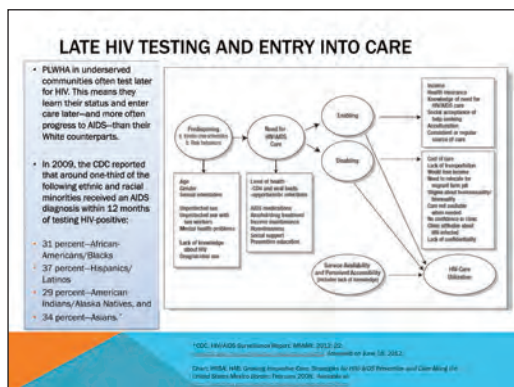
This diagram serves as an HIV testing logic model, which shows the different issues that often play a role in whether PLWHA access care. Not accessing HIV care can have serious health implications:

- PLWHA in underserved communities often test later for HIV. This means they learn their HIV status and enter care later—and more often progress to AIDS—than their White counterparts.
- Ethnic and racial minorities have been particularly impacted.
- In 2009, the U.S. Centers for Disease Control and Prevention (CDC) reported that around one-third of the following racial and ethnic minorities received an AIDS diagnosis within 12 months of testing HIV-positive:
  - 31 percent—African-Americans/Blacks
  - 37 percent—Hispanics/Latinos
  - 29 percent—American Indians/Alaska Natives, and
  - 34 percent—Asians.

SLIDE #9: WHY IS HIV/AIDS CARE IMPORTANT?

Without intervention, PLWHA most likely will progress to AIDS, undermining their health outcomes, quality of life, and life expectancy.

Research has consistently shown that PLWHA engaged in a holistic spectrum of care are more motivated to:

- Keep appointments.
- Initiate and adhere to antiretroviral therapy (ART).
- Regularly get required lab work.
- Participate in support services, such as mental health, SUDs, alcohol counseling, and dental care.
- Leverage (along with their families) ancillary/wraparound services, such as transportation, food and clothing banks, and health education classes.
- Access ART and support to ensure treatment adherence.
- Replace high-risk behaviors with a healthier lifestyle.

All of these help PLWHA avoid reinfection with HIV; transmission of the virus to others; and exposure to HIV coinfections, such as viral hepatitis, tuberculosis, and other sexually transmitted diseases.

SLIDE #10: MODULE 1 ACTIVITY: HIV/AIDS CARE CASE STUDY OF BOB S.

We are going to engage in a case study activity. Our example is the story of "Bob S."

Bob S. is a 35-year-old African-American male from Baton Rouge, LA. He works as a bartender and has engaged in sex work on and off since his late teens to make ends meet.

He knows HIV is an issue for the African-American community but never thought he was personally at risk for HIV, so he has never been tested.

He also works a lot and, most importantly, fears that family members might see him enter the clinic. He fears being outed as being gay and is worried about HIV stigma.

Bob finally decides to come in for testing after hearing from friends that his former boyfriend is HIV-positive and never told him.

Bob also has been extremely ill on and off for the past 6 months.

Testing reveals that Bob S. is HIV-positive with a CD4 count just under 100.

Be sure to encourage participants not to use real names or any other identifying information.

1) What would you do to help Bob S. deal with this new diagnosis?
2) How would you get him into care as soon as possible?
3) What are your experiences working with PLWHA testing late for HIV?
4) What kept them from getting tested and into care?
5) What steps would you take to help Bob address stigma?
6) What actions would you take to notify any partners of Bob's to get tested while keeping Bob's identity safe?

SLIDE #11: HIV/AIDS CARE SAVES LIVES

Look at this incredible statistic:

- Attending all medical appointments during the first year of HIV care doubled survival rates for years afterward, regardless of baseline CD4 cell count or use of ART.
- PLWHA in care also avoid high-risk behaviors.

What other benefits—social, economic, familial, or health-related—have you seen among PLWHA linked to care?

SLIDE #12: HIV/AIDS CARE IS COST-EFFECTIVE

Early HIV intervention and treatment is significantly cheaper—sometimes by more than 50 percent—than that associated with late HIV infection and end-of-life care.

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SLIDE #13: IMPLEMENTING THE NHAS, HELPING PLWHA ACCESS CARE

IMPLEMENTING THE NHAS, HELPING PLWHA ACCESS CARE

- The NHAS has called on clinics and agencies delivering HIV/AIDS care and services to find and implement innovative, cost-effective ways to improve their reach and access to PLWHA.
- The Ryan White HIV/AIDS Program, administered by the HIV Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB), has helped vulnerable PLWHA access care for over 20 years. It currently delivers care to over one-half of all PLWHA in the United States.
- Through its Special Projects of National Significance (SPNS) Program, the Ryan White HIV/AIDS Program has supported the development of numerous innovative models to engage hard-to-reach PLWHA into care.

The NHAS has called on clinics and agencies delivering HIV/AIDS care and services to find and implement innovative, cost-effective ways to improve their reach and access to PLWHA.

The models of care that we will be reviewing should satisfy this goal and help align clinic activities with the goals of the NHAS.

The Ryan White HIV/AIDS Program, administered by HRSA, has helped vulnerable PLWHA access care for over 20 years. The Ryan White HIV/AIDS Program currently delivers care to over one-half of all PLWHA in the United States.

Through the SPNS Program, Ryan White has supported the development of numerous innovative models to engage hard-to-reach PLWHA into care.

SLIDE #14: INTEGRATING HIV INNOVATIVE PRACTICES

INTEGRATING HIV INNOVATIVE PRACTICES

HRSA has launched the Integrating HIV Innovative Practices (IHIP) to help health care providers and others delivering HIV care in communities heavily impacted by HIV/AIDS with the adoption of SPNS models of care into their practices.

Replication of these models will help agencies improve their knowledge, skills, and abilities in recruiting, engaging, and retaining vulnerable PLWHA into care.

HRSA has launched the IHIP to help health-care providers and others delivering HIV care in communities heavily impacted by HIV/AIDS with the adoption of SPNS models of care into their practices.

This is ultimately about building our knowledge, skills, and abilities to recruit, engage, and retain vulnerable PLWHA into care.

Save the notes from Module 1 for reference during future modules.

Distribute the **Additional Engagement in HIV Care Resources Handout**.
The handout starts on the next page for easy printing/copying.

ADDITIONAL ENGAGEMENT IN HIV CARE RESOURCES HANDOUT

This handout provides information about additional resources related to the SPNS Program, marginalized and underserved PWLHA, and the theoretical foundations and practical application of the models of care discussed in this curriculum.

IHIP MATERIALS

Innovative Approaches to Engaging Hard-to-Reach Populations Living with HIV/AIDS into Care training manual and webinars available at www.careacttarget.org/library/integrating-hiv-innovative-practices-ihip.

Integration of Buprenorphine into HIV Primary Care Settings training manual, curriculum, and webinars available at www.careacttarget.org/library/integrating-hiv-innovative-practices-ihip.

SPNS RESOURCES

Download factsheets about the Special Projects of National Significance: http://hab.hrsa.gov/abouthab/aboutprogram.html.

Learn more about the following SPNS Initiatives that informed this curriculum at http://hab.hrsa.gov/abouthab/partfspns.html.

American Indian/Alaska Native (AI/AN) Initiative

AI/AN Initiative Highlights Challenge of Unique Service Settings. *What's Going on @ SPNS*. May 2005. Available at http://careacttarget.org/library/SPNS_Bulletin_AIAN_May2005.pdf.

Outreach, Care, and Prevention to Engage HIV Seropositive Young MSM of Color Initiative

Breaking Barriers, Getting YMSM of Color into Care: Accomplishments of the SPNS Initiative. *What's Going on @ SPNS*. December 2011. Available at http://hab.hrsa.gov/abouthab/files/cyberspnsdec11.pdf.

Special edition of *AIDS Patient Care and STDs* featuring research about the Young Men of Color Who Have Sex with Men (YCMSM) Initiative. August 2011. Available at http://online.liebertpub.com/toc/apc/25/S1.

Costs and Factors Associated with Turnover among Peer and Outreach Workers within the Young Men of Color Who Have Sex with Men SPNS Initiative. March 2010.

Magnus M, Jones K, Phillips G, et al. for the YMSM of Color Special Projects of National Significance Initiative Study Group. Characteristics associated with retention among African American and Hispanic/Latino adolescent HIV-positive men: results from the Outreach, Care, and Prevention to Engage HIV-Seropositive Young MSM of Color Special Project of National Significance Initiative. *JAIDS*. 2009;53(4):529–36.

Username—Outreach Worker. *What's Going on @ SPNS*. August 2006. Available at http://careacttarget.org/Library/SPNSBulletin/spnsbulletin.aug06.pdf.

Stigma and the SPNS YMSM of Color Initiative. *What's Going on @ SPNS*. February 2006. Available at http://careacttarget.org/Library/SPNSBulletin/spnsbulletin.feb06.pdf.

Hightow L, Leone P, Macdonald P, et al. Men who have sex with men and women: a unique risk group for HIV transmission on North Carolina College campuses. *Sexually Transmitted Diseases*. 2006;33(10):585–93.

Targeted Peer Support Model Development for Caribbeans Living with HIV/AIDS Demonstration Project

Cost Analysis of the Caribbean Peer Promoter Initiative: The Impact of Budget Allocation Strategies on Program Participation and Retention. March 2010. Available at http://hab.hrsa.gov/abouthab/files/caribbeanmarch10.pdf.

Demonstration and Evaluation Models that Advance HIV Service Innovation Along the United States–Mexico Border

Special edition of *Journal of HIV/AIDS and Social Services* featuring research about this initiative. October 8, 2008. Available at www.tandfonline.com/toc/whiv20/5/2.

Growing Innovative Care: Strategies for HIV/AIDS Prevention and Care Along the United States-Mexico Border. February 2008. Available at http://hab.hrsa.gov/abouthab/special/spnsproducts.html.

Innovations Along the United States-Mexico Border: Models that Advance HIV Care. 2005. Available at http://ask.hrsa.gov/detail_materials.cfm?ProdID=3550.

Targeted HIV Outreach and Intervention Model Development and Evaluation for Underserved HIV-Positive Populations Not in Care

Special edition of *AIDS Patient Care and STDs* featuring research about this initiative. June 2007. Available at online.liebertpub.com/toc/apc/21/s1.

Myers J, Shade S, Rose C, et al. Interventions delivered in clinical settings are effective in reducing risk of HIV transmission among people living with HIV: results from the Health Resources and Services Administration's (HRSA) Special Projects of National Significance Initiative. *AIDS and Behavior*. 2010;14(3):483–92.

Prevention with HIV-Infected Persons Seen in Primary Care Settings Initiative

Special edition of *AIDS Behavior* featuring research about this initiative. September 2007;11(Suppl 5). Available at www.springerlink.com/content/1090-7165/.

Peers Can Play a Vital Role in Prevention with Positives. *What's Going on @ SPNS*. January 2007. Available at http://careacttarget.org/Library/SPNSBulletin/spnsbulletin.jan07.pdf.

Prevention with Positives Is Off to a Positive Start. *What's Going on @ SPNS*. January 2005. Available at http://careacttarget.org/library/SPNS_Bulletin_PWP_Jan_2005.pdf.

Enhancing Linkages to Primary Care and Services in Jail Settings

Enhancing Linkages: Opening Doors for Jail Inmates. *What's Going on @ SPNS*. May 2008. Available at www.careacttarget.org/Library/SPNSBulletin/spnsbulletin.may08.pdf.

Jail: Time for Testing—Institute a Jail-Based HIV Testing Program. A Handbook and Guide to Assist. 2010. Available at http://enhancelink.org/sites/hivjailstudy/Training%20Manual%20ready%20to%20print.pdf.

Opening Doors: Corrections Demonstration Project for People Living with HIV/AIDS. December 2007. Available at http://hab.hrsa.gov/abouthab/files/openingdoors.pdf.

Enhancing Linkages to HIV Primary Care in Jail Settings. 2006. Available at http://ask.hrsa.gov/detail_materials.cfm?ProdID=3886.

Special Edition of *AIDS Care* featuring research about the Enhancing Linkages to HIV Primary Care and Services in Jail Settings Initiative. Summer 2012. Available at www.tandfonline.com/toc/caic20/current.

Enhancing Access for Women of Color Initiative

Lounsbury D, Palma A, and Vega V. *Simulating the dynamics of engagement and retention to care: a modeling tool for SPNS site intervention planning and evaluation*. Presented by HRSA SPNS Multi-Site Evaluation Center, Albert Einstein College of Medicine on May 4, 2012, during SPNS Women of Color Initiative Grantee Meeting May 4–5, 2012.

Common Voices: SPNS Women of Color Initiative. *What's Going on @ SPNS*. April 2011. Available at http://hab.hrsa.gov/abouthab/files/spnswomencolorapr2011.pdf.

OTHER SPNS RESOURCES

Improving linkages and access to care. *What's Going on @ SPNS*. January 2012. Available at http://hab.hrsa.gov/abouthab/files/cyberspnsjan12.pdf.

The Costs and Effects of Outreach Strategies That Engage and Retain People with HIV/AIDS in Primary Care. March 2010. Available at http://hab.hrsa.gov/abouthab/files/outreachstrategiesmar10.pdf.

OTHER HRSA, HAB RESOURCES

Download factsheets about the populations served by the Ryan White HIV/AIDS Program: http://hab.hrsa.gov/abouthab/populations.html.

Test and Treat. *HRSA CAREAction*. January 2012. Available at http://hab.hrsa.gov/newspublications/careactionnewsletter/hab_test_and_treat_january_careaction_pdf.pdf.

Social Media and HIV. *HRSA CAREAction*. June 2011. Available at www.incarecampaign.org/files/79032/HRSA%20CARE%20Action%20Jun%20Social%20Media.pdf.

CONNECTIONS That Count. *HRSA CAREAction*. February 2010. Available at http://hab.hrsa.gov/newspublications/careactionnewsletter/february2010.pdf.

Rules of Engagement in HIV/AIDS Care. *HRSA CARE-Action*. September 2007. Available at http://hab.hrsa.gov/newspublications/archivedissues.html.

Outreach: Engaging People in Care. 2005. Available at http://hab.hrsa.gov/abouthab/files/hivoutreachaug06.pdf.

HIV/AIDS in Rural Areas: Lessons for Successful Service Delivery. 2002. Available at http://ask.hrsa.gov/detail_materials.cfm?ProdID=221.

OTHER ENGAGEMENT RESOURCES

Diffusion of Evidence-Based Interventions (DEBIs). Available at www.effectiveinterventions.org/en/Home.aspx.

Academy for Educational Development Center on AIDS and Community Health (COACH) and CDC. *Antiretroviral Treatment and Access to Services (ARTAS) Implementation Manual*. Available at http://aidsetc.orgaidsetc?page=etres-display&resource=etres-546.

Making the Connection: Promoting Engagement and Retention Into HIV Medical Care Among Hard to Reach Populations. Available at www.bu.edu/hdwg/pdf/projects/LessonLearnedFinal.pdf.

25 Activities for Special Populations. Connecting to Care: Addressing the Unmet Need in HIV Rural and Formerly/Currently Incarcerated. Available at www.ask.hrsa.gov/detail_materials.cfm?ProdID=3852&ReferringID=4636.

CDC. *Using Viral Load to Monitor HIV Burden and Treatment Outcomes in the United States*. Available at http://www.cdc.gov/hiv/topics/surveillance/resources/factsheets/pdf/viral_load.pdf.

Office of National AIDS Policy (ONAP). *National HIV/AIDS Strategy*. Factsheet. July 2011. Available at http://aids.gov/federal-resources/policies/national-hiv-aids-strategy/nhas-fact-sheet.pdf.

ONAP. *National HIV/AIDS Strategy for the United States*. July 2010. Available at www.whitehouse.gov/sites/default/files/uploads/NHAS.pdf.

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Naar-King S and Suarez M. *Motivational Interviewing with Adolescents and Young Adults*. 2011. Available at www.motivationalinterviewing.org.

Rollnick S, Miller W, and Butler C. 2011. *Motivational Interviewing in Health Care: Helping Patients Change Behavior*. Available at www.motivationalinterviewing.org.

AIDS.gov's Guide to Using New Media Tools in Response to HIV/AIDS. 2010. http://aids.gov/pdf/sns-one-pager.pdf.

Connecting to Care: Addressing Unmet Need in HIV. 2010. Available at www.ask.hrsa.gov/detail_materials.cfm?ProdID=4488&ReferringID=4636.

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National Quality Center. Strategies for Implementing Your HIV Quality Improvement Activities. 2009. Available at http://www.incarecampaign.org/files/75477/Strategies%20for%20Implementing%20your%20Quality%20Improvement%20Activities.pdf.

New York Academy of Medicine. *Breaking Barriers: A Toolkit for Getting and Keeping People in HIV Care*. January 2007.

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Thompson M, Mugavero M, Amico K, et al. Guidelines for improving entry into and retention in care and antiretroviral adherence for persons with HIV: Evidence-based recommendations from an International Association of Physicians in AIDS Care Panel. *Ann Intern Med*. June 5, 2012;156(11):817–33.

Dutcher M, Phicil S, Goldenkranz S, et al. "Positive Examples": A bottom-up approach to identifying best practices in HIV care and treatment based on the experiences of peer educators. *AIDS Patient Care and STDs*. 2011;25(7):403–11.

Outlaw A, Naar-King S, Green-Jones M, et al. Brief report: predictors of optimal HIV appointment adherence in minority youth: a prospective study. *J Pediatr Psychol*. 2010 Oct;35(9):1011–5. Epub 2010 Feb 8.

Rajabiun S, Rumptz M, Felizzola J, et al. The impact of acculturation on Latinos' perceived barriers to HIV primary care. *Ethnicity and Disease*. 2008;18(4):403–8.

Drainoni M, Rajabiun S, Rumptz M, et al. Health literacy of HIV-infected individuals enrolled in an outreach intervention: results of a cross-site analysis. *Journal of Health Communication*. 2008;13(3):287–302.

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MODULE 2:
The Continuum of Care:
Is Your Clinic Effectively
Reaching Vulnerable PLWHA?
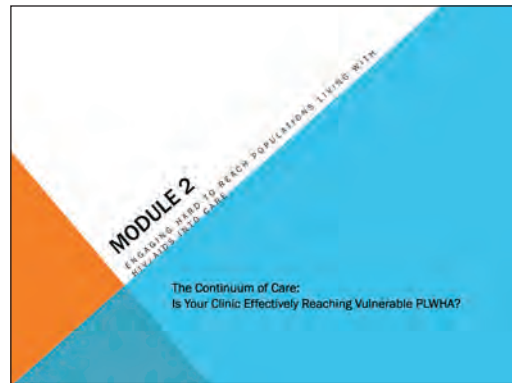
25 to 35 minutes

Time variance accounts for potential guest community clinical expert; see slide #19

PLAN module

16

SUMMARY

This section provides an overview of the continuum of care and guides discussion about:

- Hard-to-reach PLWHA populations the clinic currently serves and/or wants to serve,
- What steps currently are being taken to identify and engage hard-to-reach PLWHA into care, and
- What can be done to improve and ramp up these efforts.

MATERIALS NEEDED

- Computer and compatible LCD projector to play the PowerPoint presentation
- Notes from Module 1
- Paper and easel
- Colorful markers
- Tape for affixing paper to the wall as necessary
- Copies of the Module 2 handouts to distribute
- Invited guest speaker(s), as needed.

Module 2 features both teaching material and guided group discussion.

The Facilitator or other appointed person should write key thoughts voiced by participants throughout the presentation and subsequent discussions on the paper/easel.

Before beginning the presentation, distribute the Module 2 handouts, **Continuum of Care** and **Common Terms and Definitions**.

The handouts start at the end of the section for easy printing/copying.

The Facilitator introduces the first slide, which refreshes participants about the last session. Participants should review the **Continuum of Care Handout** as well.

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SLIDE #16: TRAINING REFRESHER

Before we begin, let's review the previous session. Namely:

- Why should PLWHA engage in HIV care as early as possible in their infections?
- What populations have been most impacted by HIV and why?

SLIDE #17: THE CONTINUUM OF CARE

Engaging in HIV care involves a spectrum of activities, not a singular event.

It begins with PLWHA learning their serostatus and ideally reaches the point where they become fully engaged and retained in HIV primary care.

SLIDE #18: THE CONTINUUM OF CARE: A SPECTRUM

- A patient's location on the continuum is not static. PLWHA move up and down the continuum.
- Movement away from full engagement often occurs in response to unmet needs, including:
  - Food insecurity and shelter instability, poverty, SUDs, mental illness, and other psychosocial and economic determinants.
  - PLWHA with limited educational attainment and histories of incarceration also have difficulty obtaining and maintaining employment and health insurance, which can further delay them from accessing care.
  - It is not uncommon for PLWHA to ignore their health needs until they require emergency room assistance. Seeing an HIV primary care provider may be their first ongoing experience with the health-care system.

- Full engagement and retention in care is essential for PLWHA to achieve optimal health outcomes.
  - These include engagement in healthy behaviors; reduction in high-risk behaviors; and better overall health.
  - Engagement and retention in care supports ART adherence, which suppresses HIV viral loads and improves the health of individual clients, while significantly reducing their chances of transmitting the virus to others.

People with undetectable HIV viral loads are less likely to transmit the virus.

SLIDE #19: CARE AND TREATMENT ADHERENCE LOWERS COMMUNITY VIRAL LOAD

The Facilitator may want to bring in a community expert to discuss the community viral load in the local community. If an expert speaks, provide them approximately 10 minutes to do so. They should speak after this slide but before the subsequent group discussion.

- Engaging PLWHA in care and helping them become adherent to ART can improve health outcomes not just for the individual, but for their entire community.
- This can be monitored through a measure called community viral load (CVL).
  - ART-adherent PLWHA can achieve significant reductions or undetectable levels of HIV in their bloodstreams. The amount of virus in the bloodstream is determined through a laboratory test, and the resulting measure is referred to as a viral load. It is an essential clinical benchmark for PLWHA.
  - Individual viral loads for an entire PLWHA population can be aggregated and averaged, resulting in a CVL. The CVLs of different populations can be compared and disparities identified.
  - A community's CVL can be lowered by engaging its PLWHA population into care and helping them become ART-adherent. A lower CVL also points to fewer HIV infections, since PLWHA with low or undetectable viral loads are less infectious.

How do you think the CVL of the populations we serve compare to one another and why?

CARE AND TREATMENT ADHERENCE LOWERS COMMUNITY VIRAL LOAD

- PLWHA in care and ART-adherent not only improve their individual health outcomes but also those of their community.
- ART-adherent PLWHA can achieve significant reductions or undetectable levels of HIV—or viral load—in their bloodstreams. (HIV levels are determined through a laboratory test.)
- Individual viral loads for an entire PLWHA population can be aggregated and averaged, resulting in a population measure called "community viral load" or CVL.
- The CVLs of different PLWHA populations can be compared and disparities identified.
- A community's CVL can be lowered when members of PLWHA populations are enlisted into care and become ART-adherent.
- Lower CVLs often mean lower rates of new HIV infections, since PLWHA with low or undetectable viral loads are less likely to transmit the virus.

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SLIDE #20: MODULE 2 ACTIVITY

MODULE 2 ACTIVITY

- As a group, review the vulnerable PLWHA populations currently served by the clinic that participants identified on newsprint during Module 1.

- Where are most of these populations currently located on the continuum of care? (Note on the newsprint.)

The Facilitator now engages the group in a discussion about what was covered in the first module, referencing the notes created. (Ideally, the paper and easel from Module 1 will be easily visible for all participants.)

- Review the vulnerable PLWHA populations currently served by the clinic that participants identified during Module 1.
- Where are most of these populations currently located on the continuum of care?

SLIDE #21: MODULE 2 ACTIVITY, CONTINUED

MODULE 2 ACTIVITY, CONTINUED

- Are there PLWHA populations the clinic wants to target more effectively?
- What activities currently take place (if any) to recruit, engage, and fully engage these populations into care?
- Are these activities informal or formal?
- Are dedicated staff, funding, and other resources set aside for these activities?
- If the clinic serves multiple vulnerable PLWHA populations, discuss whether different strategies are used—or should be used—to recruit, engage, and retain them into care.

The Facilitator goes around the room and asks participants the following questions. Notes should be recorded.

- Are there PLWHA populations the clinic wants to target more effectively?
- What activities currently take place (if any) to recruit, engage, and reengage these populations into care?
- Are these activities informal or formal?
- Are dedicated staff, funding, and other resources set aside for these activities?
- If the clinic serves multiple vulnerable PLWHA populations, discuss whether different strategies are used—or should be used—to recruit, engage, and retain them into care.

The presentation ends with a review of the module's goals and the remainder of the upcoming modules.

SLIDE #22: IHIP PROCESS AND THE PDSA CYCLE

IHIP PROCESS AND THE PDSA CYCLE

Replication of models of care developed through the SPNS Program will be framed by a Plan-Do-Study-Act (PDSA) framework.

Plan-Do-Study-Act (PDSA) Cycle

Act → Plan
Study → Do

The curriculum is designed to help us prioritize, plan, implement, and review these models of care within our operations.
Each module conforms to the PDSA model, shown here. It's conceived as cyclical and iterative, as necessary.

SLIDE #23: REPLICATION STEPS

REPLICATION STEPS

The modules guide participants through the replication process:

•Plan:
* Module 1: The Scope of the Problem
* Module 2: Continuum of Care: Is Your Clinic Reaching Vulnerable PLWHA?
* Modules 3–8: Innovative Models of Care

•Do:
* Module 9: Think Big, Start Small: First Steps to Implementing Models of Care

•Study and Act:
* The evaluation sections at the end of Modules 3–8 offer participants an opportunity to evaluate the models of care. This will help them select the model(s) of care they are going to implement at their agency.

- The **planning** modules will help participants discuss what they want to achieve in implementing one or more of these new model(s) of care.
- The **doing** modules will guide the work involved in achieving the steps outlined in the planning stage.
- The modules in this curriculum primarily are geared to helping us reach the **study** (or evaluation) and **act** (final incorporation and execution) stages of the PDSA cycle.
- However, the **doing** modules include a Group Evaluation activity, which serves, in part, as the **study** piece of this curriculum's PDSA cycle.

Save the notes from this and previous modules for reference in future sessions.

CONTINUUM OF CARE HANDOUT

Not in Care → Fully Engaged

Unaware of HIV status (not tested or never received results)	Aware of HIV status (not referred to care or did not keep referral)	May be receiving other medical care but not HIV care	Entered HIV primary medical care but dropped out (lost to followup)	In and out of HIV care or infrequent user	Fully engaged in HIV primary medical care
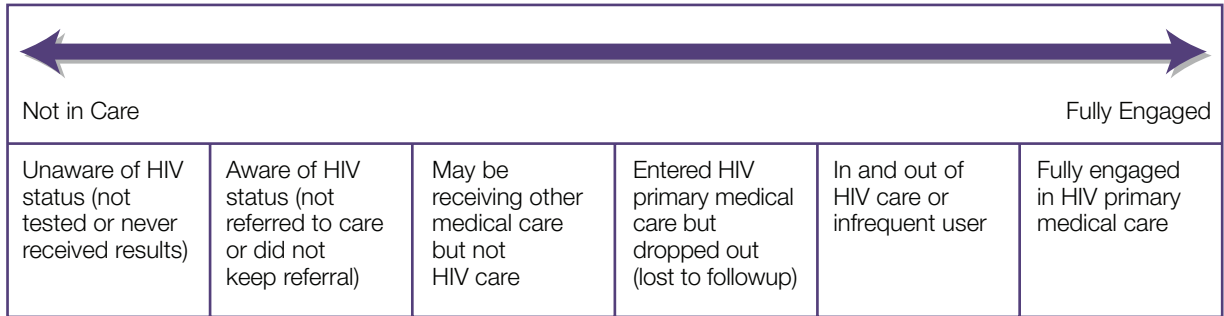
Source: Cheever L. Engaging HIV-infected patients in care: their lives depend on it. *Clin Infect Dis.* 2007;44(11):1500–02.

COMMON TERMS AND DEFINITIONS HANDOUT

Term	Definition
Adherence to ART	Adherence means taking medication regularly, as prescribed. Antiretroviral Therapy (ART) adherence refers to patients who take their HIV medications as instructed nearly 100 percent of the time. Adherence is essential to prevent drug resistance, significantly lowering or achieving undetectable viral loads, and subsequently improving PLWHA outcomes and reducing transmission risk.
Community Viral Load	The average of all viral loads of a specific community of PLWHA results in a measurement called the "community viral load" (CVL). The CVLs of different populations can be compared and disparities identified and addressed. Lowering a community's CVL requires PLWHA to become engaged and ART-adherent, since this means they are likely to have low or undetectable viral loads and less likely to transmit the virus to others.
Engagement in Care	Engagement refers to an ongoing series of interactions between PLWHA and a continuum of care with a variety of providers, including outreach workers, case managers, clinic staff, medical personnel, counselors, ancillary service providers, etc. Clinically, patients are considered engaged in care if they have had at least 1 visit in each 6-month period with a single HIV care provider within a 12-month period.
Full Engagement in Care	Full engagement in care occurs when PLWHA have a complete, regular, ongoing involvement in primary medical care. Similar to "engagement in care," it is clinically defined as 2 visits within a 12-month period that are at least 3 months apart.
Health Service Navigator	Health Service Navigators (HSNs) are staff members trained to provide intensive case management for PLWHA entering care and/or may be accessing services from partnering providers. HSNs may conduct care assessments and develop action plans to help their clients identify their care goals and understand how they can reach them.
Intensive Case Management	Intensive case management involves coordination of medical, mental health and other services in the context of frequent meetings and check-ins, often for a set period of time.
Linkage to Care	Linkage involves the initial connections and entry points of care after HIV testing and disclosure. Linkage may include referral by a case manager to a treatment program for substance use disorders (SUDs) as well as medical and mental health care. In addition, persons who test negative for HIV may be linked to a peer counselor for additional guidance around HIV prevention.
Lost to Care	Patients who have had at least 1 visit in the last 2 years with a provider, but have not been to the facility within the last 12 months.
Outreach	Outreach is a series of singular events geared to finding people who are at risk for or living with HIV, to offer education and to link people to HIV testing and care. These events can include health fairs and encounters outside of entertainment venues. They generally do not refer to ongoing activities that retain people into care, such as appointment reminders.
Peer/Near-Peer	Peers and near-peers are outreach workers or counselors who encourage people at risk for HIV to get tested, and work to keep PLWHA engaged in HIV prevention, care, and treatment. Often peers and near-peers are from the same ethnic and racial background and the same age as the clients they serve.
Retention in Care	Describes ongoing, full engagement of PLWHA in care over time. Sometimes used synonymously with "full engagement in care."
Reengagement	Reengagement refers to patients who return to care after having fallen out of care in the past.
Sporadic Care	Clinically, sporadic care refers to patients who have seen an HIV provider no more than 1 time in a 12-month period. These patients would be considered unstable in care.
Time-Limited	Time-limited interventions take place during a set time period. For instance, a new, reengaging, or unstable patient may receive intensive case management until he/she is stable and able to better navigate their care independently.
Unstable in Care	Patients who are unstable in care—indicated through factors such as missed appointments, not being adherent to ART, and substance use disorders—are considered at risk and on the verge of falling out of care.

MODULE 3:
Innovative Models of Care: An Overview and Traditional Street/Social Outreach
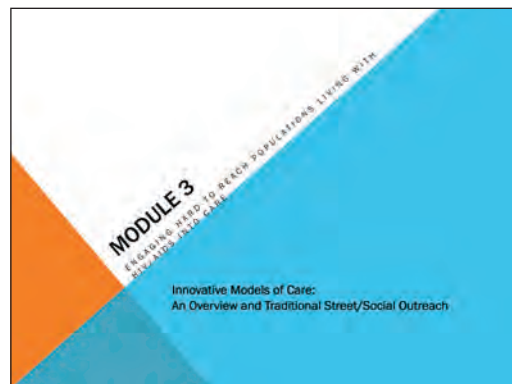
🕐 60 minutes

📝 This can be broken down into two 30-minute sessions if necessary. (First session will include slides #25 to 31, including associated discussion questions within those slides. Second session will include slides #32 and #33 as well as the "Outreach: Role Play" activity.)

🔄 PLAN module

SUMMARY

To better engage current or new vulnerable PLWHA populations, clinics are encouraged to replicate one or more of the models of care described in this curriculum.

This module provides a brief overview of the models of care developed through the SPNS Program. Particular emphasis is placed on the traditional street/social outreach model of care.

Participants will discuss the pros and cons of this model of care in targeting the marginalized and underserved PLWHA they wish to serve.

MATERIALS NEEDED

- Computer and compatible LCD projector to play the PowerPoint presentation
- Notes created during previous modules
- Paper and easel(s)
- Colorful markers
- Tape for affixing paper to the wall as necessary
- Copies of the Module 3 handouts to distribute.

Module 3 features teaching material, guided group discussion, and a group activity.

The Facilitator or other appointed person should write key thoughts voiced by participants throughout the presentation and subsequent discussions on the paper and easel.

Before beginning the presentation, distribute the Module 3 handouts: **Models of Care**, **Traditional Street/Social Outreach Logic Model**, **Outreach Encounter Form**, and **Model of Care Evaluation**.

The handouts start at the end of the section for easy printing/copying.

The Facilitator should introduce the first slide, which serves as a refresher about the last session. It may be helpful to have notes from previous module up for display to foster discussion.

SLIDE #25: TRAINING REFRESHER

Before we begin, let's review the last session.

- What PLWHA population(s) do we want to engage more effectively?
- Where are the PLWHA populations we serve (and wish to serve) on the continuum of care?

TRAINING REFRESHER

Before starting today's session, review what you discussed yesterday:

·What PLWHA population(s) do we currently reach? Who do we want to engage more effectively?

·Where are the PLWHA populations we serve on the continuum of care currently?"

SLIDE #26: INNOVATIVE MODELS OF CARE

Through this course, we are going to review several different innovative models of care geared to helping clinics like ours engage in care.

The Models of Engagement being outlined include:

- Traditional Outreach/Social Outreach Model
- Motivational Interviewing Model
- Health System Navigation/Retention in Care Coordination
- HIV Interventions in Jails
- In-reach (reconnecting with past patients lost to care)
- Social Marketing Campaigns/Social Networking Channels.

INNOVATIVE MODELS OF CARE

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- HIV Interventions in Jails
- In-reach (reconnecting past patients lost to care)
- Social Marketing Campaigns/Social Networking Channels

SLIDE #27: TRADITIONAL STREET/SOCIAL OUTREACH

Traditional Street/Social Outreach is perhaps the best-known model of care in the HIV/AIDS arena. It generally involves:

- Brief, singular encounters with persons in areas where targeted PLWHA live, work, and otherwise frequent, including public areas and events.
- Most often staffed by peers or near-peers of the target population(s). They tend to be trained volunteers or entry-level staff. They may be "stationed" in designated areas in a group or at a booth/table. They also may use the clinic health van as a central location.
- Giveaways, such as condoms, bleach kits, and brochures, are often distributed. Oral swab HIV testing, when available and allowed, is also offered (sometimes under the guise of general health services) to avoid HIV stigma.

TRADITIONAL STREET/SOCIAL OUTREACH

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·Targeted PLWHA are often given incentives—such as condoms, bleach kits, and brochures—as well as offered, if available and allowed, oral swab HIV testing.

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Who would like to share their experiences conducting outreach work? Tell us about:

- Your target audiences/populations.
- The type of outreach activities you conducted, noting what worked and didn't work.

SLIDE #28: TRADITIONAL STREET/SOCIAL OUTREACH: A BREAKDOWN
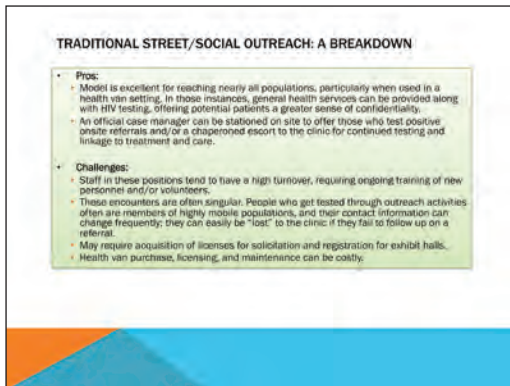
Let's discuss the pros and cons of this model of care. First, the pros:

- It offers an effective tool to reach nearly all populations, particularly when used in a health van setting. In those instances, general health services can be provided along with HIV testing, offering potential patients a greater sense of confidentiality.
- An official case manager can be stationed onsite to offer those who test positive onsite referrals and/or a chaperoned escort to the clinic for continued testing and linkage to treatment and care.

And then the cons:

- Outreach workers tend to turnover pretty quickly—particularly when they are younger and/or volunteers. That means having to train more often.
- These encounters are often singular in nature. People who get tested through outreach activities tend to be members of highly mobile populations, and their contact information can change frequently; they can easily be "lost" to the clinic if they fail to follow up on a referral.
- We may need to get solicitation licenses and register to appear at exhibit halls.
- Health van purchase, licensing, and maintenance can be costly.

SLIDE #29: TRADITIONAL STREET/SOCIAL OUTREACH LOGIC MODEL

Here we have the traditional street/social outreach logic model. We follow a patient from an initial encounter to engagement in care.

SLIDE #30: TRADITIONAL STREET/SOCIAL OUTREACH LOGIC MODEL, CONTINUED

The logic model offers an idealized vision of outreach.

What do you think of this model of care? Do you think it describes how it might work at our clinic?

SLIDE #31: TRADITIONAL STREET/SOCIAL OUTREACH LOGIC MODEL, CONTINUED

There are logistical issues to consider with this model of care, which could lead to increased costs.

First issue up: **staffing.**

- We all need to be on board with this approach, or it isn't going to work. We are doing this training, but what about focus groups? Other forms/methods of achieving buy-in?
- Should we bring consumer voices from the clinic, the local Ryan White Planning Council, and other entities into this process?
- Outreach workers represent us to the public. Should we have both experienced and new staff onsite to bring PLWHA into the clinic?
- Does the clinic have personnel already trained or who can be easily trained to serve as outreach workers for the clinic? Will staff need to be hired?

- What types of training do you think outreach workers need?
- If we offer onsite oral swab HIV testing, what will we do about providing specialized training? Also, should we have a case manager onsite to work with those who have a reactive test?

Second up: **Protocol** or the official way we set up our outreach.

- How will the agency present itself during outreach? Will staff wear anything that connects them with the clinic, such as t-shirts or backpacks? Or will they be anonymous in an attempt to enhance patients' sense of confidentiality?
- How will encounters be conducted? Will outreach workers use a script/form to guide their conversation and capture data? (See the **Outreach Encounter Form Handout**.)
- Will the clinic be able to leverage notebook computing, data-tracking software, and wireless Internet connectivity to track interactions? Who will be responsible for data collection during and after outreach encounters?
- What about confidentiality? How do we safeguard the identity of the people we contact?

Venues and Materials: The clinic also will need to consider questions such as:

- Do we know where to find our target populations in the field? Where will we go? Clubs? Public transportation areas? Health fairs? Cultural events?
- If we don't find our target population, are we willing to work with other PLWHA?
- Will we hand out materials to those we meet? Will the materials be branded with our clinic name or logo, or be generic? What will we hand out? Condoms, harm-reduction materials (as allowed) and/or educational materials?
- We may need to talk again about getting solicitation permits, as well as the rental, licensing, and maintenance of a health van or other vehicle.

Please refer to the Group Activity description below.

MODULE 3 GROUP ACTIVITIES

Two Group Activities:

•Outreach "Hot Seat"

•Outreach Role Play.
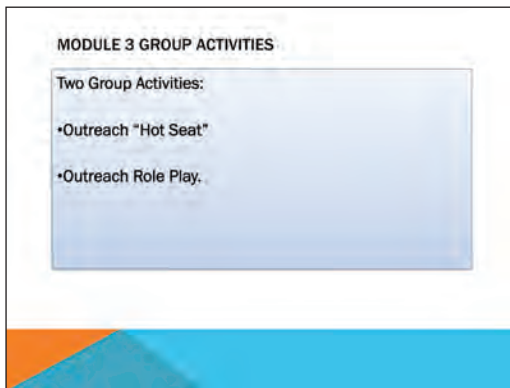
Outreach "Hot Seat"

We are now going to play two different games. The first is "Outreach Hot Seat."

I'm going to select someone to play the "outreach worker" assigned to approach potential clients at a local nightclub. You are going to answer, in character, the following questions:

The Facilitator does not have to ask all of these questions, and may switch their order, as desired.

- Are you working inside or outside the club? Both?
- Does the nightclub know you are recruiting possible PLWHA? Did the nightclub help promote these outreach efforts? Did the clinic? Are you working together? Perhaps you are not promoting your outreach work at all? Is this a set ongoing outreach event at this venue?
- Are you wearing clothing or handing out materials branded with the clinic's name?
- Are you handing out giveaways? If so, what are they?
- How do you approach potential patients? Do you have an outreach form or memorized script to guide the conversation?
- What do you do when turned down by the person you approach?
- What do you do when they say yes?
- Are you offering general information, overall health care, giveaways, HIV testing?
- How are you ensuring patient privacy? Where are you speaking with potential patients? In a health van? In the venue itself?
- Are you providing pre- and post-HIV testing counseling?
- Are you working alone or with someone? If there is HIV testing, how are you dealing with those who have a reactive test? Are you linking/referring them to care? Driving them to the clinic?
- What about those with a nonreactive test? Do you provide them

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additional information? Counseling? Referrals to other services, such as shelters, and clothing and food banks, as necessary?
- During and after the encounter, how do you handle the data you capture?
- What other issues might arise?

The second game is "Outreach Role Play."

I'm going to select two volunteers—one to play an outreach worker and the other a potential patient—to act out the following scenarios:

- An ideal outreach encounter that goes just as the clinic would want.
- An outreach encounter that does not go as planned. For example:
  – The potential patient is not interested in being approached or voices concerns about confidentiality.
  – You meet someone who is interested in getting tested, but is not exactly a member of your target PLWHA population(s).
  – You engage a patient who has a reactive HIV test, but does not want to be referred to services.

Lead the discussion on whether this model of care will work for the clinic. Have participants refer to the **Model of Care Evaluation Handout** from Module 3.
Tape several pieces of paper with the model of care's name on each.

SLIDE #33: GROUP MODULE EVALUATION

Read each question and then write down everyone's thoughts, questions, suggestions, etc. on the paper.

- Can this model of care be readily integrated within the clinic's current operations and help it reach targeted populations of PLWHA?
- Does the clinic already use this model of care, perhaps in a slightly different form?
- Can the clinic satisfy all requirements for this model of care?
- What funding streams, staffing, materials, and other resources are necessary to implement this model of care? Does the clinic have access to these? If not, how will they access them?
- How will buy-in be secured within the clinic?
- Will the implemented model of care be promoted to potential patients? If so, how? Online through social networks? Word of mouth?
- Does this model of care help the clinic identify and engage targeted PLWHA populations into care?
- Compare the pros and cons of this initiative.

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If more than 10 people are present, the Facilitator may split partici-
pants into two or three groups to discuss the following questions and
write their thoughts on the paper. After a few minutes, the Facilitator
can reconvene everyone and have a representative from each group
explain everyone's ideas.

Save the paper from this and previous modules for reference in future
sessions.

MODELS OF CARE HANDOUT

Models of Care	Definition
Traditional Street/Social Outreach Model	This outreach model often involves having peers engage in outreach with at-risk persons in their communities, often in public arenas, such as public events and entertainment venues.
Motivational Interviewing Model	Rather than a singular outreach event, motivational interviewing (MI) is delivered by peers and near-peers, who are trained to provide culturally and linguistically competent counseling. Motivational interviewing is designed to help patients align their behaviors with their treatment goals so they become engaged and retained in care.
Health System Navigation/ Retention in Care Coordination	Health System Navigators (HSNs) work with PLWHA clients to support engagement in care with partnering providers. They conduct assessments, codevelop action plans with PLWHA, and coordinate care across providers.
HIV Interventions in Jails	This model leverages the jail setting (and related correctional institutions such as parole offices) to identify and engage PLWHA into care. The uniqueness of HIV care in jail settings involves its own model, which in part is a hybrid of several others in this training manual.
In-reach (reconnecting past patients lost to care)	Providers work with partnering agencies, using their databases as a resource to identify PLWHA who have fallen out of care, contact them, and help them to reengage in care.
Social Marketing Campaigns/ Social Networking Channels	Social marketing uses commercial advertising techniques to "sell" HIV prevention, testing, treatment, and care through messages that are targeted to specific populations. Television and radio advertisements and promotional materials are often repurposed and circulated online through social networks, such as YouTube, Facebook, and Twitter.

TRADITIONAL STREET/SOCIAL OUTREACH LOGIC MODEL

```
Traditional Street/Social Outreach  ──▶  PLWHA  ───  Negative Result
                                            │
                                            │                    Education
                                    ┌───────┴───────┐
                              Positive Result    HIV Testing
                                    │
                    ┌───────────────┼───────────────┐
              Case Management   Eligible for    Ineligible for
                Assessment      Case Management  Case Management
                    │               │               │
                 Case          Primary Medical   Peer Advocacy
               Management          Care
                                    │
                        Reinforcing and Interrelated Services
```

ADAP	Mental Health	Support Services	Social Services	Substance Use Treatment	Dental Care
ART Adherence Assistance	Individual Counseling and Support Groups	Health Education	Legal, Housing, Transportation, Food, Child-Care Assistance		

OUTREACH ENCOUNTER FORM

Date of Encounter: _____ / _____ / _____
MO XX   DAY XX   YR 20XX

Outreach Worker(s) Initials: _____

Number of Outreach Workers: _____

Location of Outreach Encounter (check one):

Agency	
Mobile van	
Streets, parks, open space	
Shelter	
Apartment building	
Treatment program setting	
Correctional institution	
Community/entertainment venue (bar, club, drop-in center)	
Other (specify):	
Not applicable/Not face-to-face (specify):	

Purpose/Content of Outreach Encounter (check all that apply):

Provide information about agency program(s)/resource(s)	
Provide general HIV information	
Provide specific HIV risk reduction/counseling	
Offer HIV testing	
Hand out HIV prevention materials (specify):	
Hand out harm reduction materials (specify):	
Accompany client to medical appointment	
Accompany client to other appointment (specify):	
Refer or make appointment for medical care (specify):	
Refer or make appointment for housing services	
Refer or make appointment for substance use treatment	
Refer or make appointment for mental health services	
Refer to needle exchange	
Refer to make appointment for other services (specify):	
Provide medical services (specify):	
Provide mental health counseling (specify):	
Provide service coordination (specify):	
Provide crisis intervention (specify):	
Other (specify):	

Outreach Staff Conducting Outreach Encounter (circle all that apply):

Peer outreach worker	
Non-peer outreach worker	
Case worker	
Social worker	
Mental health clinician	
Substance use counselor	
Nurse	
Physician	
Nurse practitioner	
Administrative staff	
Client volunteer	
Staff volunteer	
Other (specify):	

Duration of Contact (check one):

Attempted contact	
<5 minutes	
6–4 minutes	
15–29 minutes	
30–59 minutes	
60–90 minutes	
90–120 minutes	
Community/entertainment venue (bar, club, drop-in center)	
Other (specify):	
Not applicable/Not face-to-face (specify):	

Type of Contact (check one):

Face-to-Face	
Telephone	
Letter	
E-mail	
Other Internet (specify):	
Collateral contact:	
Other (specify):	
Community/entertainment venue (bar, club, drop-in center)	
Other (specify):	
Not applicable/Not face-to-face (specify):	

Client Name or "Street" Name:

_____ _____ _____
First Name   Middle/"Street" Name   Surname

Location Notes: _____
_____

Other Notes: _____
_____

MODEL OF CARE EVALUATION HANDOUT

Conceptual Approach to Evaluating Effectiveness of Interventions to Improve Access, Engagement, and Retention of People Living with HIV/AIDS (PLWHA) into HIV Care

Barriers to Access, Engagement, and Retention in HIV/AIDS Care	Interventions to Improve Access to and Retention in Care	Short-Run Outcomes
Community/Cultural issues	**Community issues related to**	Reduced HIV and health-care disparities; full engagement and retention of PLWHA in HIV/AIDS care
Stigma associated with HIV and sexual orientation	Social marketing campaigns to change social norms	Increased knowledge and awareness of HIV prevention and treatment
Discrimination against marginalized populations: ethnic/racial minorities, immigrants, current/formerly incarcerated persons, non-English speaking persons, substance users, injection drug users, and sexual minorities	Partnerships with community organizations to address stigma issues	Reduced HIV stigma
	Culturally relevant, gender-specific HIV education via local media	Reduced barriers to HIV/AIDS health care
	HIV education in social networks through lay health advisors	Improved access to and use of HIV care
Lack of knowledge of HIV prevention and treatment; local/national HIV incidence and prevalence rates	HIV testing initiatives	Increased retention and engagement in HIV health care
System issues	**System issues**	Increased HIV immune system and resistance monitoring
Limited care coordination and service linkages	Network of client referrals creates multiple "doors" into the clinic's spectrum of care and services. Requires multifaceted partnerships with partnering agencies, such as homeless shelters, substance use clinics, and local jails.	Increased use of highly active antiretroviral therapy (HAART) and other HIV-related medications
Limited eligibility for publicly funded programs		Reduced morbidity and mortality
Organizational issues		Enhanced quality of life
Limited access, availability, acceptability, and affordability of HIV core medical and support services	Coordinated care between HIV testing personnel and heath service navigators (HSNs), motivational interviewing (MI) counselors, case managers, and other clinic personnel	
Limited organizational support for culturally and linguistically appropriate services (CLAS)	**Organizational issues**	
Lack of race/ethnicity data, and limited program evaluation and quality management capacity	Rapid HIV testing with same-day intake and initial clinical assessments	
Limited resources for translation and interpreter services	Effective scheduling/reminders to reduce missed appointments	
	In-reach to find clients lost to care	
	Health service navigation/intensive medical case management to increase care coordination	

Barriers to Access, Engagement, and Retention in HIV/AIDS Care		Interventions to Improve Access to and Retention in Care		Short-Run Outcomes
Provider-client interaction issues related to Lack of frontline provider HIV clinical expertise and linguistic and cultural competence Cultural, linguistic, and gender provider–client discordance Lack of Spanish-speaking providers and interpreters Communication and trust between provider and client **Client characteristics** From historically underserved population High rates of poverty, lack of insurance, limited educational attainment, low health literacy, housing instability HIV rate of risk factors and HIV serostatus Co-occurring mental illness, addiction, and chronic diseases Psychosocial issues: fear of disclosure of HIV status, deportation, etc.		**Provider–client interaction issues related to** Use of HIV+ peers or near-peers for outreach, education, motivational interviewing, health service navigation, advocacy, translation, and psychosocial support Medical care integrated into outreach through mobile units Organizational support for and evaluation of CLAS practices Improved provider communication with patients regarding health care, cultural beliefs, traditional medication, and so on Linguistically/culturally competent staff and materials **Client characteristics** HIV education, health literacy, and life-skills training Early intervention services tailored to special populations Assistance with basic needs that compete with HIV care Facilitation of entry to care for special populations (post-incarceration, youth aging up to adult services, pregnant women) Gender-specific support groups		

Environmental Factors Economic conditions, structure of safety net system, geographic location, Medicaid and other public insurers, Ryan White Program sun-setting, Federal immigration policies, and Federal health-care reform legislation

MODULE 4:
Innovative Models of Care:
Health System Navigation/
Retention in Care Coordination
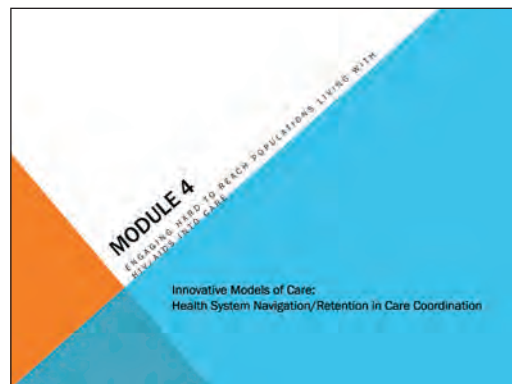
30 minutes

PLAN module

SUMMARY

This module provides an overview of the health system navigation/ retention in care model of care. Participants will discuss the pros and cons of this model of care in targeting the marginalized and underserved PLWHA they wish to serve.

MATERIALS NEEDED

- Computer and compatible LCD projector to play the PowerPoint presentation
- Notes created during previous modules
- Paper and easel(s)
- Colorful markers
- Tape for affixing paper to the wall as necessary
- Copies of the Module 4 handout to distribute
- Invited guest speaker(s), as needed.

Module 4 features teaching material, guided group discussion, and a group activity.

The Facilitator or other appointed person should write key thoughts voiced by participants throughout the presentation and subsequent discussions down on paper.

Before beginning the presentation, distribute the Module 4 handout, **Health System Navigation/Retention in Care Coordination Logic Model**.

The handout starts at the end of the section for easy printing/ copying.

The Facilitator should introduce the first slide, which serves as a refresher about the last session. It may be helpful to refer to notes from previous sessions to jumpstart discussion.

SLIDE #35: TRAINING REFRESHER

Before we begin, let's review what we thought were the pros and cons of the previous model we reviewed.

SLIDE #36: HEALTH SYSTEM IN-CARE NAVIGATION/ RETENTION IN CARE COORDINATION LOGIC MODEL

Health System Navigators (HSNs) help PLWHA access HIV/ AIDS care services from different providers.

They conduct assessments, codevelop action plans with PLWHA, and coordinate care.

HSNs are trained to provide empathetic support to vulnerable PLWHA. This personal approach alleviates PLWHA's fears about linking and engaging in care, and offers them an opportunity to learn how to navigate the health system on their own.

They also serve as advocates for clients, acting as a liaison between the patient's medical providers, case managers, and other clinical staff.

SLIDE #37: HEALTH SYSTEM NAVIGATION/RETENTION IN CARE COORDINATION LOGIC MODEL

Here we have the HSN/retention in care coordination logic model.

We follow a patient from initial encounter to engagement in care.

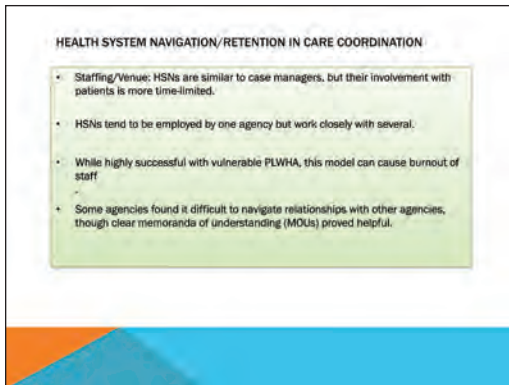HSNs normally follow these steps in linking PLWHA to care:

- The HSN's clinic or agency partners with one or more organizations.
- Unstable PLWHA are identified at each organization through interviews and other channels.
- Patients identified as unstable in care are assigned an HSN, who conducts assessments designed to identify their care goals.

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- HSNs help patients become fully engaged and retained in care, as well as stay treatment-adherent. This is accomplished through intensive clinic contacts that include, but are not limited to:
  - Appointment reminder calls.
  - Chaperoned visits to medical and support service appointments, court dates, health education classes, and so on.
  - Provision or linkage to housing assistance.
  - Linkage to or provision of medical case management.
  - Additional support to PLWHA who are experiencing challenges with remaining engaged in care. For instance, patients may be offered directly observed therapy, where HSNs and/or other staff help PLWHA take their medications, ensuring ART adherence.
- These steps help improve the health and well-being of PLWHA.

SLIDE #38: HEALTH SYSTEM NAVIGATION/RETENTION IN CARE COORDINATION LOGIC MODEL

HEALTH SYSTEM NAVIGATION/RETENTION IN CARE COORDINATION
- Staffing/Venue: HSNs are similar to case managers, but their involvement with patients is more time-limited.
- HSNs tend to be employed by one agency but work closely with several.
- While highly successful with vulnerable PLWHA, this model can cause burnout of staff
- Some agencies found it difficult to navigate relationships with other agencies, though clear memoranda of understanding (MOUs) proved helpful.

Some hallmarks of HSNs:

- HSN services include time-limited intensive case management. After a set amount of time, HSNs generally follow up with PLWHA at 6 and then 18 months, depending on the protocol of their clinic.
- HSNs often are employed by a single clinic or agency, but work with a network of partnering providers to engage PLWHA into care.
- In this manner, PLWHA are provided a virtual medical home, where core medical and ancillary care services are coordinated across different providers, often in close proximity to one another.
- While highly successful with vulnerable PLWHA, this model can cause staff burnout.
- Establishing memoranda of understanding (MOUs) can help clarify provider relationships and expectations.

The Facilitator may want to ask an HSN to come speak to participants if there are none on staff.

Please be sure to tell HSNs in advance not to use their patient's real names or any other identifying information. You may want to ask HSNs the following questions for them to address in their talk:

- What does it take to be an HSN?
- What type of training did you receive to become an HSN?

- Would you suggest additional training?
- Is there a personality type that works best in this role? Should HSNs be patient? Tough?
- Does it help to have HSNs mirror the PLWHA they serve? That is, should they be peers or near-peers?
- Do you think the clinic has the capacity to train current, or recruit new, employees to become HSNs?
- How did you identify PLWHA? Did you interview them or were they assigned to you?
- Did your work help create a virtual "medical home" for the PLWHA you served? What were the challenges and benefits of working with different agencies to coordinate care? Can you provide some examples from your current and/or previous work?
- With what types of agencies did you (do you) work? Were these official partnerships, such as those brokered through an official MOU or tacit agreement? How did you maintain communication?
- How many PLWHA did you serve? Did you feel your caseload was heavy? Did you ever feel you might burn out? What about the HSNs with whom you worked? How do you try to avoid burnout?
- Intensive guidance is supposed to be provided to PLWHA during a set time period. Did you find that PLWHA became fully engaged—and ultimately retained—in care? Were they able to take over their own primary care, support, and social services routine after that time?
- The literature says that HSNs generally follow up at regular time intervals, depending on the needs of the clients and the resources of the home agency and its partners. How often did you follow up with your patients?
- Was this type of enhanced support helpful to PLWHA currently not in care or unstable in care? Both?
- What are the life and health circumstances of PLWHA who generally need enhanced support from an HSN?

Lead the group evaluation discussion concerning whether this model of care will work for the clinic. Have participants refer to the **Model of Care Evaluation Handout** from Module 3.

Tape several pieces of paper with the model of care's title on each.

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SLIDE #39: GROUP MODULE EVALUATION

Read each question and then write down everyone's thoughts, questions, suggestions, etc. on paper.

- Can this model of care be readily integrated within the clinic's current operations and help it reach targeted populations of PLWHA?
- Does the clinic already use this model of care, perhaps in a slightly different form?
- Can the clinic satisfy all requirements for this model of care?
- What funding streams, staffing, materials, and other resources are necessary to implement this model of care? Does the clinic have access to these? If not, how will they access them?
- How will buy-in be secured within the clinic?
- Will the implemented model of care be promoted to potential patients? If so, how? Online through social networks? Word of mouth?
- Does this model of care help the clinic identify and engage targeted PLWHA populations into care?

If more than 10 people are present, the Facilitator may split participants into two or three groups to discuss the following questions and write their thoughts on paper. After a few minutes, the Facilitator should reconvene participants. Representatives from each group will explain their colleagues' thoughts.

Save the paper/notes from this and previous modules for reference in future sessions.

HEALTH SYSTEM NAVIGATION/RETENTION IN CARE COORDINATION LOGIC MODEL

Provider 2

Mental Health Services
and Dental Care

Provider 1
(Home Base for HSN)

Case Management
and Primary Care

Provider 3

Support Services
Social Services

Health Service System
Navigator (HSN)
PLWHA
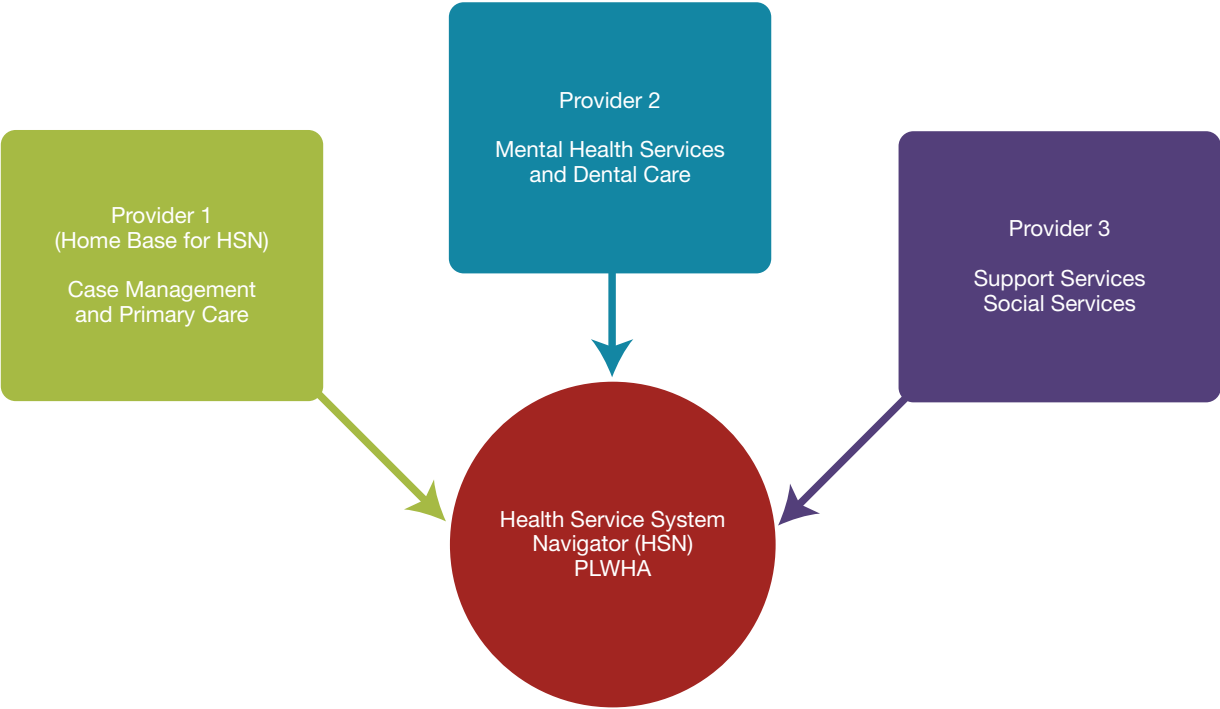
MODULE 5:
Innovative Models of Care:
Motivational Interviewing
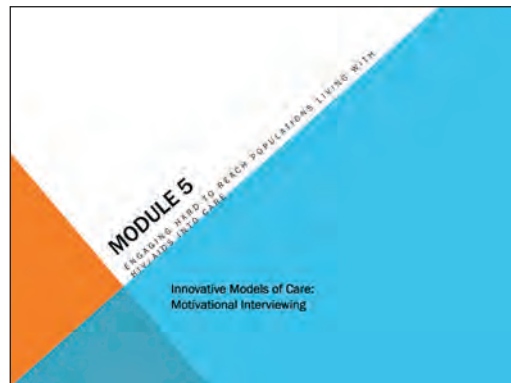
35 minutes

PLAN module

SUMMARY

This module provides an overview and will foster discussion about the motivational interviewing model of care. Participants will discuss the pros and cons of this module in targeting the marginalized and underserved PLWHA they wish to serve.

MATERIALS NEEDED

- Computer and compatible LCD projector to play the PowerPoint presentation
- Notes created during previous modules
- Paper and easel(s)
- Colorful markers
- Tape for affixing paper to the wall as necessary
- A bowl or hat for the group activity
- A print-out of the Module 5 Motivational Interviewing Role Playing Scenarios cut into individual strips and folded for selection from bowl
- Copies of the Module 5 handouts to distribute
- Invited guest speaker(s), as needed.

Module 5 features teaching material, guided group discussion, and a group activity.

The Facilitator or other appointed person should write key thoughts voiced by participants throughout the presentation and subsequent discussions on the paper/easel.

Before beginning the presentation, distribute the Module 5 handouts: **Sample Motivational Interviewing Session Script** and **Motivational Interviewing Logic Model**.

The Facilitator should introduce the first slide, which serves as a refresher about the last session. It may be helpful to have notes from the previous module up for display to foster discussion.

SLIDE #41: TRAINING REFRESHER

Before we begin, let's review the pros and cons of the previous model we reviewed.

Today's model of care involves motivational interviewing, or MI. Can anyone describe what MI is to the group? How does it help PLWHA?

SLIDE #42: MOTIVATIONAL INTERVIEWING

MI is grounded in the transtheoretical model (TTM) of change and can help explain a person's success or failure in making a proposed behavior change.

In practice, it involves culturally and linguistically competent counseling geared to creating a welcoming environment for PLWHA and encouraging them to get tested and engage in care.

Though time-limited, MI is not a singular encounter, but part of an ongoing relationship that helps PLWHA identify their health goals and develop relationships with clinicians and staff.

It is often followed up with intensive case engagement, including referrals to support and ancillary services, as well as access to incentives or contingencies, such as cash benefits and clothing.

SLIDE #43: MI: STAGES OF CHANGE

MI is like the continuum of care—it is *not* static, but an iterative process, in which MI counselors help PLWHA change their current patterns of behavior in a manner that helps them become engaged and retained in care.

The stages of MI involve:

- **Precontemplation:** This stage occurs at the start of the conversation, when most PLWHA have not yet acknowledged that there is a problem behavior that needs to be changed.
- **Contemplation:** At this point in the conversation, the MI counselor has helped the person acknowledge there is a problem, even if he/she may not be ready or even want to make a change.

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- **Preparation/Determination:** Here, the MI counselor helps the patient get ready to change.
- **Action/Willpower:** The MI counselor empowers patients to outline and start engaging in behavioral change.
- **Maintenance or Relapse:** MI counselors check in periodically with PLWHA to see if they have maintained their behavior change and are still in care.

Those who make a change and then relapse—fall out of care and/or returned to past high-risk behaviors—can repeat the MI process, perhaps with intensive case management or HSN support.

SLIDE #44: MI LOGIC MODEL

Here we have the MI logic model.

We follow a patient from initial encounter to engagement in care.
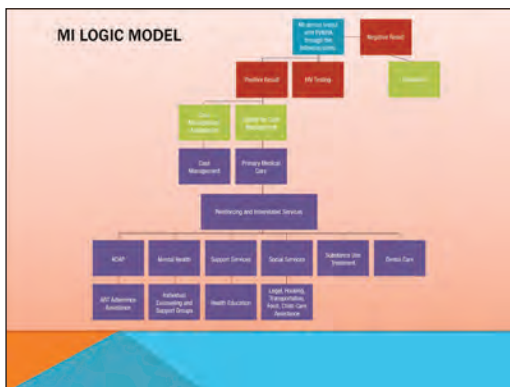
SLIDE #45: MI LOGIC MODEL, CONTINUED

This model is similar to the traditional street/social outreach approach; however, in MI, staff engage in an extensive dialog with PLWHA.

Some issues to consider with this model:

- **Staffing/Venue:** MI counselors are required to undergo special training to conduct these sessions. They tend to be entry- and mid-level staff and may serve as peers and near-peers to clients.
- **Possible Limitations:** MI training can be expensive and time-consuming, particularly for agencies that have high turnover rates.
- Tell participants they can learn more at the Motivational Interviewing Web site: www.motivationalinterviewing.org. It is listed on the **Additional Engagement in HIV Care Resources Handout** from Module 1.
- **MI's Impact:** This model may be particularly successful in reaching younger PLWHA in need of support to engage in testing and care. (Its success also may reflect,

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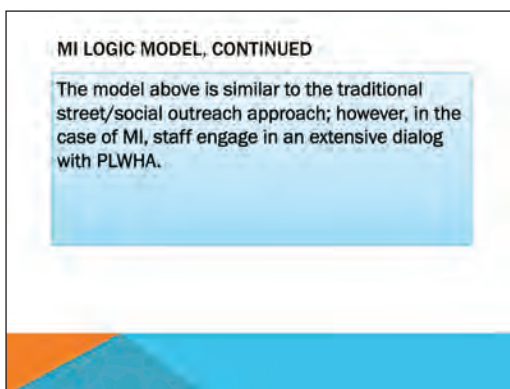
in part, the model's use more often with younger rather than older PLWHA.)

- **Unexpected MI Benefits:** SPNS participants report that PLWHA who engaged in care following MI often referred their peers to the same clinic—an unexpected, though welcome, spillover effect.

SLIDE #46: MODULE 5 ACTIVITY: MI ROLE PLAYING

The individual scenarios below should be copied, cut out, and folded for selection from a bowl or hat.

MODULE 5 ACTIVITY: MI ROLE PLAYING

- The group is going to break into pairs.
- Everyone is going to pick a scenario from the bowl.
- Each person is going to take turns playing "The MI Counselor" and "The Patient."
- Using the tenets covered in this training session and in the handouts, act out the scenario you selected.

We are going to break into pairs. Each person will take turns playing "The MI Counselor" and "The Patient."

Everyone is going to select a scenario from the bowl.

Using the tenets covered in this training session and in the handouts, act out the scenario you selected.

Motivational Interviewing Role-Playing Scenarios

- The Counselor is speaking to Macy, a 25-year-old African-American woman who has two children under the age of 4. She recently tested positive for HIV, but did not fill her ART prescription. She says taking medications would be difficult, since she does not like pills and often feels overwhelmed by work and family responsibilities.
- The Counselor meets with John, a 45-year-old Hispanic/Latino man who moved to New York from Puerto Rico last year. Though he has known he is HIV-positive for 5 years and would like to be treatment-compliant, his IDU and unstable housing situation get in the way.
- The Counselor meets with Kayla, a 30-year-old Asian-American woman living with HIV, hepatitis B, tuberculosis, and several sexually transmitted diseases. She is unmarried and lives at home. She is wary of starting treatment due to fears her family might learn about her serostatus. Her job as a registered nurse also makes her wary of taking any medications that might interfere with her job performance.
- Michael is a 21-year-old African-American gay man in a small city. Though diagnosed with both HIV and AIDS, he does not want to take HIV medications. He says he feels fine. Currently, he resides with an older boyfriend.
- Brenda is 42-year-old Native American transwoman originally from the Lakota reservation. She maintains her appearance through

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hormone injections, and believes she may have contracted HIV through needle-sharing about a decade ago. She was fully engaged in HIV treatment and care until 2 years earlier, when she met her current boyfriend. Brenda says he is violent. Fearing for her safety, she stopped taking her medications to prevent her boyfriend from finding out she is HIV-positive.

The Facilitator will have participants reconvene and share:

- What they learned from the activity overall.
- If they believe this type of interaction would help PLWHA become better engaged in HIV care at the clinic.
- Whether the clinic could help the PLWHA populations referenced in these examples.

Lead the group evaluation discussion on whether this model of care will work for the clinic. Have participants refer to the **Model of Care Evaluation Handout** from Module 3.

Tape several pieces of paper with the model of care's title on each.

SLIDE #47: GROUP MODULE EVALUATION

Read each question/statement and write down everyone's thoughts, questions, suggestions, etc. on the paper.

- Can this model of care be readily integrated within the clinic's current operations and help it reach targeted populations of PLWHA?
- Does the clinic already use this model of care, perhaps in a slightly different form?
- Can the clinic satisfy all the requirements for this model of care?
- What funding streams, staffing, materials, and other resources are necessary to implement this model of care? Does the clinic have access to these? If not, how will it access them?
- How will buy-in be secured within the clinic?
- Will the implemented model of care be promoted to potential patients? If so, how? Online through social networks? Word of mouth?
- Does this model of care help the clinic identify and engage targeted PLWHA populations into care?
- Compare the pros and cons of this initiative with those of the modules.

If more than 10 people are present, the Facilitator may split participants into two or three groups to discuss the questions above and write their thoughts on the paper. After a few minutes, the Facilitator should reconvene participants. Representatives from each group will explain their colleagues' thoughts.

Save the paper from this and previous modules for reference in future sessions.

SAMPLE MOTIVATIONAL INTERVIEWING SESSION SCRIPT HANDOUT

Ensure that the Readiness Ruler is administered just before the session, ideally by someone other than you.

Opening Statement

- I'm not here to preach to you or tell you what you "should" do; how would I know, it's your life and not mine! I believe people know what's best for them.

- I don't have an agenda, just a goal: to see if there is anything about the way you take care of your health that you would like to change, and if so, to see if I can help you get there.

- How does that sound to you?

The Session

Begin with a general question regarding their health and health-related behavior. For example, **"I'm curious—how happy are you with how well you take care of your health?"**

- Follow up by using all your best MI skills: reflections, open-ended questions, affirmations, and eliciting change talk (e.g., "You said you feel you could be doing better. In what way?"). The overall goal here is to communicate a genuine desire to understand, not a desire to push them into anything.

- Try to stay focused on health-related behavior. This part should take 5–10 minutes, but could be more or less depending on the client.

Next, mention that you have some information to share, if it's OK with them. **"I've got some information here that's related to you and your health. Is it OK with you if we go over this a minute?"**

- Remember the keys to good feedback: Be completely objective (you are providing them with information that they can take or leave, you are NOT evaluating them). Never argue, and ask a simple question: **"What do you make of all this?"**

- Follow up with reflections, etc. Be sure to use the Pros and Cons exercise and at least one other strategy to elicit change talk, usually the Readiness Ruler ("On a 0–10 scale, if 0 is not in the least bit ready to see the doctor at least once every 3 months and 10 is as fired up as you can be, where are you?) Remember with the Readiness Ruler to ask, "Why a 3 and not a 0?" if they give you a low number, and "Why such a high number?" if they give a high number (7 or higher).

- Remember, never argue, never push, just be curious and accepting. There's no hurry. Remember also, the goal here is to maximize change talk by using questions that elicit change talk, by asking for explanation (if they give a little, ask for more details), and by using exercises like Pros and Cons or the Readiness Ruler.

When there are 5–10 minutes left in your session (or when you feel like you're not going to get any further with Phase I), move into Phase II.

- Do a good summary of everything that's been said so far. **"Let me see if I understand where you're at with your health right now. . . ."** Summarize the things they feel good about and the positive health behaviors you have noticed, starting with general health stuff and ending with specific stuff about their attending doctor's appointments. Next, move into the things that concern them in general, and things that concern them about appointments in particular. Note, if there is one, the disparity between recommended number of appointments and the number they kept last year. Ask if your summary is about right. If not, correct it.

Ensure that the Readiness Ruler is administered after the session, ideally by someone other than you.

Revised 8/6/04

MOTIVATIONAL INTERVIEWING LOGIC MODEL

```
                          MI person works
                          with PLWHA          Negative Result
                          through the
                          following steps.

          Positive Result      HIV Testing              Education

   Case              Eligible for Case
   Management        Management
   Assessment

   Case              Primary Medical
   Management        Care

              Reinforcing and Interrelated Services

   ADAP      Mental Health   Support Services   Social Services   Substance Use   Dental Care
                                                                  Treatment

   ART       Individual      Health Education   Legal, Housing,
   Adherence Counseling and                     Transportation,
   Assistance Support Groups                    Food, Child-Care
                                                Assistance
```

MODULE 6:
Innovative Models of Care:
In-reach
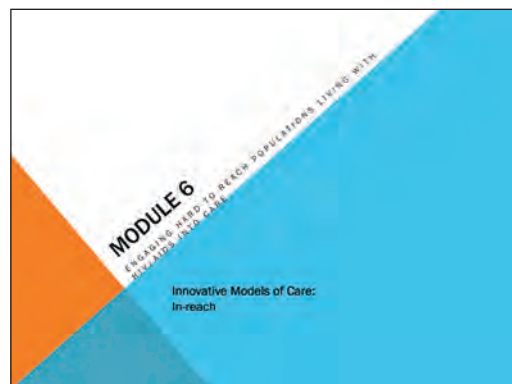
🕐 30 to 40 minutes

PLAN module

SUMMARY

This module provides an overview and fosters discussion about the in-reach model of care. Participants will discuss the pros and cons of this model of care in targeting the marginalized and underserved PLWHA they wish to serve.

MATERIALS NEEDED

- Computer and compatible LCD projector to play the PowerPoint presentation
- Notes created during previous modules
- Paper and easel(s)
- Colorful markers
- Tape for affixing paper to the wall as necessary
- A bowl or hat for the group activity
- A printout of the Module 6 Case Study Profiles cut into individual strips and folded for selection from bowl
- Copies of the Module 6 handouts to distribute
- Invited guest speaker(s), as needed.

Module 6 features teaching material, guided group discussion, and a group activity.

The Facilitator or other appointed person should write key thoughts voiced by participants throughout the presentation and subsequent discussions on the paper.

Before beginning the presentation, distribute the Module 6 handouts: **In-reach Script and Log** and **In-reach Logic Model**.

The Facilitator should refresh participants about the previous models of care discussed, referring to the paper notes as necessary.

The Facilitator should introduce the first slide, which serves as a refresher about the last session.

SLIDE #49: TRAINING REFRESHER

Before we begin, let's review the pros and cons of the previous model we reviewed.

TRAINING REFRESHER

Before starting today's session, review what you discussed previously:

•What were the pros of the previous model?
•The cons?

SLIDE #50: IN-REACH (RECONNECTING PAST PATIENTS LOST TO CARE)

In-reach involves reaching out to former patients of the clinic and reengaging them in care. Some things to consider about this intervention:

IN-REACH (RECONNECTING PAST PATIENTS LOST TO CARE)

In-reach efforts involve clinics finding and reengaging former PLWHA patients who had fallen out of care.

•Cost-effective intervention.

•Requires staff familiar with Clinic staff versed in of Health Insurance Portability and Accountability Act of 1996 (HIPAA) rules go through client records and contact patients who have fallen out of care.

•Often serves as a lifeline for PLWHA unsure how to reconnect with care. Most require intensive case management and support.

•Administrative limitations may include incomplete or out-of-date records, which can make finding lost patients nearly impossible.

- It is extremely cost-effective.
- Both medical personnel and other clinic staff can facilitate this model with little training. They must be versed in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) before accessing records and contacting patients. Staff also must be able to quickly identify patients lost to care in the clinic's database and/or paper patient records.
- Contact with patients should be guided by a script, such as that described in the **In-reach Script and Log Handout**.
- Other methods of in-reach might involve concepts borrowed from other models of care:
  - Conducting traditional street/social outreach efforts where you know many PLWHA who have fallen out of care may be, such as bars, clubs, and drug treatment and syringe programs.
  - Leveraging social marketing techniques, such as printed flyers and advertisements in public transportation areas, to encourage patients to return to the clinic.
  - Sending out general messages through social networking outlets via platforms commonly used by patients, such as Facebook and Twitter.
- Reconnecting with patients offers them a lifeline back to care. They often require the assistance of an HSN and/or MI counselor to work out issues that

drove them from care in the first place. Though time-limited, this intensified support may yield greater results than other models of care, depending on the stability of the PLWHA's personal situation.

- Administrative limitations such as out-of-date client records can hinder implementation of this model, although current patients with connections to those out of care may be able to provide support and connection to targeted PLWHA by referring them back to the clinic. Providers that have electronic medical records (EMRs) equipped with analytical tools can benefit particularly from this model.

SLIDE #51: IN-REACH (RECONNECTING PAST PATIENTS LOST TO CARE) LOGIC MODEL
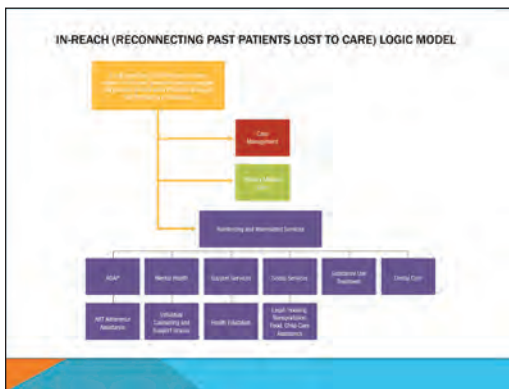
Here we have the in-reach logic model.

We follow a patient from initial encounter to engagement in care.

In-reach borrows from other models of care, but is still a unique approach to engaging PLWHA.

It is focused on developing a relationship with the lost patient and bringing him/her back into care.

The Facilitator should invite participants who have conducted in-reach to respond to the material covered in this training and offer their thoughts.

SLIDE #52: MODULE 6 ACTIVITY: IN-REACH ROLE PLAYING

The individual scenarios below should be copied, cut out, and folded for selection from the bowl.

To test whether this model of care may work for the clinic, we are going to break into pairs and engage in a role-playing exercise using the **In-reach Script and Log Handout** as a guide.

Everyone is going to pick a scenario from the bowl and take turns playing the "Clinic Employee" and "The Patient."

Before beginning a dialog, the "Clinic Employee" describes how he/she identified "The Patient" for this in-reach effort, answering the following questions:

- Did you find this person in paper files or the clinic's EMR system?
- How are you logging the information collected during and after your interaction? How are you contacting this person? By telephone?

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Case Study Profiles

- The Clinic Employee is speaking to Bea, a 60-year-old African-American woman who has four adult children. She was diagnosed with HIV and AIDS 5 years ago. She was engaged in care until becoming the legal guardian of her grandchildren 1 year ago. Her EMR indicates that she has missed several laboratory tests and did not fill her last prescription. When contacted by telephone, she says she does not have time to go to appointments.
- The Counselor meets with Brian, a 45-year-old White man who has a long history of SUDs and has been sporadic to care since learning his serostatus 6 years ago. He is resistant to several HIV medications due to a history of treatment-adherence issues. Brian also frequently experiences food insecurity and shelter instability, and engages in sex work to survive.
- Dwayne, a 22-year-old African-American gay man had a reactive oral swab HIV test in a mobile van. He came to the clinic several times after that initial encounter to have his results confirmed and other lab work done. He returned for his results but has not been seen at the clinic for the past 9 months. Several friends have come to the clinic and shared with staff that Dwayne broke up with his much older boyfriend and is now living on the street.
- Mary is a 45-year-old transwoman living with HIV and hepatitis C. She has struggled to stay clean. For a while, she came to the clinic regularly and even began training to be a peer counselor. When she started using heroin again, however, she disappeared. The only contact information the clinic has is her e-mail address, since her phone has been turned off.
- Guy is a 42-year-old Native American man who lives in the city. He and his wife have been married 10 years and have 2 children. They often experience food insecurity and shelter instability since Guy lost his job in 2007. After learning his HIV status 2 years ago, Guy has come to the clinic sporadically. He often misses appointments and is not treatment-adherent. He seems depressed but refuses to see a counselor. He is extremely concerned that his family, especially his wife, will learn he has HIV.

Lead the group evaluation discussion on whether this model of care will work for the clinic. Have participants refer to the **Model of Care Evaluation Handout** from Module 3.
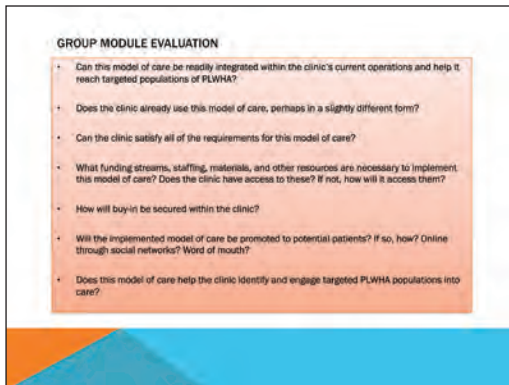
Tape several pieces of paper with the model of care's title on each.

SLIDE #53: GROUP MODULE EVALUATION

Read each question/statement and then write down everyone's thoughts, questions, suggestions, etc. on the paper.

- Can this model of care be readily integrated within the clinic's current operations and help it reach targeted populations of PLWHA?
- Does the clinic already use this model of care, perhaps in a slightly different form?
- Can the clinic satisfy all the requirements for this model of care?
- What funding streams, staffing, materials, and other resources are necessary to implement this model of care? Does the clinic have access to these? If not, how will it access them?
- How will buy-in be secured within the clinic?
- Will the implemented model of care be promoted to potential patients? If so, how? Online through social networks? Word of mouth?
- Does this model of care help the clinic identify and engage targeted PLWHA populations into care?
- Compare the pros and cons of this initiative with those of the modules.

If more than 10 people are present, the Facilitator may split participants into two or three groups to discuss the questions above and write their thoughts on the paper. After a few minutes, the Facilitator should reconvene participants. Representatives from each group will explain their colleagues' thoughts.

Save the paper from this and previous modules for reference in future sessions.

IN-REACH SCRIPT AND LOG

In-Reach Script
Please note that the following script does not name the clinic or use the phrase "HIV" or "AIDS." This helps ensure the patient's confidentiality, particularly if his/her family, friends, or coworkers hear the call or message. (This script can be adapted for use in person, as well.)

Timing: Approximately 10 to 30 seconds

[If you reach the person directly on the telephone]
Script: This is [staff person's name]. I am calling from the doctor's office.
If you have a moment, I would like to talk to you about arranging an appointment.

[If you reach the person's voicemail]
Script: This is [staff person's name]. I am calling from your doctor's office about a check up. If you have time to make an appointment, please do not hesitate to call me at [staff person's direct line].

E-mail and texting are not recommended, since the address and numbers may be out of date, possibly compromising the patient's confidentiality.

In-Reach Call Log
It is best to track all calls made to past patients using a basic call log such as this:

Contact First Name	Contact Last Name	Last Known Address	Telephone Number	Other Contact Details	Date of Contact(s)	Results

IN-REACH LOGIC MODEL

Staff identifies PLWHA out of care; refers to MI staff person/case manager. MI person works with PLWHA through the following processes.

Case Management

Primary Medical Care

Reinforcing and Interrelated Services

ADAP	Mental Health	Support Services	Social Services	Substance Use Treatment	Dental Care
ART Adherence Assistance	Individual Counseling and Support Groups	Health Education	Legal, Housing, Transportation, Food, Child-Care Assistance		

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MODULE 7:
Innovative Models of Care:
HIV Interventions in Jails

30 minutes

PLAN module

SUMMARY

This module provides an overview and will foster discussion about the HIV Interventions in Jails model of care. Participants will discuss the pros and cons of this model of care in targeting the marginalized and underserved PLWHA they wish to serve.

MATERIALS NEEDED

- Computer and compatible LCD projector to play the PowerPoint presentation
- Notes created during previous modules
- Paper and easel(s)
- Colorful markers
- Tape for affixing paper to the wall as necessary
- Copies of the Module 7 handout to distribute
- Invited guest speaker(s), as needed.

Module 7 features teaching material, guided group discussion, and a group activity.

The Facilitator or other appointed person should write key thoughts voiced by participants throughout the presentation and subsequent discussions down on paper.

Before beginning the presentation, distribute the Module 7 handout, entitled **HIV Interventions in Jails Logic Model**.

The Facilitator should introduce the first slide, which serves as a refresher about the last session. If possible, affix the paper notes from the last module where they are visible to participants.

SLIDE #55: TRAINING REFRESHER

Before we begin, let's review the pros and cons of the previous model we reviewed.

TRAINING REFRESHER

Before starting today's session, review what you discussed previously:

• What were the pros of the previous model?
• The cons?

SLIDE #56: HIV INTERVENTIONS IN JAILS

This model of care leverages the jail setting (and related correctional institutions such as parole offices) to identify and engage PLWHA into care.

The uniqueness of HIV care in jail settings involves its own model, which in part is a hybrid of several other models of care outlined in this curriculum.

HIV INTERVENTIONS IN JAILS

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The uniqueness of HIV care in jail settings necessitates its own model of care.

SLIDE #57: WHAT IS THE DIFFERENCE BETWEEN A JAIL AND A PRISON?

The terms "jail" and "prison" are often used interchangeably—but there are key distinctions.

- Prisons are State or Federal facilities that house people who have been convicted of a criminal or civil offense and sentenced to 1 year or more.
- Jails, however, are locally operated facilities whose inmates are typically sentenced to terms of 1 year or less, or are awaiting trial or sentencing following trial. The average jail stay is 10 to 20 days, according to the U.S. Department of Justice.
- Although jails have average daily populations that are half those of prisons, their populations experience greater turnover. The ratio of jail admissions to prison admissions is more than 16 to 1, and approximately 50 percent of people admitted to jails leave within 48 hours.

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HIV INTERVENTIONS IN JAILS LOGIC MODEL
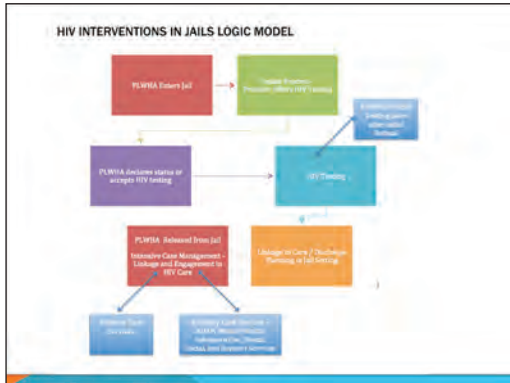
Here we have the HIV Interventions in Jails Logic Model.

We follow a patient from initial encounter to engagement in care.

Some things to keep in mind when adopting this model of care include:

- **Socks make a great gift:** Patient confidentiality in jails is limited. Greeting *everyone* with gifts of socks and/or underwear, as well as an offer of HIV testing, is a great way to make inmates feel less threatened by health-care workers.

  Since everyone experiences the same encounter, it is impossible for staff and inmates to discern who decided to get tested for HIV and who did not.

  PLWHA who do not wish to declare their status upfront to staff will opt for HIV testing as a backdoor to accessing care.

- **Ensure that inmates know they are not required to participate in testing.** The atmosphere of corrections often makes everything, even health care, seem mandatory. Creating a set protocol will help reassure incarcerated persons of their rights.

- **Time is of the essence:** Jail stays often last only hours, so linkages to care must occur as soon as possible.

- **Release = Another Chance for Engagement:** Consider giving PLWHA a transitional care coordination package. This may include:
  - A letter from the provider with all lab work results
  - A packet of paperwork, such as AIDS Drug Assistance Program (ADAP) and/or Medicaid insurance applications
  - A list of referrals
  - Condoms and harm reduction/bleach kits
  - Clothing
  - Food
  - Prescriptions
  - Starter supply of medications.

- **Linkage upon release:** Recently released PLWHA should be immediately connected with a case manager (sometimes an HSN) who helps get them engaged in care. Incentives, such as housing and other specialized services, may be used to help stabilize PLWHA released from jail settings into care.

- **Don't stop at HIV testing:** Clinics with social workers on staff may want to consider working with courts to help vulnerable PLWHA be released to drug treatment facilities or monitored halfway houses.

SLIDE #59: ISSUES TO CONSIDER BEFORE WORKING WITH JAILS

Partnering with a jail can be challenging:

- **Select jails closest to the clinic.** Recently released PLWHA will be able to access services more easily.
- **These are formal partnerships, generally based on an MOU.** Jails often take the lead in these relationships, since the safety of inmates, staff, visitors, and the public is its responsibility.
- **Jail administrators may view HIV testing as an administrative and staffing burden.** To counter this issue, clinics should carefully outline what services they want to deliver.
  - How many staff will be on site?
  - What materials will be brought in?
  - What services will you deliver?
  - How long will patient consultations be?
  - Consider having more than one staff person to ensure that all tasks are done in as little time, and with as minimal intrusion, as possible.
- **Alternative venues are just as powerful:** Consider working with local probation and parole offices and other related agencies serving recently released inmates in the event that an agreement cannot be reached with the local jail system.
- **There are potential hidden costs:** There may be additional laboratory and staffing costs associated with this model of care. Costs often can be offset though partnerships with local and State health departments, and bulk purchasing contracts with vendors.

What are your experiences delivering HIV/AIDS care in a correctional setting?

SLIDE #60: MODULE 7 ACTIVITY: Q&A QUICKTIME

Now we are going to play a fast-paced game called "Q&A Quicktime."

I am going to ask a question and then call on one of you to answer it. You have 2 seconds to respond —or to say "pass."

Anyone who says "pass" has to ask a question of his/her own to someone else in the room. After that person answers, the "control" of the game returns to me for the next question.

I may ask questions that are not necessarily on this list, so be ready!

Below are some game questions:

- How are you going to select your partnering jail?
- Will you find compromises with staff when issues inevitably arise, such as:

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- *Jail administrators view HIV testing as a potential administrative and staffing burden.*
- *Some inmates believe that testing is not opt-out due to the coercive nature of corrections.*
- *Staff are not given enough time to test and counsel patients.*

If so, what other compromises do you anticipate?

- Who is going to be the point of contact?
- What type of MOU will you have?
- How are you going to enlist participants within the jail setting?
- Alternate venues such as parole offices may allow you to reach your target population(s) without having to enter the jail system itself.
- Are you going to be able to engage PLWHA in jails in a timely fashion? If so, how?
- Do you have the resources to provide support in court and/or release packages?
- Are you able to provide transitional care coordination (similar to health systems navigation) when PLWHA are released from jail?
- Will you be able to link and fully engage PLWHA in care before/after their release?
- What about the cost of additional staff, lab, and materials?

Lead the group evaluation discussion on whether this model of care will work for the clinic. Have participants refer to the **Model of Care Evaluation Handout** from Module 3.

Tape several pages of paper with the model of care's title on each.

SLIDE #61: GROUP MODULE EVALUATION

Read each question/statement and then write down everyone's thoughts, questions, suggestions, etc. on paper.

- Can this model of care be readily integrated within the clinic's current operations and help it reach targeted populations of PLWHA?
- Does the clinic already use this model of care, perhaps in a slightly different form?
- Can the clinic satisfy all requirements for this model of care?
- What funding streams, staffing, materials, and other resources are necessary to implement this model of care? Does the clinic have access to these? If not, how will it access them?
- How will buy-in be secured within the clinic?

- Will the implemented model of care be promoted to potential patients? If so, how? Online through social networks? Word of mouth?
- Does this model of care help the clinic identify and engage targeted PLWHA populations into care?
- Compare the pros and cons of this initiative with those of the modules.
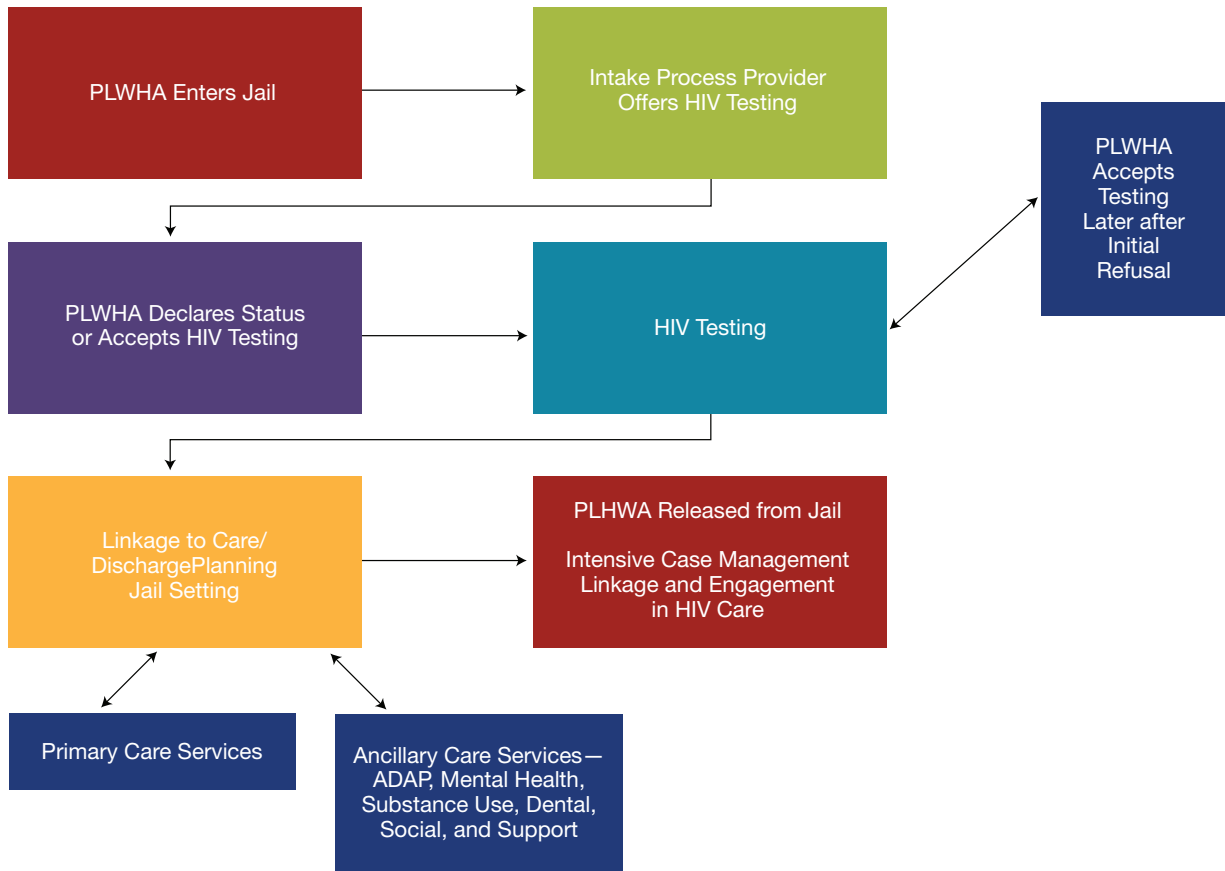
If more than 10 people are present, the Facilitator can split participants into two or three groups to discuss the questions above and write their thoughts on paper. After a few minutes, the Facilitator should reconvene participants. Representatives from each group will explain their colleagues' thoughts.

Save the paper from this and previous modules for reference in future sessions.

HIV INTERVENTIONS IN JAIL LOGIC MODEL

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┌─────────────────────┐        ┌─────────────────────┐              ┌──────────────┐
│                     │        │                     │              │    PLWHA     │
│  PLWHA Enters Jail  │───────▶│  Intake Process     │              │   Accepts    │
│                     │        │  Provider Offers    │              │   Testing    │
│                     │        │  HIV Testing        │              │  Later after │
└─────────────────────┘        └─────────────────────┘              │   Initial    │
           │                             │                          │   Refusal    │
           ▼                             ▼                          └──────────────┘
┌─────────────────────┐        ┌─────────────────────┐                     ▲
│                     │        │                     │                     │
│  PLWHA Declares     │───────▶│    HIV Testing      │◀────────────────────┘
│  Status or Accepts  │        │                     │
│  HIV Testing        │        │                     │
└─────────────────────┘        └─────────────────────┘
           │                             │
           ▼                             ▼
┌─────────────────────┐        ┌─────────────────────┐
│  Linkage to Care/   │        │  PLHWA Released     │
│  DischargePlanning  │───────▶│  from Jail          │
│  Jail Setting       │        │                     │
│                     │        │  Intensive Case     │
│                     │        │  Management         │
│                     │        │  Linkage and        │
│                     │        │  Engagement         │
│                     │        │  in HIV Care        │
└─────────────────────┘        └─────────────────────┘
      │         │
      ▼         ▼
┌──────────┐  ┌──────────────────┐
│ Primary  │  │ Ancillary Care   │
│ Care     │  │ Services—ADAP,   │
│ Services │  │ Mental Health,   │
│          │  │ Substance Use,   │
│          │  │ Dental, Social,  │
│          │  │ and Support      │
└──────────┘  └──────────────────┘
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MODULE 8:
Innovative Models of Care: Social Marketing Campaigns/ Social Networking Channels
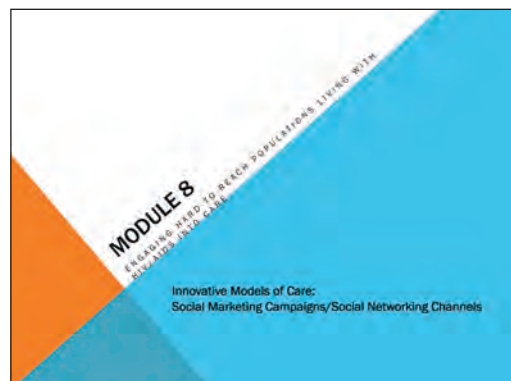
30 to 35 minutes

PLAN module

SUMMARY

This module provides an overview and will foster discussion about the Social Marketing Campaigns/Social Networking Channels model of care. Participants will discuss the pros and cons of this model of care in targeting the marginalized and underserved PLWHA they wish to serve.

MATERIALS NEEDED

- Computer and compatible LCD projector to play the PowerPoint presentation
- Notes created during previous modules
- Paper and easel(s)
- Colorful markers
- Tape for affixing paper to the wall as necessary
- Invited guest speaker(s), as needed.

Module 8 features teaching material, guided group discussion, and a group activity.

The Facilitator or other appointed person should write key thoughts voiced by participants throughout the presentation and subsequent discussions on paper.

If staff is unfamiliar with general terminology used to discuss social media or, as a complement to this module, suggest printing out and distributing HRSA's "Social Media and HIV" newsletter (particularly pages 4 and 5 with terminology), accessible at www.hab.hrsa.gov/newspublications/careactionnewsletter/june2011.pdf.

The Facilitator should introduce the first slide, which serves as a refresher about the last session. If possible, affix the notes from the last module where they are visible to participants.

SLIDE #63: TRAINING REFRESHER

Before we begin, let's review the pros and cons of the previous model we reviewed.

TRAINING REFRESHER

Before starting today's session, review what you discussed previously:

•What were the pros of the previous model?
•The cons?

SLIDE #64: SOCIAL MARKETING CAMPAIGNS/SOCIAL NETWORKING CHANNELS

Social marketing uses commercial advertising techniques to "sell" HIV prevention, testing, treatment, and care through messages targeted to specific populations.

Television and radio advertisements and promotional materials are often repurposed and circulated online through social networks, such as YouTube, Facebook, and Twitter.

SOCIAL MARKETING CAMPAIGNS/SOCIAL NETWORKING CHANNELS

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Television and radio advertisements and promotional materials are often repurposed and circulated online through social networks, such as YouTube, Facebook, and Twitter.

SLIDE #65: SOCIAL MARKETING CAMPAIGNS

Refer to your clinic's past social marketing/social networking campaigns, as appropriate.

Social marketing campaigns can be time- and resource-intensive, requiring staff and consumer cooperation to create the materials—such as commercials and printed collateral—to roll out on television, radio, and public transportation.

Yet, they can effectively target hard-to-reach members of populations with little staff involvement, though this is difficult to measure.

Many HIV campaigns are repurposed through reposting in abbreviated form on social networking sites, such as YouTube, Facebook, and Twitter. This can be cost-effective, though professional channels on these sites involve membership and backend coding costs.

SOCIAL MARKETING CAMPAIGNS

• Social marketing campaigns can be time– and resource–intensive, requiring staff and consumer cooperation to create the materials–such as commercials and printed materials–to roll out on television, radio, and on public transportation.

• Yet, they can effectively target hard-to-reach members of populations with little staff involvement, though this is difficult to measure.

• Many HIV campaigns are repurposed through reposting in abbreviated form on social networking sites, such as YouTube, Facebook, and Twitter. This can be cost-effective, though professional channels on these sites involve membership and backend coding costs.

Have you seen any marketing materials take on a new life online? If so, how?

SLIDE #66: SOCIAL MARKETING/SOCIAL NETWORKING EVALUATION CHALLENGES

Evaluation can be difficult, though Web site traffic metrics, focus groups, and surveys can offer some insight.

Below are some questions that may glean insight from your audience:

- What do you like most about social marketing materials? What do you like least?
- Did you feel that social marketing materials speak to the target populations? You?

SLIDE #67: SOCIAL NETWORKING AND HIV/AIDS CARE: A WORK IN PROGRESS

Refer to your clinic's past social marketing/social networking campaigns, as appropriate.

How do you think social marketing and social networking might benefit our clinic? What are the pros and cons of such an approach?

Some things we need to consider:

- **Staffing:** Who would handle our social marketing/social networking activities?
  - We might have to turn to younger staff members. While technology savvy, these staff members often require greater oversight, which can be difficult in a virtual atmosphere. Who would oversee them?
- **Financial considerations:** How will we pay for these social marketing efforts?
  - Will they appear on television, radio, and/or print?
  - Will we need to upgrade our presence on social networking sites, like YouTube, Facebook, and Twitter? These are free to join, but often require expert back-end coding to function appropriately in a business environment.
  - Text messaging, while another powerful way to connect with clients, may also be expensive or time-consuming.
- **Security can be a concern.** We may need to develop a security protocol in dealing with patients in a "social setting" online.
  - Do we want to be "friends" with our clients or *vice versa,* whether through our clinic's page or our personal accounts?

– Are we going to approach patients in online chat rooms? Those can be awkward, since most users do not want to discuss health matters with strangers.
- Who is going to see the information we disseminate? Many vulnerable PLWHA, and particularly young PLWHA, have little access to Smartphones and other technology due to limited finances. They also are less likely to pick up social marketing information.

Lead the group evaluation discussion on whether this model of care will work for the clinic. Have participants refer to the **Model of Care Evaluation Handout** from Module 3.
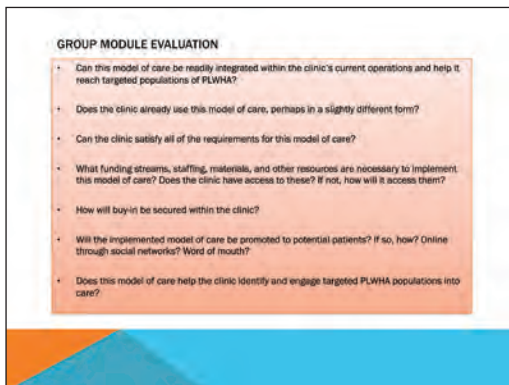
Tape pieces of paper with the model of care's title on each.

## SLIDE #68: GROUP MODULE EVALUATION

Read each question/statement and then write down everyone's thoughts, questions, suggestions, etc. down on paper.

- Can this model of care be readily integrated within the clinic's current operations and help it reach targeted populations of PLWHA?
- Does the clinic already use this model of care, perhaps in a slightly different form?
- Can the clinic satisfy all requirements for this model of care?
- What funding streams, staffing, materials, and other resources are necessary to implement this model of care? Does the clinic have access to these? If not, how will it access them?
- How will buy-in be secured within the clinic?
- Will the implemented model of care be promoted to potential patients? If so, how? Online through social networks? Word of mouth?
- Does this model of care help the clinic identify and engage targeted PLWHA populations into care?
- Compare the pros and cons of this initiative with those of the modules.

SLIDE #69: FINAL EVALUATION
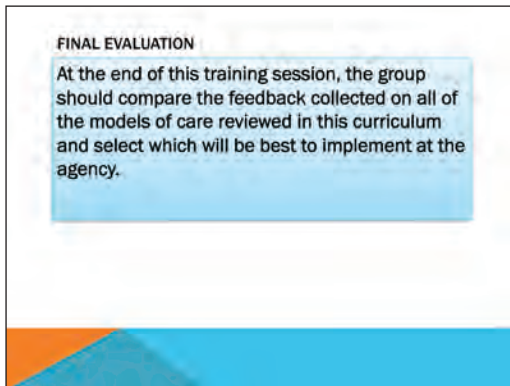
At the end of this training session, the group should compare the feedback collected on all of the models of care reviewed in this curriculum and select which will be best to implement at the agency.

FINAL EVALUATION

At the end of this training session, the group should compare the feedback collected on all of the models of care reviewed in this curriculum and select which will be best to implement at the agency.

If more than 10 people are present, the Facilitator may split participants into two or three groups to discuss the questions above and write their thoughts on paper. After a few minutes, the Facilitator should reconvene participants. Representatives from each group will explain their colleagues' thoughts.

Save the notes from this and previous modules for reference in future sessions.

MODULE 9:
Think Big, Start Small:
First Steps to Implementing
a Model(s) of Care

MODULE 9

Think Big, Start Small:
First Steps to Implementing a Model(s) of Care
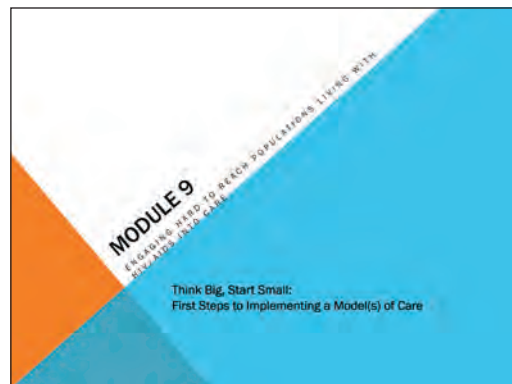
20 minutes

PLAN module

SUMMARY

In this module, participants will discuss small ways to jumpstart the implementation of their selected model(s) of care at their agency.

MATERIALS NEEDED

- Paper and easel(s)
- Colorful markers
- Tape for affixing paper to the wall as necessary.

Module 9 features a group activity.

The Facilitator or other appointed person should write key thoughts voiced by participants throughout the presentation and subsequent discussions on paper.

The Facilitator should introduce the first slide, which serves as a refresher about the last session.

SLIDE #71: TRAINING REFRESHER

Before we begin, let's review the pros and cons of the previous model we reviewed.

TRAINING REFRESHER

Review the pros and cons of the model(s) of care selected for implementation at our agency.

SLIDE #72: MODULE 9 ACTIVITY: READY, SET, GO!

Put three sheets of paper on the wall, labeling one Group 1, another Group 2, and the last one Group 3. After the vote, be sure to designate who will carry out the activities.

This module celebrates the selection of the model(s) of care to be implemented at the clinic.

Today, we are going to brainstorm small activities that can help jumpstart the implementation process and start engaging hard-to-reach PLWHA more effectively.

Please divide into three groups. In each, choose a representative who will write your ideas on your assigned paper.

Once we are done and have shared our ideas with each other, we will vote as a group to implement one to three of them as soon as possible.

Be sure to keep your ideas simple and, preferably, fun. Some examples include:

- Add plants and posters to the waiting area to make it seem less clinical and more inviting to clients.
- Hold patient "art days" for the patients and display their projects throughout the clinic.
- Change the way patients are greeted when they call and enter the clinic, as well as at the start of an appointment.
- Create new, more effective ways to remind patients of appointments.

MODULE 9 ACTIVITY: READY, SET, GO!

In this activity, brainstorm small activities to jumpstart the implementation process and start engaging hard-to-reach PLWHA more effectively.

Some examples include:

- Adding plants and posters to the waiting area to make it seem less clinical and more inviting to clients;
- Holding patient "art days" for the patients and displaying their projects throughout the clinic;
- Changing the way patients are greeted when they call and enter the clinic, as well as at the start of an appointment; and
- Creating new, more effective ways to remind patients of appointments.

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