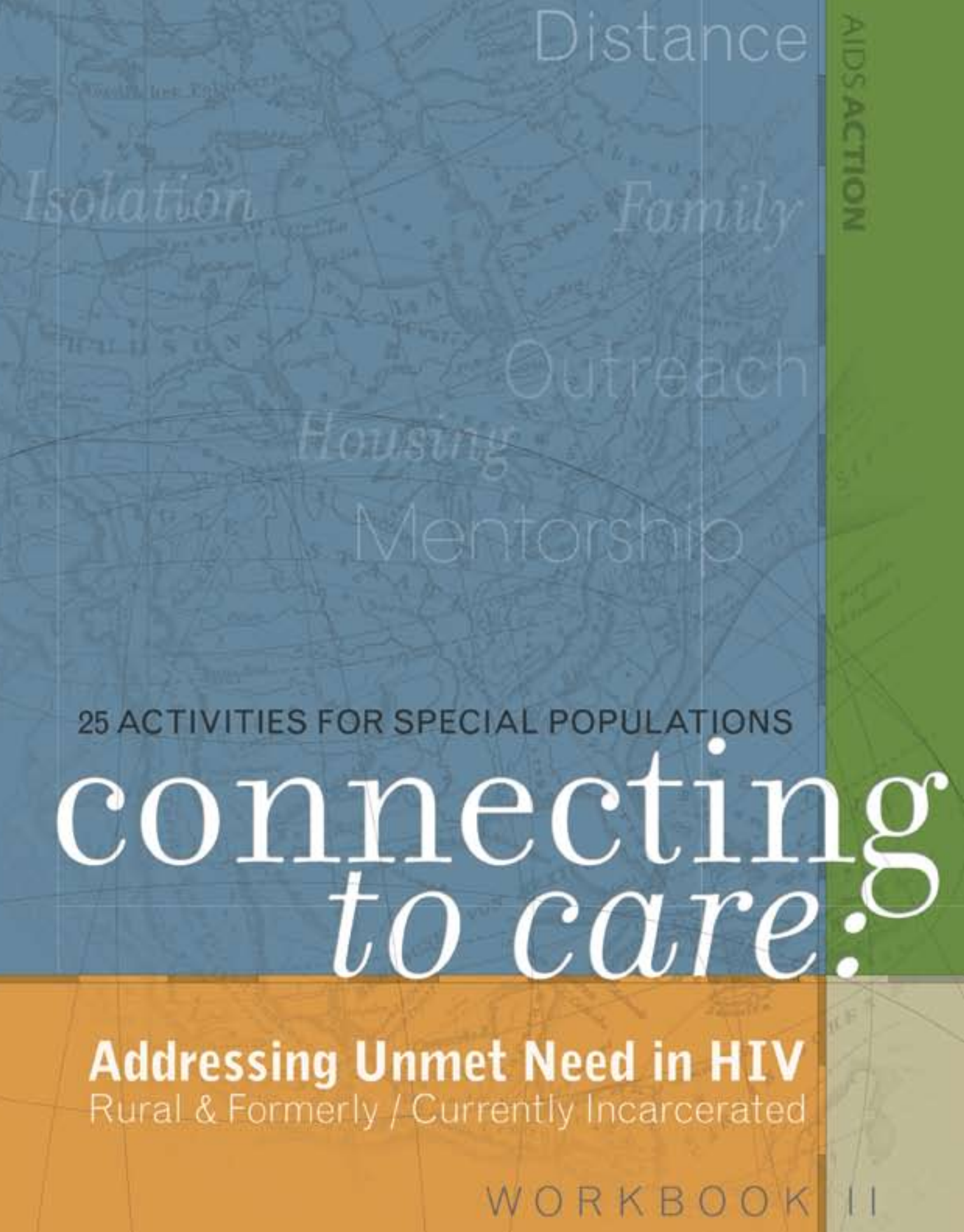


AIDS ACTION

25 ACTIVITIES FOR SPECIAL POPULATIONS

connecting *to care:*

Addressing Unmet Need in HIV

Rural & Formerly / Currently Incarcerated

WORKBOOK II

Founded in 1984, AIDS Action is a national nonprofit organization, based in Washington, D.C., which conducts educational and advocacy activities in support of sound and effective HIV policies and funding. AIDS Action addresses the needs of people who are at risk for and living with HIV infection and the organizations that serve them.

AIDS Action has two components: AIDS Action *Foundation* [501(c)(3)], which develops and disseminates educational materials on the latest public policies and programs, the demographic impact of HIV, and medical research. AIDS Action *Council* [501(c)(4)] serves as a national voice for community-based organizations, local health departments and clinics, service providers, and health educators by advocating for effective legislative and social policies and programs for HIV prevention, treatment, and care.

TABLE OF CONTENTS

Connecting to Care

Connect: To bring or come together into some manner of union; a loose or external attachment with little or no loss of identity. (Merriam-Webster)

UNMET NEED:

Individuals who are living with HIV, are aware of their status, and are not receiving regular primary medical care. (HRSA)

This workbook is about connecting people who are HIV+ to care and treatment. It is about thinking in new ways about the relationship an HIV+ individual has with service and care systems, and how we as providers can improve that experience. In the spirit of the *Connecting to Care I* workbook published in 2004, this second edition explores the often complex barriers to connecting to medical services, and how providers have successfully overcome those barriers to ensure that their clients access appropriate medical care. The workbook highlights a collection of interventions and methodologies that have been successful in accomplishing the goal of helping HIV+ individuals initiate and maintain connections to medical care and treatment.

It is our hope that readers of this workbook can relate to the experiences of other service providers and identify successful model activities or elements of activities that can be adapted to their local situations. We encourage providers to use the workbook as a tool to design and develop new interventions that meet the needs of local populations and communities. Our shared goal is to bring more of the nation's HIV+ population into regular medical care.

Connecting to Care I highlighted 17 interventions from around the country. *Connecting to Care II* enriches this collection with 25 additional activities that focus on two special populations: people living in rural communities and currently or formerly incarcerated individuals.

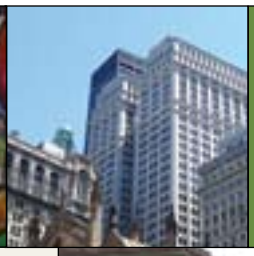
SPECIAL POPULATIONS

HIV and Rural Communities

"Rural America" is spread out across four fifths of the land mass of the U.S. and is home to one-fifth of our country's population and a growing share of the HIV epidemic. Between 1991 and 1995 alone, AIDS diagnoses in rural America increased 80%.[i] Since then, HIV has continued to permeate rural communities through new infections and people returning home from metropolitan areas after being diagnosed as HIV+.

Finding out one's HIV status and then connecting with a medical professional is complicated by very real impediments in rural settings where the average roundtrip drive to an infectious disease doctor may be 86 miles or more.[ii] The quality of care may also be an issue since 38% of HIV+ people in rural areas see doctors who have treated fewer than ten patients living with the virus.[iii]

Discussions about connecting to care must focus on ways to overcome these obstacles. How does a community with few HIV cases provide those individuals with a highly qualified medical professional? How does a client learn to feel comfortable disclosing his/her HIV status to family members and friends who have limited information about the virus and its transmission?

Connecting to Care II documents the work of professionals in rural communities who have designed and implemented interventions that increase the information flow about HIV in order to help reduce discrimination, bring HIV specialists to patients in order to provide higher quality care, and create support systems for HIV+ clients in order to break down isolation and stigma.

HIV and Currently/Formerly Incarcerated Populations

The number of individuals with criminal justice involvement in the U.S. is significant and growing. In 2004, there were over two million individuals incarcerated in correctional facilities in the U.S.[iv] There were also approximately 4.9 million individuals in our communities under parole or probation supervision.[v]

According to a 2003 *Bureau of Justice Statistics Bulletin,* approximately two percent of state prison inmates and 1.1% of federal prison inmates were reported to be HIV+. Rates of infection among prison and jail inmates vary across the country, ranging from 0.2% in Montana to 7.6% in New York and the District of Columbia, New York, Texas, and Florida alone house nearly half of all HIV+ inmates in state prisons.[vi] When compared with the general population, the rate of confirmed AIDS cases is three times greater in the prison population.[vii]

Since testing policies vary, calculating the exact number of incarcerated individuals living with HIV is not easy. Correctional institutions across the country nonetheless have made measurable progress in addressing the needs of HIV+ inmates. However, the ongoing efforts of corrections professionals and community organizations working with incarcerated individuals and those returning to their

communities after incarceration continue to face numerous challenges. Reaching out to inmates and formerly incarcerated individuals who are HIV+ to connect them to care means overcoming documented barriers:

- lack of HIV knowledge/expertise among staff in correctional settings;
- lack of privacy and confidentiality in the correctional setting;
- interruption in care upon release;
- lack of awareness of care resources when released;
- substance use; and
- lack of trust of providers.

Connecting to Care II offers readers a selection of evidence-based interventions that effectively address barriers and obstacles.

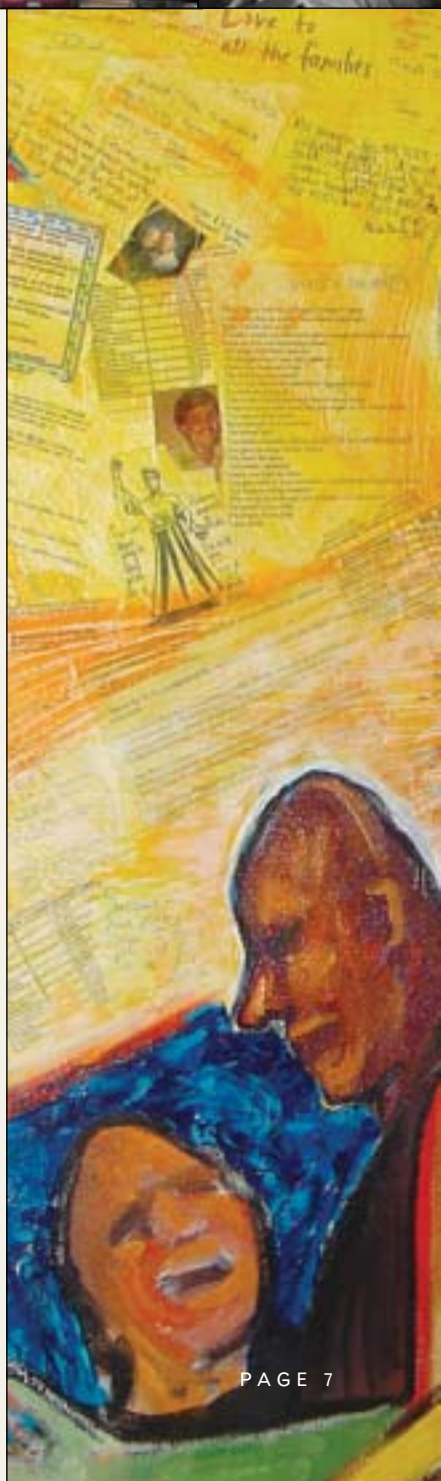
UNMET NEED

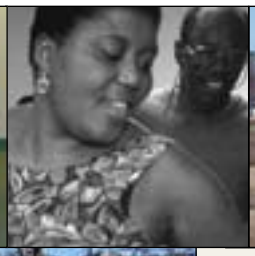
The Centers for Disease Control and Prevention estimates that over one million people are currently living with HIV in the United States.[viii] Half of this population is currently receiving medical treatment. Among the other half million HIV+ individuals, approximately 250,000 are not aware of their infection and consequently are not receiving regular medical care for HIV. The other 250,000, though aware of their infection, are not receiving regular medical care.[ix] This population falls under the Health Resources and Services Administration's "unmet need" category, which is defined as "individuals who are living with HIV, are aware of their HIV+ status, but are not engaged in regular medical care."

Using the "unmet need" framework, service providers across the country are designing new strategies to connect their clients to regular and high quality care and treatment. Through the *Connecting to Care* initiative, we hope to increase knowledge about the reasons that HIV+ individuals have precarious, inconsistent, or unsuccessful relationships with medical care, and identify best practices and programs that address barriers. Addressing "unmet need" means helping to change people's relationship with health care. To this end, the workbook highlights a rich sample of individual, group, and community level activities. The collection can serve as a guide and tool for all readers to continue to bridge the gap between a diagnosis of HIV and full engagement in continuous medical care.

SELECTION OF WORKBOOK CONTENT

AIDS Action, in collaboration with the HIV/AIDS Bureau (HAB) of the Health Resources and Services Administration (HRSA), researched interventions and methodologies implemented by different types of service providers in four states and the District of Columbia. We researched interventions, programs, and methodologies (referred to as 'activities' in the workbook) from an array of service provider settings, including health departments, AIDS service organizations, housing services, community-based organizations, faith-based organizations, clinics, and hospitals. The counties, cities, and states included in the research offer a variety of cultural representations and reflect some of the diversity of the epidemic and those it impacts. The twenty-five activities featured offer a wide-ranging collection of intervention methodologies and approaches.




REVIEWING THE 25 ACTIVITIES

Each activity profile is broken down into four main categories:

- Description
- Logistics
- Strengths and Difficulties
- Outcomes

The first page of each activity begins with a brief description of the activity, followed by a box that includes different statements about how close people get to regular medical care through the activity. The purpose of these references is to quickly orient the reader to the type of intervention and the key characteristics of the activity, which are presented in more detail on the pages that follow.

BEFORE YOU BEGIN

Connecting to Care's objective is to raise awareness of "unmet need" among those who serve HIV+ clients, and to offer examples of interventions that have been successful in improving clients' connection to care and treatment. Every agency, region, and individual is different, but we all share a common goal. We want to help those whom we serve to receive the best possible medical care and treatment. The activities documented in this workbook are only a few of the many programs and services that have successfully connected HIV+ individuals to medical care. And yet, as we all know, there are still many HIV+ people across our country who are not yet identified and/or in regular medical care.

Our hope is that this research and workbook will inspire people to look at new ways to connect HIV+ individuals to medical care and treatment. Please share your ideas with us at www.connectingtocare.net and take a moment to respond to the feedback form at the back of the book.

We will continue to make new activities and programs available through our Web site. We can all learn from each other and ensure that no one in this country who is infected by HIV goes undetected, untreated, or underserved. Together we can stop this epidemic and ensure that care and treatment are provided to those in need.

AIDS Action Foundation

Connecting to Care Team

Endnotes:

[i] National Rural Health Association Issue Paper. *HIV/AIDS in Rural America: Disproportionate impact on minority and multicultural populations.* http://www.nrharural.org/advocacy/sub/issuepapers/HIVAids.pdf. Accessed July 2006.

[ii] State Legislatures. Trends and Transitions fact sheet. (April 2004) *HIV and AIDS on the rise in rural America.*

[iii] State Legislatures. Trends and Transitions fact sheet. (April 2004) *HIV and AIDS on the rise in rural America.*

[iv] Harrison, P.M., & Beck A.J. (October 2005). *Bureau of Justice Statistics Bulletin: Prisoners in 2004*. U.S. Department of Justice. Office of Justice Programs. NCJ210677

[v] *Summary Findings.* Parole and Probation Statistics. Bureau of Justice Statistics Website. http://www.ojp.usdoj.gov/bjs/pandp.htm#findings. Accessed May, 2006.

[vi] Maruschak, L.M. (September 2005). *Bureau of Justice Statistics Bulletin. HIV in Prisons, 2003.* U.S. Department of Justice. Office of Justice Programs. NCJ 210344. See also
Kantor, E. (April 2006). *HIV Transmission and Prevention in Prisons.* http://hivinsite.ucsf.edu/InSite?page=kb-07&doc=kb-07-04-13. Accessed July 2006.

[vii] Maruschak, L.M. (September 2005). *Bureau of Justice Statistics Bulletin.* HIV in Prisons, 2003. U.S. Department of Justice. Office of Justice Programs. NCJ 210344.

[viii] *Spotlight: Commemorating 25 Years of HIV/AIDS.* Retrieved from http://www.cdc.gov/hiv/spotlight.htm. Accessed July 2006.

[ix] Fleming, P. (June 2005). *HIV Prevalence in the U.S. 2000, 9th Conference on Retroviruses and Opportunistic Infections.*

INDEX OF ACTIVITIES

Rural

Formerly / Currently Incarcerated

Rural

HOME-BASED TREATMENT COORDINATOR

1

Home-Based Treatment Coordinator is an individual level intervention designed to link HIV+ individuals in rural areas to medical centers in urban areas and to help them navigate the complexities of the acting health care system. The key characteristics of the Home-Based Treatment Coordinator are: staff acting as a medical advocate for clients; client's home as the location for the activity; high level client rapport and comfort with staff; client-centered identification of general health care needs; client involvement in the development of suitable treatment plan; and coordination with other social and mental health resources.

CURRENT ACTIVITY SETTING
AIDS Service Organization, Family and Medical Services

- ✔ Directly links the client to medical care
  Gets the client in a conversation about starting medical care
- ✔ Brings the agency closer to where HIV+ people are so that the conversation can begin

I. Description

OBJECTIVES

- To identify and close gaps in HIV treatment and other medical care for clients
- To serve as a bridge between people in rural areas and medical centers in urban areas

POPULATION SERVED

- Clients who qualify for Ryan White CARE Act (RWCA) Title IV services, HIV+ individuals and affected family members, particularly African American women of all ages
- Clients who qualify for RWCA Title II services, predominantly African American men, 25 years and older, with no family in the home

ACTIVITY DESCRIPTION

The treatment coordinator reaches out to HIV+ clients in rural areas, providing information on HIV and available care services and help in managing and overcoming obstacles to care, largely due to living far from major care centers.

QUICK NOTES:

"I'm somebody who cares about the people around me. I'm here for them . . . to help them navigate though a difficult process."

— REGISTERED NURSE

- The treatment coordinator meets with clients who have just started HIV care, are having problems with their care, or have dropped out of care.
- The treatment coordinator receives a referral from the case manager and they discuss together the client's needs, how to best approach the client, and where the client is currently receiving care.
- The treatment coordinator then contacts the client, introducing him or herself as someone who works with the case manager.
- S/he offers to help the client solve specific problems or identify current care needs. If the client consents, the coordinator schedules a time to meet at a place that is convenient for the client.
- In preparation for the meeting, the treatment coordinator gathers relevant forms for the client to complete during the first visit.

Client Scenario

- During the first meeting (usually in the client's home), the treatment coordinator takes time to establish rapport.
- S/he guides the conversation to HIV care by asking about the client's last medical visit, current medications and, if the client is female, gynecological care. Then s/he asks if the client knows their CD4 count and its significance.
- The client is encouraged to talk about other health care issues that interest them, and the treatment coordinator continues to assess the client's understanding of, and engagement in, health care.
- If the client is receiving medical care for HIV infection, the coordinator may ask what they think is missing from their current health services.
- If the client has limited or no engagement in their health care, the coordinator tries to gain a clearer, factual picture of the client's situation. Depending on the client's knowledge of HIV, the treatment coordinator may begin informing the client of the basics of HIV infection and treatment.
- The treatment coordinator may ask questions about mental health status and the client's experience with counseling or mental health care.
- Once rapport has been established between the treatment coordinator and the client, a formal intake screening and assessment is completed in which the client's demographic information and relevant medical and mental health history are covered.
- After the intake, the treatment coordinator describes his/her role, the services of the agency, and the confidentiality policy with specifics on how the client's information will be used.
- S/he explains why the client's medical records are important for their work together and fills out a medical information release form for the client to sign. The coordinator also discusses with the client sources of funding for health care.
- Then the treatment coordinator discusses the client's rights and responsibilities, the importance of keeping appointments, and the reasons adhering to treatment is important.
- The treatment coordinator asks the client to inform the agency of any changes to their living situation, health status, etc.
- S/he completes a Health Maintenance Assessment, a personalized document reflecting the client's specific HIV care information.
- The client and treatment coordinator review the client's needs, develop a treatment plan, and identify next steps.
- The treatment coordinator gets confirmation of the client's desire for counseling or resource coordination services from the agency. If there is a strong need for these services, the coordinator may even bring appropriate staff members to the client's home for an in-person introduction.
- The treatment coordinator closes the meeting by reminding the client that s/he will review the medical records, treatment plan, and next steps. S/he then goes over the client's responsibilities and expectations for care.
- The treatment coordinator's role may end here, or it may continue with periodic visits. The frequency of meetings is determined by the client's needs and individual ability to manage their treatment and health care.
- Once back at the agency, the treatment coordinator begins or updates the client's file and schedules for the client medical appointments discussed during the meeting. S/he also may contact the client's health care providers to resolve any conflicts or difficulties the client is having.

PROMOTION OF ACTIVITY

- Information about the treatment coordinator's services is sent to case managers and home care providers within the greater community.
- Case managers distribute agency publications and brochures to home care patients.

II. Logistics

STAFF REQUIRED

Registered nurse working as treatment coordinator

TRAINING & SKILLS

- The treatment coordinator must have high-level knowledge of the local health care system and other local resources and a medical understanding of HIV. S/he must be able to frame questions that encourage frank and open responses about the client's situation and needs.
- Staff is trained to listen and respond to the client's needs, as described, and refrain from imposing their own professional or personal beliefs about appropriate care.

PLACE OF ACTIVITY

Places familiar and "safe" for the client (the client's home, case management office, hospital offices, and home care office) or over the phone

FREQUENCY OF ACTIVITY

Ongoing. Clients are re-enrolled in the program annually. Contact and visits throughout the year depend on clients' needs.

OUTSIDE CONSULTANTS

None

SUPPORT SERVICES

- Transportation
- Translation or interpretation
- Childcare services, when necessary

CONDITIONS NECESSARY FOR IMPLEMENTATION

State and local political support for comprehensive health and social services

III. Strengths and Difficulties

STRENGTHS

- The treatment coordinator acts as a medical advocate for the client.
- The treatment coordinator helps clients in rural areas navigate the urban health care system.

- Because the activity occurs in the homes of clients and other spots that are familiar to them, they often feel more "in control" and safe.
- Access to a wider range of services can lead to direct improvements in the client's quality of life.
- The activity is an expression of compassion in the community.

WEAKNESSES

The treatment coordinator is a "third party" added to the patient-health professional relationship. Health professionals sometimes respond defensively to third-party intervention, perceiving it as a criticism of their job performance.

DIFFICULTIES FOR CLIENTS

- If a client feels overwhelmed by the number of service providers, a treatment coordinator may be seen as "just another face in the crowd."
- Some clients are not ready to embrace the activity because they do not see HIV care as their primary need.

DIFFICULTIES FOR STAFF

- Because of the great distances that the case manager must travel to meet with rural clients, the caseload can be overwhelming.
- The car travel is time-consuming, and gas is expensive.

OBSTACLES FOR IMPLEMENTATION

- Lack of awareness about the program
- Not enough coordination among hospitals, medical providers, and social service programs

ACTIVITY NOT SUITED FOR

Children six to 18 years-old who are affected by but not infected with HIV

IV. Outcomes

EVALUATION

- The staff tracks the client's attendance at medical appointments and monitors CD_4 counts.
- The agency logs the number of women clients who have pap smears each year.
- The agency offers a client-survey questionnaire.
- Clients call the treatment coordinator to self-report their medical appointments and how they are feeling.

EVIDENCE OF SUCCESS

- Client progress reports show that health care needs identified by the clients are met.
- Client logs show that after participating in the activity, clients are less likely to miss medical appointments.
- The staff reports an increase of CD_4 counts in clients receiving this service.

UNANTICIPATED BENEFITS

- The activity helps community health providers and allied organizations work together more closely to meet client needs.
- Helping adults get their health care on track also helps to meet their children's health care needs.

"CONNECTING TO CARE" ELEMENTS OF ACTIVITY

- Clients get personal attention from an individual dedicated to understanding the "big picture" and to helping clients overcome barriers in a fragmented health care system.
- The treatment coordinator is committed to the well-being and care of the whole person.
- Home-based care solves problem of rural clients' distance from centralized health care facilities.
- The personalized approach elicits better information and cooperation from clients.

KEEP IN MIND...

- HIV infection sometimes represents only one symptom of the many issues in a person's life.
- The service must be tailored to the client, and the staff must be willing to give clients control.
- The staff must develop a strong network of health care providers and social resources.
- Set realistic expectations for your client's treatment. Try not to over-promise.
- Be mindful of the presence of others in the client's home at the time of the visit. Remember that other people in the household may not be aware of the client's HIV status or other health issues.

Notes page

Rural

TRIAGE COUNSELING 2

Triage Counseling is an individual level intervention that establishes a direct link between primary medical care and mental health services for patients living with HIV. The key characteristics of Triage Counseling are: the immediate access patients have to mental health counselors; the co-location of primary medical and mental health services; the nature of the first counseling session, which establishes an immediate bond between the counselor and the client; and the support provided to the clinician to help patients fully engage in their HIV care.

CURRENT ACTIVITY SETTING
Community Health Center, Mental Health Services

- ✔ Directly links the client to medical care
- ✔ Gets the client in a conversation about starting medical care
- Brings the agency closer to where HIV+ people are so that the conversation can begin

I. Description

OBJECTIVES

- To help clinic patients stabilize their life situations in order to improve their capacity to function well and actively participate in their HIV medical care
- To contribute to the overall good health of the patient
- To offer a mental health resource to the HIV clinician in order to better care for the patient

POPULATION SERVED

- People who have difficulty staying in medical care, are not doing well in care, or are at risk for dropping out of care
- People who have shown signs of, or been diagnosed with, mental disorders
- Substance users

ACTIVITY DESCRIPTION

Co-location of primary care and mental health services allows clinic patients living with HIV to add mental health support to their overall health care regimen.

QUICK NOTES:

"Our focus is on total health care, and the messages we share with clients are consistent in reinforcing this."

— MEDICAL DIRECTOR

Development and Implementation

A clinic first carries out the following:

- Determines the number of staff members needed to cover walk-in and scheduled counseling sessions, including counselors, psychiatrists, and clinical supervisors.
- Establishes clinical supervision for counselors, as well as linkages to psychiatrists who can manage psychiatric drugs.
- Determines the budget and finds funding for the activity.
- Decides on a location for counseling sessions. The space should be next to or near the facility that provides medical services.
- Once the initial logistics are completed, the clinic develops a training for counselors on HIV infection and care, clinical nomenclature, and the impact HIV and HIV medication can have on a patient's mental health. This training also introduces counselors to a new "triage" model in which the initial appointment with a client lasts 30 minutes (rather than a full hour), and counselors give their immediate attention to the client's most pressing issues.
- After the in-depth training, counselors continue to receive monthly, half-hour update trainings on HIV.
- The clinic sets up the schedule of counselors "on–call" and has this calendar available at the reception area.

Client scenario

- The HIV clinician identifies a patient in need of a counseling session and, at the end of the medical appointment, urges the patient to see a mental health provider, whom s/he personalizes with a name.
- The doctor either escorts the patient to the on-call counselor's office or walks the counselor to the room where the patient is. The doctor gives the counselor some details about the patient either privately or with the patient present.
- The counselor spends the next 30 minutes addressing the client's acute issues. In this triage session, the counselor tries to establish a rapport and "bonds" with the client.
- Utilizing a checklist that helps focus the session, the counselor listens to the client, assesses the principal issues and any diagnosable conditions, and asks if the client currently has a mental health provider. S/he may also check the clinic's database for the client's clinical history.
- Together, the counselor and client develop a plan of action to address the client's mental health and medical needs. The plan includes the frequency of future mental health appointments and whether or not the client must see a psychiatrist.
- At the end of the first session, the counselor completes two client charts: one for the mental health department and the other for an electronic, clinic-wide database of medical and clinical information.
- The counselor may either arrange for the client to see a psychiatrist on staff, or wait until they have had a few counseling sessions together.
- The counselor walks the client to the reception area, where the receptionist schedules the next mental health appointment. Using a centralized scheduling database, the receptionist can coordinate mental health visits with medical visits (e.g., dental, primary care, lab) to minimize patient travel.
- For the subsequent counseling sessions, the client may see a different counselor who can better address the specific needs identified in the triage session.
- Follow-up visits depend on the client's needs. Visits may occur as frequently as one to two times a week, but typically occur about five to six times per year.
- If the client sees a psychiatrist, the counselor supports the client's adherence to psychiatric medications. Prescriptions can either be picked up at an on-site pharmacy or mailed.
- Following the triage session, the counselor tells the referring physician about the plan established with the client. This communication ensures consistency in the messages that the providers share with the client.

Staff Follow-Up

- The clinical staff (primary care and dental), front desk staff, administration, mental health counselors, social workers, and pharmacy staff hold weekly team meetings to review new and "crisis" patient cases.
- Counselors generate a list of clients to discuss at the meeting. They identify client needs and monitor medical progress (in terms of CD_4 counts, viral loads, adherence, etc.).

- The team determines an interdisciplinary strategy to meet the identified client needs, and assigns tasks to "action staff."
- In the next meeting, action staff reports on the tasks that were completed.
- The counselors hold separate weekly meetings to discuss their sessions and issues that require attention.

PROMOTION OF ACTIVITY

- The service is offered to patients during intake screening.
- Flyers in agency packet for HIV+ patients
- Word of mouth from patients
- Physician referrals

II. Logistics

STAFF REQUIRED

- Four counselors, each with a different specialty (substance abuse, trauma, child abuse, etc.)
- Administrative supervisor

TRAINING & SKILLS

- Staff should have strong knowledge of client rights and confidentiality.
- All staff members must be able to work with diverse populations and be open and tolerant.
- Licensed counselors must have HIV training and receive monthly HIV updates from clinical staff.
- Two counselors should each be fluent in English and another language spoken in the client community.

PLACE OF ACTIVITY

The activity takes place in a private room of a community health center.

FREQUENCY OF ACTIVITY

The service is available five days a week.

OUTSIDE CONSULTANTS

- Three part-time psychiatrists (one bilingual)
- Clinical supervisor

SUPPORT SERVICES

Social Security payee services to pay some patients' housing and utility bills

CONDITIONS NECESSARY FOR IMPLEMENTATION

- Physicians need to be willing and able to provide in-person introductions for their patients and the counselors and facilitate the relationships in their early stages.
- Proper clinical supervision must be established for counselors.
- It's important to have support from a pharmacy so that clients have convenient access to medications and pharmacy staff.
- The agency administration must fully support the activity.

III. Strengths and Difficulties

STRENGTHS

- The counselors are integrated into a health team whose members share the same objectives.
- The team supports the complete well-being of patients.
- The co-location of the services easily connects mental-health and clinical care.
- The "on-demand" availability of the counselors
- The activity helps break through the denial some patients may have about their illness or life situation which prevents them from engaging fully in care.

WEAKNESSES

- It is difficult for classically trained counselors to adopt an approach from the primary health care model.
- Counselors may find it difficult to adjust to a 30-minute initial session with a client instead of the traditional one hour session.
- Lack of mental health funding makes it difficult to obtain reimbursement for the service.

DIFFICULTIES FOR CLIENTS

The counselor who patients see for the triage session may not be the one they will consult thereafter.

DIFFICULTIES FOR STAFF

- It's hard work helping clients to keep regular mental health follow-up appointments.
- Few funds are available for mental health services.

OBSTACLES FOR IMPLEMENTATION

- Lack of available private space
- Low reimbursement for services that are in high demand

ACTIVITY NOT SUITED FOR

N/A

IV. Outcomes

EVALUATION

- The supervisor analyzes the Global Assessment Functioning (GAF) Scale Score for all patients seen by a counselor/psychiatrist.
- The agency tracks yearly patient visits and number of missed appointments.

EVIDENCE OF SUCCESS

- Increased GAF Score for patients who meet with counselor/psychiatrist
- Improved clinical health of patients
- Increased access to and use of mental health services
- Improvement in patients' overall life condition and stability
- Lower mortality rate for patients utilizing the service
- Increase in the number of patients maintaining a consistent relationship with medical care services
- Eliminated "no shows" to medical appointments
- Increase in the number of yearly clinic visits by patients
- Decrease in number of patients dropping out of care

UNANTICIPATED BENEFITS

- Medical providers feel more secure because they have someone available to attend to issues that they may not be comfortable addressing or that they see requires more attention than they are able to give.
- The activity fosters a team atmosphere and lessens isolation among staff members.

"CONNECTING TO CARE" ELEMENTS OF ACTIVITY

- Coordinating mental health and medical visits to minimize travel is especially helpful for clients who live at a distance from the clinic.
- The counselor's inclusion in the primary health team conveys the message to the patient that it is important to address mental health as an aspect of their "total health."
- The "on-demand" availability of the counselors addresses the needs of clients in crisis.
- The primary care providers show that they care about the patient's emotions and total health.
- Patients don't have to re-tell their story to different agencies.
- Clients can combine other health care appointments with this service.
- Having one chart and an electronic database allows providers to review the total health care experience of the patient/client.

KEEP IN MIND...

- Mental health care providers must understand they are delivering services in a primary care context. Create a dialogue between counselors and primary care providers to make this connection explicit.
- Develop an acute client assessment tool that counselors can complete in a short period of time.
- Set up support for mental health counselors.
- Don't expect the activity to be a "money maker."

Notes page

"MANAGING OUR HIV" WORKSHOP SERIES 3

"Managing Our HIV" Workshop Series is a group level intervention designed to provide a better understanding of medications and basic health management to HIV+ individuals initiating or having difficulty managing their HIV treatment. The key characteristics of the "Managing Our HIV" Workshop Series are: the confidential nature of the workshops which helps clients to feel "safe" discussing their HIV infection; the use of non-technical language in workshop materials; and the provision of transportation, which allows clients from remote areas to participate.

CURRENT ACTIVITY SETTING
Community Health Center, Early Intervention Clinic

- Directly links the client to medical care
- ✔ Gets the client in a conversation about starting medical care
- Brings the agency closer to where HIV+ people are so that the conversation can begin

I. Description

OBJECTIVES

- To strengthen clinic patients' ability, through a group intervention, to adhere to their recommended treatment regimens
- To help patients develop tips and strategies that will help to make medication adherence manageable and their lives easier
- To encourage patients to become active in their health care
- To provide patients with information that helps them understand how HIV specific medications affect their bodies
- To help increase CD_4 counts and lower viral loads through adherence to medication

POPULATION SERVED

- Patients living in rural or remote areas who are having difficulty adhering to anti-retroviral medications
- Patients who are initiating anti-retroviral medications

ACTIVITY DESCRIPTION

"Managing Our HIV" Workshop Series provides HIV+ individuals with a safe group environment in which to learn about HIV disease and ways to adhere to medication regimens and build strong relationships with medical providers.

QUICK NOTES:

"I say to patients, 'HIV moved in with you—you didn't move in with it. So you have to be the head of your household and take control.'"

— HIV EDUCATOR

Development and Preparation

- The clinic decides to offer a workshop series on HIV infection, its symptoms and treatment regimens, adherence to medication, nutrition, and safer sex practices.
- The HIV educator, who is responsible for coordinating the workshops, meets with clinic care providers to describe the workshop series and to ask them to refer patients who are either starting or having problems adhering to their treatment regimens.
- S/he lines up appropriate facilitators for the workshops and asks them to prepare presentations.
- Next, s/he creates a "Certificate of Completion" which participants will receive upon successfully completing the workshop series.
- The educator develops a budget for the workshop and secures funding to cover food as well as gift certificates—an incentive for completing the series successfully.
- The educator develops and distributes a flyer advertising the workshop and each session.
- Providers send the educator the contact information for the patients whom they have referred.
- The educator calls each person and invites them to participate, telling them about the content, stressing the different ways attending can be beneficial, and highlighting the free food, gift certificate, and travel assistance available to participants. If a person seems uninterested, the educator follows up with a later call to encourage them once again to attend.
- Each class is limited to ten participants. The educator reserves a private room in a clinic for the five weekly workshops that comfortably accommodates the size of the class.
- Once the workshop roster is full, the educator makes arrangements for transportation services (i.e., bus tickets and van pick-up appointments) for each session, giving priority to clients traveling from rural areas of the county.
- The educator prepares participant packets that include a copy of the facilitator's Power Point slides and additional information on the subject to be covered in the first session. A similar packet is distributed at the beginning of each class.
- The clinic's security staff is alerted to the time and location of the workshop. To protect client confidentiality, security monitors traffic to the room, stopping individuals who are not registered for the workshop from entering.

Five Week Curriculum

Week One: *Stop and Think: HIV 101 and Introductions*

- The first session has two health educators as facilitators, one of whom is HIV+.
- One of the two begins by introducing the five sessions, handing each participant the circulating flyer.
- The HIV+ facilitator discloses his/her status.
- The participants introduce themselves to the group.
- Food is served, and participants eat as the session begins. Engaging in a social activity, such as eating, allows clients to feel more comfortable talking and sharing information. All remaining sessions begin with the serving of a meal.
- As participants eat, a facilitator explains the rules of the sessions, stressing the confidentiality agreement. To support the confidentiality of the group, no one other than the registered participants—all of whom are HIV+—is allowed to attend the sessions.
- A facilitator explains the workshop incentives: $15 gift certificates for participants who attend all five sessions and, for winning an exercise, the selection of a caterer for the next session.
- A facilitator follows with a presentation on HIV, how it affects the body, and some possible symptoms of opportunistic infections.
- Next, the facilitators lead a group discussion on treatment regimens, inviting the group to participate by asking, "What tips do you have for taking medications?"
- They administer a written quiz that asks patients to read vignettes of different pill-taking styles and select the one with which they most identify.
- A facilitator leads a discussion about participants' responses, attitudes, and styles of taking medications.
- At the closing of the first session, a facilitator introduces the next session's topic and distributes a business card encouraging participants to get in touch if any needs arise (such as transportation) before the next session.

- Participants are told of any relevant community events on HIV and treatment management, and offered additional incentives to attend the events.

Week Two: *Ready, Set, Go: Difficulties with Adherence and My Provider and Me*

- The second session is facilitated by the same two individuals as the first session.
- The facilitator who is HIV+ takes the lead and reviews highlights from the first session; the other educator co-facilitates.
- The lead describes how HIV works in the body and how "classes" of medications function in the body, using stories and analogies to explain complex concepts.
- The lead shares with participants his/her own experience with medications and leads an informal discussion about side effects and symptoms and how participants can manage them.
- The other HIV educator facilitates the first of several exercises that occur over the course of the second, third, and fourth workshops. For example, s/he might read scenarios about people living with HIV and invite the participants to suggest ways for them to improve their health and well-being.
- Following the exercise, the lead facilitator begins a discussion about the relationship participants have with their current health care provider. The participants are coached on the questions to ask a provider, the information they should disclose during various appointments, and when they ought to reveal "secret" issues relating to their health (e.g., substance use).
- The lead facilitator stresses the importance of attending each medical appointment and emphasizes that participants must be involved in their health care by asking questions and never leaving an appointment without understanding everything the provider has told them.
- Lastly, the lead facilitator opens a lengthy discussion on provider-client relationships, where participants often share personal experiences.
- At closing, a facilitator announces any relevant community events participants can attend.

Week Three: *Eating Healthy: Nutrition and HIV*

- A nutritionist facilitates this session and explains what foods the participants can add to their diets in order to help ease the side effects of HIV medications.
- For participants who want it, the nutritionist then offers one-on-one counseling on nutrition and HIV health management.
- The participants regroup and ask questions of the nutritionist.

Week Four: *What About the Sex Thang? Safer Sex Education*

- One of the HIV educators facilitates this session, which focuses on how participants can engage in safer sex, including sex with HIV+ or sero-discordant partners, and demonstrates proper use of condoms (female and male) and dental dams.
- The HIV educator opens conversation, explaining the health consequences of unprotected sex and discourages it.
- Then, the educator coordinates a theme and audience-appropriate game. For example, there is a fantasy game that is appropriate for a group of mostly female participants: Celebrity Groove Bag. Participants grab a prop from a bag, which contains a mix of sensual products (e.g., massage oil, a stiletto shoe). Each woman describes how she would use the item to be intimate with the celebrity of her choice without having intercourse. The game helps to raise the comfort level for participants, giving the facilitator the opportunity to demonstrate how to negotiate and apply a condom in a sensual, playful manner that does not interrupt the mood of intimacy.
- After the game, the HIV educator leads a question and answer session that closes the workshop.

Week Five: *Wrapping-It-Up Q & A, Celebration, and Presentation of Certificates*

- Participants complete evaluations of the series, identifying what they found most useful, what they liked or disliked, and what they wish the series had included.
- Next, the HIV educator leads a group conversation on what the participants learned and how they changed. Participants are asked to share "tips" they can now give others on managing HIV.
- The HIV educator plays music and creates a festive atmosphere for this closing session.
- The HIV educator leads a graduation ceremony in which clients walk to receive their certificates of completion and gift certificates.
- The group spends the remaining time socializing in a low-key, informal setting.

PROMOTION OF ACTIVITY

A flyer advertising the workshop series is sent via e-mail to health care providers at the clinic and to local substance abuse treatment centers. It is also posted throughout the clinic, handed out to patients in the clinic waiting room, and advertised in the clinic newsletter.

I. Logistics

STAFF REQUIRED

- HIV educator to organize, facilitate, and evaluate the training
- HIV educator/counselor who is HIV+ to co-facilitate
- Guest speakers from the community
- Case manager to transport rural patients to session

TRAINING& SKILLS

- All facilitators must have an understanding of HIV infection and basic knowledge of anti-retroviral medications and treatment adherence.
- Facilitators must be knowledgeable about safer sex practices and have familiarity with common misconceptions in the community about HIV and safer sex.
- Facilitators should have familiarity with the vernacular or "slang" used by the target population.

PLACE OF ACTIVITY

- Conference room at the health clinic, equipped with an overhead projector or LCD screen, a table and enough chairs to accommodate speakers and participants.
- The workshop can also take place at meetings of substance abuse and mental health support groups for HIV+ individuals.

FREQUENCY OF ACTIVITY

A workshop series starts every month and meets weekly for five sessions.

OUTSIDE CONSULTANTS

Training consultant for two medication and adherence sessions

SUPPORT SERVICES

- The case manager, using a van provided by the clinic, picks up and drops off patients who lack means of transportation.
- Roundtrip bus tickets are provided to participants who live on a bus route.

CONDITIONS NECESSARY FOR IMPLEMENTATION

The workshops must take place in a convenient, enclosed, and "intimate" space that is clean enough to eat in and is not cramped.

III. Strengths and Difficulties

STRENGTHS

- One facilitator is HIV+.
- Games and activities facilitate dynamic participation by getting participants involved and interested in the subject matter.
- The confidential nature of the workshops allows participants to be open. It gives them an opportunity to ask questions they don't ask their medical providers.
- The facilitators present the information in a less technical language than many providers.
- Spoken communication helps continually engage participants who may have few or no literacy skills.
- The use of analogies and figurative speech helps to stimulate the interest of people who initially are disengaged.
- Participants have an opportunity to meet people they can relate to in a safe environment.

WEAKNESSES

- Attendance is highly dependent on the $15 incentive.
- There is a low percentage of male participants.

DIFFICULTIES FOR CLIENTS

- Participants who have problems adhering to medications may also have problems adhering to the schedule of workshop sessions.
- Certain clinic patients don't feel the need to attend the workshops because they don't feel ill.
- The time of day that the workshop is held poses a problem for some participants.
- Five sessions isn't sufficient to cover all the relevant issues for people who have been on medication for some period of time.

DIFFICULTIES FOR STAFF

- It can be challenging to get clinic patients to attend and actively participate in each session.
- Some classes are smaller than others because there are fewer new patients within the network who are beginning anti-retroviral treatment.
- Five sessions isn't sufficient to cover all the relevant issues for people who have been on medication for a period of time.

OBSTACLES FOR IMPLEMENTATION

None

ACTIVITY NOT SUITED FOR

- Non-English speakers if there is no translator or bilingual staff
- People under the age of 18

IV. Outcomes

EVALUATION

- Agency administers a pre- and post-workshop written and oral questionnaire to participants on their pill-taking styles.
- Participants complete a final written evaluation of the program.

- The HIV educator reviews patients' medical charts to track CD4 counts, viral loads and the scheduling and completion of medical provider appointments.
- The HIV educator tracks the clinic's "no-show" lists for workshop participants.
- The agency monitors participant workshop attendance through the use of a spreadsheet.
- The agency receives provider feedback.

EVIDENCE OF SUCCESS

- Medical providers report that patients who participate in the workshop show a greater interest in their own health care.
- Staff observes participants meeting people and discussing their health and life situations.
- Staff observes that participants get motivated as they see their viral levels go down.

UNANTICIPATED BENEFITS

Participants report that they have more faith in the medications.

"CONNECTING TO CARE" ELEMENTS OF ACTIVITY

- The HIV+ facilitator is essential to reaching and influencing other HIV+ people. As someone who is healthy and taking medication, s/he can relate to clients and reassure them.
- The activity explains the virus and the effect of medications on the body, allowing clients to visualize what occurs in their body. This helps the participants to think in a new way about what they can do and to realize the importance of taking medications.
- The activity encourages participants to "buddy up" and help to support others in the group.
- Participants are able to meet and talk with other HIV+ people in a safe environment, which can often be difficult for people living in rural settings.
- Often patients don't feel comfortable asking questions of medical providers, and this activity allows them to discuss issues and concerns in a comfortable, peer environment.
- The activity allows for extended conversations with counselors who have more time to talk about medication issues than medical providers do.
- The transportation service allows individuals from remote areas to participate.

KEEP IN MIND...

- All facilitators need to be well-informed and prepared to answer clients' numerous questions.
- Make sure there is funding available for incentives.
- Keep an accurate account of participant attendance.
- Make sure the food provided for each workshop is tasty and nutritious so that it reinforces the nutritional information participants receive in the session.
- A newly diagnosed participant who is in denial about his/her status can often steer the first session's focus to their specific needs.

Rural

HOLIDAY SOCIAL 4

Holiday Social is a group level intervention that aims to alleviate the isolation of HIV+ individuals living in rural communities. The key characteristics of the Holiday Social are: the non-health related venue of the event; the connection individuals make with others living with HIV in their community; the creation of care support networks; and the opportunity for agency staff to strengthen its relationship with clients.

CURRENT ACTIVITY SETTING
AIDS Service Organization, Case Management

- ✔ Directly links the client to medical care
- ✔ Gets the client in a conversation about starting medical care
- ✔ Brings the agency closer to where HIV+ people are so that the conversation can begin

I. Description

OBJECTIVES

- To help create a network of HIV+ individuals who can support one another when the case manager is not scheduled for a local visit
- To improve the relationship between case managers and their clients
- To break the emotional and physical isolation of clients who live in rural settings

POPULATION SERVED

- HIV+ clients with infrequent agency contact who reside in rural settings

ACTIVITY DESCRIPTION

Holiday Social provides regular opportunities for HIV+ individuals and service providers in rural areas to socialize and share health-related information and experiences in a festive environment. Through these social events, participants receive support in continuing or resuming utilization of health and social services.

QUICK NOTES:

"We started to say, 'Hey, this might just be a new way to reach people.'"

— OUTREACH COORDINATOR

Planning

Planning for Holiday Social includes the following steps:

- Set a budget for the event.
- Select a theme, which can be based on an approaching holiday.
- Develop an invitation list including current clients and clients who may have recently dropped out of agency services.
- Find an appropriate location for the event.
- Create an invitation letter that includes the time and place for the event, the theme, and the case manager's contact information to RSVP.
- Mail invitation letters to clients.
- Follow up the invitation letter with a phone call to each client. Emphasize that the event will be held in a confidential location; repeat the event details. Encourage the client to bring a special dish or favorite CD. If the event is held around a holiday, encourage the client to bring a holiday appropriate gift or something they don't need from around the house (books, videos, crafts, etc.).
- During the calls, ask about clients' hobbies, passions, and special interests. Use this information to design group icebreaker games for the event.
- Ask if the client requires assistance with transportation. If not, ask if the client can offer a ride to another client to and from the event.
- Coordinate transportation with the help of client volunteers.
- Arrange for food and non-alcoholic beverages for the event.

The Day of the Event

- The case manager, who facilitates the event, outreach staff members, and client volunteers set up the space one to two hours before the start time. They arrange chairs, tables for food and, if the event or holiday calls for it, a gift table.
- The case manger also picks up the food order.
- As clients start to arrive, the case manager greets and offers them a beverage.
- Once most people have arrived, the case manager welcomes everyone and facilitates an icebreaker game to get clients comfortable and talking with one another. The game uses the information gathered during the follow-up calls. For example, each person may receive an index card with a description of another person's interests. Participants then mingle and try to guess whose interests have been written on their cards.
- Following the game, clients eat, listen to music, and talk with each other and agency staff.
- The staff introduces clients with shared interests and helps to stimulate conversation about doctors, medical appointments, and support groups they may be attending.
- The case manager and outreach workers talk with clients they have not seen in awhile, trying to reconnect and learn the reason they have not been in touch.
- Gifts and other items clients have brought are exchanged.
- Chairs are rearranged in a circle for a group conversation. The clients are asked to talk a little about who they are, how long they have been in the area, and about their families. This allows for further connections to be made among clients.
- The case manager closes the discussion by asking for feedback about the event such as the appropriateness of the location, whether they would attend similar events and, if so, how often. The case manager also asks what the clients enjoyed about the event and what could be improved.
- At the end of the event, staff prepares plates of leftover food for clients to take home. Clients exchange contact information with one another.
- Everyone helps clean up.

Follow-Up

- Agency staff who attended the event meets to discuss and evaluate it.
- Case manager follows up with each client who attended.

PROMOTION OF ACTIVITY

Agency clients are invited to the event through mailed invitations and a phone call from the case manager.

II. Logistics

STAFF REQUIRED

- Case manager to coordinate and facilitate the event
- Outreach worker
- Volunteers to help set up and provide transportation

TRAINING & SKILLS

- The case manager must be a good facilitator, personable, and have highly developed social skills.
- Good food preparation skills are a plus.

PLACE OF ACTIVITY

- The event takes place in a non-HIV related, "neutral" community meeting room or shopping mall conference room where confidentiality is maintained in order to protect anonymity of clients within the broader community.
- The space should be a large room, accessible to people with physical disabilities.
- It should include a kitchen facility, a bathroom with soap and running water, and chairs and tables.

FREQUENCY OF ACTIVITY

Four times a year (quarterly)

OUTSIDE CONSULTANTS

None

SUPPORT SERVICES

Volunteers drive clients who lack transportation.

CONDITIONS NECESSARY FOR IMPLEMENTATION

- In order for clients to feel comfortable and "safe," the location of the event must not be identified with HIV, and confidentiality must be assured.
- The event must be free of alcohol and drugs.
- The location should be chosen so that no client must drive more than ten miles.

III. Strengths and Difficulties

STRENGTHS

- The compassionate, inclusive, caring nature of the intervention provides personal attention from a supportive staff.
- The case manager gets to know clients, and clients get to know the case manager and other staff socially in a comfortable environment.
- Clients see the staff put their paperwork down and show a desire to socialize and connect with them personally, not just professionally.
- The case manager gains increased trust from clients.

WEAKNESSES

None

DIFFICULTIES FOR CLIENTS

- Some clients may not have enough money to bring gifts or "dress up."
- It is often a "leap of faith" to attend an event for HIV+ people. "Exposure" in the broader community would be difficult for many clients.

DIFFICULTIES FOR STAFF

- Not every client RSVPs or attends the event.
- The case manager's time is limited, making it difficult to follow up with everyone who did not RSVP or attend.
- Out-of-date information for clients
- Staff would like to hold the event more frequently but lacks sufficient resources and time.

OBSTACLES FOR IMPLEMENTATION

- Some clients lack of financial resources could affect their willingness to participate, especially if they think they are expected to do something that requires money.
- Lack of transportation in rural areas
- Fear of being associated with an HIV organization
- Literacy challenges: some clients are unable to read the invitation the case manager sends.

ACTIVITY NOT SUITED FOR

N/A

IV. Outcomes

EVALUATION

- The case manager and staff monitor success by observing client moods and behaviors at the event.
- Clients complete a post-event survey.
- The case manager and staff evaluate the activity based on the reactions they see and hear in follow-up conversations with the clients.
- The case manager monitors clients' utilization of agency services after this activity.

EVIDENCE OF SUCCESS

- The case manager and staff conclude that the activity is successful by observing clients' good humor, enjoyment, engagement in conversation with other clients, and the gratitude they express throughout the event.
- In client surveys, participants request future events of the same nature.
- Clients report connecting with others, sharing information and developing supportive bonds. Those without their own means of transportation discuss with others the possibility of ride-sharing to medical appointments.
- The case manager reports an increase in clients' utilization of agency services after participation in this activity.

UNANTICIPATED BENEFITS

- Staff members reconnect with clients who have drifted away.
- Agency staff becomes aware of the importance of creative interventions and social activities that bring together people who may have limited opportunities for connections with others in their rural communities.

"CONNECTING TO CARE" ELEMENTS OF ACTIVITY

- The case manager is able to establish or re-establish trust with clients.
- Having met socially with other people who share their HIV and health related experiences, clients are encouraged to network.
- Clients who have fallen out of touch often renew their engagement in health care services.
- Clients, who are often isolated, are able to socialize, even dress up, which is something that many of them don't have the chance to do very often.

KEEP IN MIND...

- Be aware of and respect the racial, social, and cultural realities of the clients you invite.
- Do not accidentally "blow the whistle" on your clients. Be mindful when choosing the location for the event: clients must feel comfortable and trust that their HIV status is not going to be disclosed.
- Remember, "the more diverse the crowd, the better!"

Notes page

Rural

HIV ADVISORY SUPPORT GROUP

5

HIV Advisory Support Group is a group level intervention designed to bring together HIV+ and HIV- community stakeholders, service providers, and church leaders to help identify and address the specific needs of people living with HIV and break down the constructs of HIV stigma in the local rural population. The key characteristics of the HIV Advisory Support Group are: the "neutral" location of the meeting space; the high level of confidentiality; the right of participants to disclose or not disclose their HIV status; and the trust established between different community members, health providers, and individuals living with HIV.

CURRENT ACTIVITY SETTING
County Health Department, Infectious Disease Clinic

Directly links the client to medical care
- ✔ Gets the client in a conversation about starting medical care
- ✔ Brings the agency closer to where HIV+ people are so that the conversation can begin

I. Description

OBJECTIVES

- To promote awareness and education about HIV in the local community and surrounding counties
- To help break down the constructs of stigma perpetuated within the local community
- To identify and address the specific needs of HIV+ people in the local community and surrounding counties
- To update the community on the most current HIV regimens and opportunistic-infection treatments

POPULATION SERVED

- HIV+ individuals interested in group support, particularly African American women
- Community stakeholders (HIV+ and HIV-)
- County nurses, mental health and social service providers
- Church leaders

ACTIVITY DESCRIPTION

HIV Advisory Support Group brings together a group of community stakeholders in a rural area to raise awareness about HIV and to help reduce barriers to support and care for individuals living with HIV.

QUICK NOTES:

"Some people drive two hours for a meeting that's only half that long."

— HIV PROGRAM ADVOCATE

Initial Logistics

- Permission is obtained to involve the city health department and to use church space for the support group.
- Conversations to generate support from community stakeholders are held and provide the activity's time, location, and a brief description.
- The agency case manager develops a list of potential participant candidates for the group, including HIV+ clients, social and health service providers, and members of the general public.
- The case manager calls the list to explain the group's purpose and to offer to send an invitational flyer to interested parties. S/he sends it two weeks before the meeting.

Meeting Logistics

- Meetings are held for an hour each month. The case manager facilitates, taking minutes.
- Several days before a meeting, reminder calls are placed to invitees.
- The case manager develops an agenda based on the minutes of the previous meeting, special events on the community calendar, breaking news and developments on HIV or treatment regimens, and information on the care services provided by the county health department.

The Meeting

- The meeting, whose tone is friendly, open, and "conversational," has a planned but flexible structure. Each meeting begins with introductions.
- As the meeting facilitator, the case manager begins the introductions by talking briefly about the agency. S/he stresses the importance of respecting confidentiality, both at the agency and among group participants.
- The case manager lets participants know that disclosure of their HIV status is at their own discretion.
- After introductions, the minutes of the last meeting are read.
- The facilitator invites discussion of topics that are not part of the formal agenda.
- Participants begin to share and discuss any relevant news pertaining to HIV infection and treatment.
- The facilitator invites participants to share any personal concerns or experiences related to HIV (e.g., being HIV+ or involved with HIV as a provider, caregiver, or loved-one).
- Upcoming community health events are announced and discussed. The group will often decide to participate in such an event or to organize one of their own. The group can plan its participation and delegates tasks.
- Toward the end of the meeting, the facilitator opens the floor to questions. Any unaddressed questions from one meeting are considered at the next.
- The case manager schedules the next meeting and the group closes with a prayer, often led by the church minister if present.
- Refreshments are served as participants have an informal, post meeting "meet and greet." Participants make connections with other individuals and service providers. Some may choose to share their HIV status if they have not already done so with the entire group.

PROMOTION OF ACTIVITY

- The agency sends a flyer each month to target service providers and HIV+ clients.
- Participants are invited to bring guests and inform other community members of the activity.

II. Logistics

STAFF REQUIRED

- The case manager conducts the meeting.
- Health support staff helps select participants, prepare refreshments, and clean up after meetings.
- A volunteer from the community, involved with HIV+ clients, acts as a peer liaison.

TRAINING& SKILLS

The case manager must have skills and experience working with HIV+ clients and a knowledge of HIV infection, treatment management, and prevention strategies. This person must also be a skilled listener.

PLACE OF ACTIVITY

- Community church
- Meeting room, such as a Sunday school room, with a table and chairs arranged in a semi-circle

FREQUENCY OF ACTIVITY

Monthly

OUTSIDE CONSULTANTS

None

SUPPORT SERVICES

None

CONDITIONS NECESSARY FOR IMPLEMENTATION

- The agency must have strong rapport with a church in the community that is well-known and active.
- The facilitator must be trusted by community members and health care professionals.
- The church, health department, and/or community-based organizations should develop strong working relationships.
- Clients must be able to transport themselves to the activity, often driving long distances (20, 40, or more miles).

III. Strengths and Difficulties

STRENGTHS

The comments provided by HIV+ people (whether they disclose or not) provide crucial insight into community needs and issues of living with HIV in a rural environment.

WEAKNESSES

Fluctuation of attendance

DIFFICULTIES FOR CLIENTS

Clients who cannot transport themselves to the meeting are unable to participate.

DIFFICULTIES FOR STAFF

Limited staff resources coupled with infrequent meetings makes it difficult for the group to function at its full potential.

OBSTACLES FOR IMPLEMENTATION

Lack of transportation from remote areas

ACTIVITY NOT SUITED FOR

- The activity is not suited for people actively using illegal substances.
- If a host church does not openly accept homosexuality, a person who discloses as homosexual may feel uncomfortable or unwelcome.

IV. Outcomes

EVALUATION

- The minutes, which are logged and filed, include participant comments and inquiries about health services.
- The number of participants is monitored to observe different trends of growth or change.

EVIDENCE OF SUCCESS

- There is an increase in the number of people who self disclose during the meeting, and this helps "set the tone" and encourages others to discuss their HIV status openly.
- There is a reported increase in attendance for HIV+ members of the community.
- There is an increase in attendance of family members of HIV+ people.
- Self reported accounts by HIV+ participants indicate they are making and keeping new medical appointments.
- Participants report a sense of comfort from meeting other people who are either HIV+ or sensitive to HIV issues, and learning about services available in the community.

UNANTICIPATED BENEFITS

- HIV+ participants often find comfort in knowing that participants are a mixed group (HIV- and HIV+), which eliminates feelings of being "singled out."
- Because participants discuss situations of being mistreated by family or members of the community, the agency works to create public events at other churches and community spaces to inform people about HIV.

"CONNECTING TO CARE" ELEMENTS OF ACTIVITY

- Participants respect the intimacy of disclosure and the meeting's high level of confidentiality.
- Participants begin to see that different people in the community care about HIV and how it affects people, and are offering services, care, and treatment possibilities.
- The meeting provides a "safe" space for HIV+ individuals to meet and get to know community service providers and makes it easier for people to initiate a formal medical relationship with them.
- The meeting helps to establish trust between different community stakeholders and HIV+ individuals.

KEEP IN MIND...

The church location is considered a "neutral" space within the rural community with no overt identification to health or HIV related issues.

CARE RENEWAL BY POST 6

Care Renewal by Post is an individual level intervention that helps HIV+ people in rural areas to maintain their enrollment in a state-based HIV care program. The key characteristics of Care Renewal by Post are: the use of postal services to maintain connection with clients; the client-centered case management; the easily accessible support offered by the agency; and the careful review of the client's re-enrollment materials.

CURRENT ACTIVITY SETTING
AIDS Service Organization, Case Management

- ✔ Directly links the client to medical care
  Gets the client in a conversation about starting medical care
- ✔ Brings the agency closer to where HIV+ people are so that the conversation can begin

I. Description

OBJECTIVES

- To assist people in remaining enrolled in a state HIV care program so that they receive continuous HIV care and treatment
- To ensure that HIV+ individuals are able to receive their medications without compromising their privacy

POPULATION SERVED

- HIV+ individuals eligible for program services who live in rural areas

ACTIVITY DESCRIPTION

Individuals enrolled in an HIV care program and who reside in rural areas receive support in renewing their enrollment by mail to prevent lapses in care.

QUICK NOTES:

"*Behind the letters and the forms, there is a person who is supportive, trustworthy, and easy to access.*"

— CASE MANAGER

- The agency receives a 30-day, need-to-renew notice and reapplication materials for a client who is enrolled in the state HIV care program, funded by the Ryan White CARE Act. (The program eligibility requirements call for all participants to register their case manager's name so that the program can share information with these case managers.)
- The case manager copies the notice for the client's file, mails the original notice to the client, and enters information in the agency database.
- After a telephone conversation with the client, the case manager mails them the reapplication forms with a request for any additional information or documentation that will be needed to re-enroll (e.g., income verification and HIV lab reports).
- Over the phone, the case manager and client review the information and documentation necessary to reapply. One of them will contact the client's doctor(s) later on to request any required medical information.
- On the same call, the case manager and client review any changes in the state's program requirements and services, as well as the enrollment forms the client must fill out.
- This call also provides an opportunity for the client to ask any questions about their needs and health care.
- The client fills out the application materials and mails them back to the case manager.
- Upon receipt of the materials, the case manager reviews them to verify that they are complete.
- S/he mails or faxes the full application for renewal to the appropriate office within the state health department.
- The health department receives and processes the application. There are three possible outcomes: approval, temporary approval, or denial. If the application is approved, the health department issues an updated card for the client. If it approved temporarily, a temporary card is issued until a decision can be made. If it is denied, the case manager works with the client to problem-solve the crisis.
- When an updated or temporary card arrives at the agency, the case manager copies it to the client's file and sends it to the client.
- If the health department has issued a temporary card, the case manager will send it to the client with notification of any additional information that the health department is requesting.

Prescriptions by Confidential Mail

- A separate function of Care Renewal by Post is to ensure that clients receive their HIV medications without compromising their privacy.
- When clients seek medical care, they ask the doctor to send their HIV medications to the agency.
- The agency repackages medications it receives and mails them to the clients' homes. The packages bear no markings other than a return address, which does not include the agency's name.

PROMOTION OF ACTIVITY

- By agency staff in telephone conversations or individual meetings with clients
- By staff in hospitals within the agency's service area who inform HIV+ patients from the rural areas of the activity

II. Logistics

STAFF REQUIRED

- Case manager to guide clients through program re-enrollment
- Support staff to prepare mailings and paperwork and to maintain the filing system

TRAINING& SKILLS

Case managers should have strong communication skills, including the ability to convey instructions clearly and concisely to clients over the phone as well as good writing and editing skills.

PLACE OF ACTIVITY

Private office space

FREQUENCY OF ACTIVITY

- Each client must apply for renewal every six months. The process takes one to six weeks to complete.
- In the case of prescriptions by mail, the service is rendered "as needed."

OUTSIDE CONSULTANTS

None

SUPPORT SERVICES

None

CONDITIONS NECESSARY FOR IMPLEMENTATION

- Participating clients must be currently enrolled in the program.
- The state health department must permit case managers to file renewal paperwork.
- The organizations that regulate and fund the agency must support the activity's implementation.

III. Strengths and Difficulties

STRENGTHS

- Preserves the confidentiality of clients and ensures they receive necessary care
- Provides a human support system that is trustworthy and easy to access
- Allows clients to re-enroll before their care lapses without having to drive to a major city
- The direct contact that the case manager has with clients shows that someone genuinely cares about their health and welfare.

WEAKNESSES

- Communication by phone and mail lacks immediacy; materials can't be checked "on the spot."
- Clients might misplace a form or forget to send in required documentation.
- Use of the U.S. postal service opens the possibility of the mis-delivery of sensitive materials.

DIFFICULTIES FOR CLIENTS

- Some clients may miss the personal contact they receive in face-to-face meetings.
- Communications between the client and agency take time.

DIFFICULTIES FOR STAFF

- Sometimes the client doesn't call back or follow up, necessitating multiple attempts at making contact.
- It is more difficult to assess a person's wellness over the phone than in person.

OBSTACLES FOR IMPLEMENTATION

None

ACTIVITY NOT SUITED FOR

- Clients enrolling for the first time (Initial application is too complex to do by mail or phone.)
- Anyone who has a severe and persistent psychiatric disability
- Individuals with limited literacy
- Clients living with people to whom they do not want to disclose their HIV+ status

IV. Outcomes

EVALUATION

- Communications with clients' HIV care doctors
- Client feedback
- Observation of client visits to agency and follow-up

EVIDENCE OF SUCCESS

- Participating clients over the last two years have stayed "100% connected" to their program benefits, the agency case manager, and their HIV doctor.
- Improved capacity of agency to identify and resolve barriers that clients face to regular medical care.
- Clients report a high level of satisfaction with the activity and say that it makes renewal easier and less time-consuming for them.
- Clients also report less frustration in program renewal when the case manager is part of the process.

UNANTICIPATED BENEFITS

- Cost savings in gas and travel expenses for both the client and the agency
- Because clients often discuss their care issues and concerns more openly with case managers than with the medical providers, the case managers can address problems the medical doctor may not be aware of.

"CONNECTING TO CARE" ELEMENTS OF ACTIVITY

- Establishes a human connection between client and case manager
- Facilitates clients' realization that the agency is there to help them
- Enables clients to maintain privacy in their community
- Eliminates long distance as a barrier to renewal
- Leads to regular contact between the case manager and clients which helps clients to establish and maintain a continuous relationship with health care
- Establishes a trusting relationship between agency and client which benefits agency efforts to address the client's other care-related issues

KEEP IN MIND...

- It is important to be clear and concise with clients and to frequently ask if your explanations are understandable.
- Clients don't always follow up right away, which can be frustrating, but it pays to be persistent.

THE HOUSING PLAN

7

The Housing Plan is an individual level intervention that permits a person living with HIV to evaluate their overall life conditions and priorities with respect to finances, housing, and health care. The key characteristics of the Housing Plan are: the identification of needs through a self-assessment tool; the listening skills, patience, and cultural sensitivity of the staff; the formulation of a client plan that contains both short- and long-term goals; and a schedule for the achievement of desired outcomes.

CURRENT ACTIVITY SETTING
University Medical Practice Association, Housing Intake Assessment

- ✔ Directly links the client to medical care
- ✔ Gets the client in a conversation about starting medical care
- Brings the agency closer to where HIV+ people are so that the conversation can begin

I. Description

OBJECTIVES

- To identify what the needs and difficulties of the clients are with regard to housing, finances, medical and mental health, and substance use
- To formulate a plan that will address the client's needs, both short- and long-term
- To help clients put HIV into perspective as a part of their life and to help widen their focus on current life needs

POPULATION SERVED

- HIV+ individuals with incomes at 50% of median income or less
- Caucasian, African American, Hispanic, Native American, and Asian men and women ages 25 to 44

ACTIVITY DESCRIPTION

The Housing Plan is a screening tool that engages low income HIV+ individuals living in rural areas in formulating a comprehensive plan to address their housing, financial, physical, and mental-health care needs. Additionally, the agency is able to use The Housing Plan to track changes in clients' housing and health conditions.

QUICK NOTES:

"If you want to engage the client in the process, you've got to be human and fully present—not like paperwork that's walking around."

— CASE MANAGER

Training and Implementation

- The agency hosts a statewide training for housing case managers on using a set of new housing-assistance forms, including The Housing Plan.
- Each case manager receives templates of the new forms to take back to their agencies.
- The agency also provides on-the-job training and technical assistance for managing the forms.

Housing Plan Scenario

- An HIV+ client identifies a need, or is identified as having a need, for housing assistance.
- The housing case manager invites the client for an hour-long intake meeting. In the first ten minutes, the case manager focuses on building a relationship with the client, emphasizing that any information the client shares is confidential including disclosure of HIV status.
- The case manager asks the client to talk about what is going on in his/her life.
- As the client begins to talk about home life, finances, HIV infection, personal relationships, and changes in employment, the case manager listens attentively.
- S/he then asks if the client is seeing a doctor or is keeping up with medical appointments. When needed, the case manager will make an appointment for the client to see a medical professional.
- After this initial conversation, the case manager opens the client's file and suggests they complete the necessary paperwork together.
- First, they complete the intake assessment form to document the client's demographic information and clinical indicators, including CD4 count and viral load.
- The case manager then introduces The Housing Plan with a one-page "assessment for assistance" form. S/he explains that The Housing Plan forms ask the client to describe their full life situation. This portion of the meeting takes about 45 minutes.
- The case manager reads the questions to the client and writes down the responses. The assessment form opens with questions that include: What situation or event has led you to needing short-term assistance? When did this need begin?
- It also asks the client to think about steps to take toward securing stable housing and how to manage their housing independently.
- As the client answers the questions, the housing case manager helps the client commit to reachable goals whose outcomes can be measured. Some of the key questions are:
  - How long do you need housing assistance and why do you need it now as opposed to last month or the month before?
  - What are you doing to increase your income, reduce your housing expenses, or improve your situation, so you will not need this assistance?
- These questions often lead clients into conversations about health care. The case manager may respond by making referrals to resources in the community.
- When the plan is complete, the case manager asks the client to read it, make any desired changes, and sign it. The forms then go into the client's file, and the case manager supervisor receives copies.
- The case manager and client then complete other forms (applications for benefits, release of liability and obligation, income verification, etc.).
- When the client file contains all the necessary paperwork, the case manager submits it to the supervisor, who makes housing-assistance determinations.
- To arrive at an appropriate determination, the supervisor considers these key questions: Has the case manager helped to motivate the client? Is the client truly engaged? Are there habits the client could change to help with housing and health? The supervisor also consults the housing plan and assessment forms for background on the client's situation.
- In addition, the supervisor may ask follow-up questions of the case manager or ask him/her to seek additional information from the client so that The Housing Plan is more complete.
- When the supervisor has arrived at a decision, s/he tells the case manager what type of housing assistance the client will receive.
- The case manager informs the client of the decision over the phone or via letter.

Housing Plan Follow-Up

- The case manager has contact with the client on a quarterly basis, either in person or over the phone, to help the client progress in their action steps and to take care of other needs, such as health care.
- If the client returns for additional housing assistance, the case manager and client will review the housing plan to measure the client's progress against the action steps in the plan.
- The client revises or updates The Housing Plan annually or whenever there's a change in the type of housing needed or other life changes that affect the plan (e.g., beginning substance use treatment or moving from short- to long-term housing).
- Each year, the plan is reviewed, and approval for further assistance is determined. The supervisor reviews the new housing plan, compares it to former plans, and makes an assessment of the client's progress.
- When a client's housing assistance approaches its end, and the client is exiting the program, the case manager will place a reminder phone call to invite the client to come in for an exit interview.
- At the exit interview, the case manager and client complete a "termination of assistance" form, which asks the client what they will do when the assistance ends. This form and the client's housing plan are then kept on file.
- The case manager will follow up quarterly with the client to keep abreast of the client's progress, assess medical and psychosocial needs, and inquire about the client's housing situation to ensure that it remains stable.

PROMOTION OF ACTIVITY

- Professional information networking between housing case managers, medical case managers, and service providers
- Brochures and information available at case management services and medical clinics
- Word of mouth

II. Logistics

STAFF REQUIRED

- Housing case manager to update clients on housing awards, and maintain client files and database
- Case manager supervisor or program coordinator to review and approve awards and to analyze and report on statistics

TRAINING & SKILLS

- It is important that the housing case manager demonstrate a genuine interest in their clients.
- The staff must have knowledge of the range of psychosocial and health care needs of HIV+ individuals.
- The case management staff must understand the vocabulary of the housing profession and participate in housing assistance training.
- Good interviewing skills are important, as are active listening skills, patience, and cultural sensitivity.

PLACE OF ACTIVITY

The activity takes place in the client's home, a clinic, or at any of the agency's case management sites. The room must be private and have seating for the client and case manager.

FREQUENCY OF ACTIVITY

The renewal process and The Housing Plan development occur annually or when there is a change in the life situation of a client that affects their housing.

OUTSIDE CONSULTANTS

None

SUPPORT SERVICES

- Transportation to meetings with housing case manager
- Translation of the housing plan into any language spoken by the client community

CONDITIONS NECESSARY FOR IMPLEMENTATION

- The client must be a willing participant.
- Clients need to get past embarrassment or the idea that they should leave this type of assistance "for people who really need it."

III. Strengths and Difficulties

STRENGTHS

- The Housing Plan encourages clients to "think and do" as a way of bringing about changes in their lives and helping to stabilize both their housing and health.
- The activity helps clients identify gaps and needs in their lives, look for solutions, and take action.
- Clients receive the same message from everyone in their health care network, which facilitates a non-fragmented care strategy and builds teamwork among the network's staff members.

WEAKNESSES

Some clients just "go through the motions" without making changes in their lives.

DIFFICULTIES FOR CLIENTS

- Some clients have a "fear of change."
- It can be painful for clients to admit in this detailed and signed housing plan that they have done something to "hit bottom." The Housing Plan as a tool tells the client that they "need help."

DIFFICULTIES FOR STAFF

- There is an inconsistent level of commitment by housing case managers to spending time on The Housing Plan.
- Staff often has a heavy caseload; it can be difficult to arrange travel and time to meet the most remote clients.

OBSTACLES FOR IMPLEMENTATION

None

ACTIVITY NOT SUITED FOR

N/A

IV. Outcomes

EVALUATION

- Client Quality of Life Surveys
- Client reports and feedback

EVIDENCE OF SUCCESS

- Client Quality of Life Surveys show that 91% of clients report they "are better able to manage their lives because of the assistance."
- In client reports, 70% of clients note experiencing "less stress." The number of people who "lost sleep because of bills" decreased by 50%.
- Clients report that developing the plan helps to put HIV in perspective. It's not just because they're HIV+ that they need assistance; it's because of their overall life situation and environment.
- After participating in the activity, 92% say that management of their health care has improved.
- More clients request transportation to medical appointments (among other services), which shows that clients' basic needs are getting met so that they can take care of the next level of their needs.
- Clients who missed a medical or other appointment because they lacked transportation decreased by 46% after the implementation of the new housing plan process.
- More clients need only short-term, as opposed to long-term, housing assistance.
- Seventy to 80% of the clients fulfill the action steps of their housing plan.
- Client feedback indicates that the completion of a housing plan helps them seriously think about their housing, psychosocial conditions, and life situations and take some form of action.

UNANTICIPATED BENEFITS

- Because the activity helps staff members to stay aware of a "reality of life" that they might not otherwise be connected to, it keeps staff grounded.
- It gives staff an appreciation for other people's circumstances.
- The development of a housing plan establishes a relationship between people who take care of clients and experts in the discipline. The activity builds a strong team among case managers.

"CONNECTING TO CARE" ELEMENTS OF ACTIVITY

- The plan allows clients the opportunity to seriously think about their housing, psychosocial conditions, and life situations, and to take some form of action.
- The plan identifies service gaps that are more prevalent in rural settings.
- The process makes clients feel they are not alone.
- It puts focus on things other than being HIV+.
- It's as simple as someone taking the time to sit down and talk with a client. It forces people to slow down and communicate.

KEEP IN MIND...

Be sensitive that a client who comes to us has "hit the bottom" when they request this type of service.

Notes page

Rural

HIV MINISTRY EMERGENCY SHELTER

8

HIV Ministry Emergency Shelter is a community level intervention that aims to meet the basic physical needs of its clients. The shelter is able to offer individuals housing and greater access to health and social services by increasing the involvement of local church congregations in HIV related service. The key characteristics of the HIV Ministry Emergency Shelter are: the education and promotional outreach to the local faith community; the church database and training created for shelter volunteers; the "drop-in center" where medical, psychosocial, and spiritual support needs are addressed; and the compassion shown to all shelter clients.

CURRENT ACTIVITY SETTING
Christian HIV Ministry, Outreach

- ✔ Directly links the client to medical care
- ✔ Gets the client in a conversation about starting medical care
- ✔ Brings the agency closer to where HIV+ people are so that the conversation can begin

I. Description

OBJECTIVES

- To provide temporary shelter and care to homeless people
- To help HIV+ and HIV- people stabilize their life situations in order to access health care services, job opportunities, and permanent housing
- To introduce community churches and their congregations to HIV service through emergency shelter volunteer work

POPULATION SERVED

- Men, women, and children of any racial, ethnic or religious background in need of emergency housing
- HIV+ residents of rural areas in need of emergency or temporary housing
- Community church leaders and local congregations who offer volunteer services

ACTIVITY DESCRIPTION

The HIV Ministry Emergency Shelter uses volunteers from the greater faith community in a rural area to support individuals in securing stable housing, employment, and health and social services. In doing so, it is able to involve a greater number of residents in HIV related issues.

QUICK NOTES:

"People in this area are much more comfortable with homelessness than HIV."

— DIRECTOR

Development and Implementation

- The ministry creates a taskforce that includes pastors from the area congregations most affected by homelessness and poverty.
- Then, it creates an advisory board for the shelter, which includes a school teacher, a real estate agent, two social workers from community service providers in the area, ministry staff, and owners of construction companies.
- The taskforce secures space for the shelter and donations from construction companies to begin renovations.
- A public meeting follows to inform community members of the vision and upcoming plans for the shelter; to solicit donations of money, supplies, and time; and to invite partnerships with local service providers.
- The taskforce holds an open house for members of the local chamber of commerce to encourage their involvement in the emergency shelter.
- It is determined that the shelter will provide emergency housing (one to seven days) and transitional housing (one week to six months). The latter requires clients to seek employment and to meet with a case manager to help plan for stable housing.

Volunteers and Training

- A database of all the churches in the area is developed, and church leaders are contacted and invited to participate.
- At each participating church, a "volunteer team leader" is identified to organize the church's volunteer staffing and schedule.
- The ministry develops a training that covers the objective of the shelter and its policies, values, and procedures in handling client referrals. In addition, an HIV training "short-course" is developed to ensure that volunteers have a basic understanding of HIV infection.
- A one-year schedule is developed. Each participating church staffs the shelter for a period of four weeks. The churches' volunteer team leaders organize their members to ensure necessary coverage.
- Volunteers work out between themselves the delegation of responsibilities.
- They welcome first-time clients at all hours and record client needs every night in a log book. The volunteer team leader prepares a weekly, team-log summary for the ministry.

At the Shelter

- When a new client arrives at the shelter, a volunteer invites him/her to the intake office to determine the appropriate housing option and to complete the intake forms. Information is collected on the client's medical conditions and medications.
- The client also signs a release of liability form and, if the client wants the shelter's help in finding other social services, a release of information.
- If other services are needed, the volunteer invites the client to go to the ministry's "day drop-in center" the next day to speak with a case manager or other staff.
- A hospitality volunteer offers the client toiletries and clean clothes and clean bedding.
- The client signs up on the shower, laundry, and chore lists.
- Volunteers prepare and serve dinner at 6:30 p.m., and lights go out at 10:00 p.m.
- At 6:30 a.m., the volunteers wake the clients for showers and lay out breakfast and supplies for clients to pack their own lunches.
- If a client visits the ministry's day drop-in center, housed in the same building as the shelter, they can request such services as pastoral care (spiritual counseling and prayer), referrals to area social-service providers, HIV testing, and support for HIV care.

HIV+ Client Scenario

- At the drop-in center, an HIV+ client may disclose their HIV status to a staff member who then begins a conversation with the client about care. All ministry staff members have HIV training and can provide emotional and spiritual counseling and support.
- The client meets with the case manager, who helps the client obtain medical care and social services (e.g., nutritional services, mental health care).
- The case manager makes appointments with an established HIV specialist and an HIV case manager in the nearest metropolitan area. The case manager then arranges transportation for the client to the appointments.
- The HIV case manager in the metropolitan area signs the client up for entitlements.
- Ministry staff supports clients by accompanying them on their first few appointments and, when appropriate, explaining information that the clients receive.

- The case manager keeps in close communication with the HIV specialist to address any issues that may prohibit the client from staying in care.
- Ministry staff logs client appointments on a master appointment calendar and reminds clients of upcoming medical visits.
- Clients stay in the shelter's transitional housing program until their lives stabilize, their health indicators improve (weight gain, higher CD_4 counts), and they find a source of income and permanent housing.
- Once a client leaves the shelter, a staff member completes a "date of exit" form which documents the client's future plans (for employment, type of housing, etc.).
- Agency staff works to maintain a relationship with the client, making sure the person has the support and assistance necessary for a smooth transition out of the shelter. Often, HIV+ clients who leave the shelter stay connected to ministry staff to "give something back" and to find continued emotional and physical support.

PROMOTION OF ACTIVITY

- The taskforce advertises volunteer trainings in the local paper, church bulletins, and through phone calls to church leadership.
- It is promoted at community events and fairs and as a part of the ministry's outreach to college chapels, area churches, and Christian radio broadcasts.
- Community organizations and health care providers—particularly the HIV specialist in the nearby metropolitan area—make referrals.
- The ministry hangs posters at truck stops, gas stations, police stations, and other public places.
- The ministry's number and address are listed in the phonebook.

II. Logistics

STAFF REQUIRED

- Two volunteers per night to complete intake process with new clients, orient them to the shelter, prepare meals, provide oversight, and make referrals to case manager and other ministry staff
- Volunteer team leaders to coordinate volunteer schedules, raise money to buy food for meals, and troubleshoot volunteers' problems
- Case manager

TRAINING & SKILLS

- The staff and volunteers must have the skills and ability to communicate and build a trusting, non-judgmental relationship with a client.
- All staff and volunteers must show compassion and have a desire to serve the community.
- Staff and volunteers must have basic understanding of HIV infection—an HIV training "short-course" is offered by the agency.

PLACE OF ACTIVITY

The emergency shelter and the ministry offices share a 3,000 square-foot building in a small, rural town.

FREQUENCY OF ACTIVITY

- Everyday, 365 days per year
- Clients are housed for periods ranging from one day to six months.

OUTSIDE CONSULTANTS

Community taskforce

SUPPORT SERVICES

- The ministry arranges interpreters for clients who don't speak English by enlisting available volunteers from local social-service or church organizations.
- The ministry provides transportation for clients to get to social-service and medical appointments.

CONDITIONS NECESSARY FOR IMPLEMENTATION

- There must be a general "community-mindedness" locally.
- The community must have an existing culture of church volunteering.
- A positive relationship must exist between community churches and the agency. Ministry must be built on mutual respect and a willingness to "task together" for a common goal.
- The principal staff should have a calling to this work.
- The people involved in the initiation of the activity must have a "pioneering spirit" that enables them to get past potentially negative responses from the community about the opening of a shelter.

III. Strengths and Difficulties

STRENGTHS

- The activity meets clients' immediate need for housing and gets people out of a crisis situation so they can begin to address other life and health needs.
- It offers a safe place for HIV+ individuals to discuss and think about their needs. Clients can identify different types of needs—medical, mental health, housing—in a way that places their experience with HIV within a larger picture of their life and offers a holistic approach to their care.
- The staff invests time with each client which allows more personal relationships to form, and this helps the staff to better understand and meet the needs of each client.
- Because the shelter involves many people in the community, it doesn't place an undue burden of time or money on any one person.

WEAKNESSES

- Some people may not want to go to a shelter that is housed in a Christian ministry.
- Some clients need more purposeful and organized mentoring than the staff or volunteers can provide.

DIFFICULTIES FOR CLIENTS

- Clients don't have much independence. They must adhere to many rules.
- Clients sometimes don't like to be held accountable for the performance of certain tasks, such as daily chores or for following shelter service requirements.
- Some clients want more access to transportation.
- HIV+ clients are housed with HIV- clients, which makes the decision to disclose more difficult.
- If a client dislikes a staff member, it can cause problems for everyone involved.
- Many clients who have been living in the residence for five to six months begin to want fewer rules and restrictions.

DIFFICULTIES FOR STAFF

- The day-to-day organization of the shelter can be complex and fraught with "issues" that must be addressed by the staff.
- It is hard to keep ministry staff members longer than two years because they are unpaid.
- There are volunteer church members who have little or no experience with HIV, homosexuality, drug use, homelessness, and related issues. As a result, some may have pre-conceived ideas or prejudices. They may find it challenging to work with the shelter's diverse staff, volunteers, and clients.

OBSTACLES FOR IMPLEMENTATION

It can take a long time to obtain community acceptance of a shelter in a rural community.

ACTIVITY NOT SUITED FOR

- Clients who are actively using substances, because they may disrupt other residents who are in recovery from substance use
- Individuals who have a history of serious and long-term psychiatric disorders.

IV. Outcomes

EVALUATION

- Volunteers complete intake forms for client files, which document demographic information, medical conditions, medications, and mental health issues.
- The case manager meets weekly with each client in transitional housing to help each organize a personal budget and achieve health and life goals.
- The case manager keeps in close communication with the nearest HIV specialist, and appointments are logged on a master appointment calendar that helps keep track of the number of client visits to providers.
- Once the client leaves the shelter, a staff member completes a "date of exit" form which documents the client's departure date and future plans (place of employment, type of housing, etc). This form is then added to the ministry's client files.

EVIDENCE OF SUCCESS

- Client case files document people making changes in their lives while at the shelter. Examples of these changes include reconciling with family and friends, entering 12-step programs or substance abuse programs, meeting community service commitments, obtaining employment, and successfully linking to social and medical services.
- After spending time in the shelter and linking to different health services, clients report a return of their "dignity and self-worth."
- According to the client case files, an increasing number of clients come to the homeless shelter, disclose their status, and link to medical care with an HIV specialist in the nearby metropolitan area.
- The clients who link to HIV care services continue the care during their entire stay in the housing program.
- There is a steady increase in the number of community church members who participate in the volunteer training.
- Where follow-up has been possible, agency records show increases in the CD4 counts of HIV+ clients in care.
- The agency served 175 clients in 2005. Thirty-three percent are now in permanent housing, 22% have jobs, and there is an increase in referrals and visits to the local HIV specialist.
- The agency staff has observed a greater tolerance within the community for the diverse client population, which is reflected in more donations, partnerships, and volunteers.

UNANTICIPATED BENEFITS

- The activity's community involvement has helped many "idle" churchgoers get involved in something that doesn't require too great a commitment of work or time.
- The generosity of community members, which is demonstrated in donations of money, time, and gifts, has created a "ripple effect" within the community.
- Because of the reputation of the shelter, people perceive the ministry as a safe and confidential place for clients and volunteers.

"CONNECTING TO CARE" ELEMENTS OF ACTIVITY

- The activity first meets the most basic physical needs of a person, opening the opportunity for a client's medical needs to be addressed.
- The ministry is the one central place in the community where an HIV+ person can go to connect with health services without having to disclose their status.
- Clients build relationships with the volunteer staff based on acceptance without judgment, and they feel safe discussing their care needs.
- The ministry's offices and drop-in center provide a safe and accessible place for clients to disclose their status and begin to look for medical care.
- Because many people in rural areas have a religious affiliation, the shelter's faith component encourages people to embrace and become involved in the activity.

KEEP IN MIND...

- You have to earn the right to enter someone's life before you can recommend care.
- Staff and volunteers should not proselytize.
- Be known in your community before you start this activity, and develop trust with community members: "Plant the seed before you harvest."
- Take time building relationships and acquaint yourself with what the community is already doing. Become a friend of city officials who will be important to running the shelter and meet with community organizations (e.g., the chamber of commerce, local business, community-based organizations, churches, etc.) that could be donors, supporters, volunteers, or employers for your clients.
- Network with local service providers and medical care providers to make sure you can work closely to meet the special needs of your clients.
- Try to keep relationships going with clients even after they leave the shelter.

Rural

FOOD PROCESSING PLANT OUTREACH 9

Food Processing Plant Outreach is a community level intervention designed to offer information about HIV and community medical care services in strategic venues within the workplace environment. The key characteristics of Food Processing Plant Outreach are: the positive and trusting relationship developed between the host corporation and agency; the targeting of new workers during orientation sessions and the general worker population during scheduled shifts; the agency staff's knowledge of the largely migrant community and their ability to communicate in the dominant language spoken; and the promotion of no-cost, no-discrimination HIV medical services offered in the community.

CURRENT ACTIVITY SETTING
Medical Clinic and Social Services Agency, Minority HIV Prevention Program

- ✔ Directly links the client to medical care
- ✔ Gets the client in a conversation about starting medical care
- ✔ Brings the agency closer to where HIV+ people are so that the conversation can begin

I. Description

OBJECTIVES

- To increase knowledge and awareness of HIV in the greater community
- To provide information about HIV in a workplace that employs a large percentage of the area's population
- To provide information to new workers during their initial orientation sessions and to the general work population during regular shift hours
- To inform workers about the care and services available at the local agency
- To help link people to health care services

POPULATION SERVED

- Migrant working populations living in rural communities
- Latino men and women who speak English and Spanish

ACTIVITY DESCRIPTION

Food Processing Plant Outreach allows agency staff to reach a large number of rural residents and to share with them information about HIV and the health care services available in their community.

QUICK NOTES:

"In HIV outreach work, have a big heart and be compassionate!"

— HIV PROGRAM COORDINATOR

Targeting of Outreach Location

- The agency identifies the food processing plants within the general area that employ the greatest number of workers.
- Then the agency identifies the appropriate contact at each plant's corporate office and sends a letter requesting permission to offer the outreach activity at the plant in question. The letter also outlines the agency's history and service portfolio.
- When approval is granted, usually after several rounds of communication with plant management, HIV outreach is scheduled during strategic points in the plant's operations: 1) during the orientation session for newly hired workers; and 2) at specified hours during the regular shifts for the entire work population.

Preparation

- The agency secures approval for bringing in and distributing materials to workers by contacting the person in charge of safety coordination at the plant (often a nurse).
- The person in charge of orientation contacts an agency outreach worker with details of the next new-hire orientation, including the date and time, the number of new hires expected to attend, and the amount of time allotted to the outreach (usually 15 minutes).
- The outreach worker prepares a presentation on agency services appropriate for an audience of new-hires who are also new to the processing plant culture. Bearing in mind that many new hires are overwhelmed by the amount of information they receive during orientation, the outreach worker plans a brief but friendly presentation that does not exceed the time allotted.
- Safe-sex packets are prepared for the orientation session. They include condoms, lubricant, a safer-sex information card, and the name and number of a case manager from the agency. The packets are left at the nurse's station or office.

Outreach Session at New-Hire Orientation:

- When the outreach worker enters the room where orientation is taking place, the plant's orientation trainer introduces him/her as someone from the community who has come to talk about health issues and available health care services.
- The outreach worker delivers the orientation in English, Spanish, or both, depending on the language preference of the group.
- The outreach worker introduces him or herself and, in briefly describing the agency, stresses the confidential nature of the services it provides. S/he communicates a "welcoming" and friendly attitude by saying things like, "I'm here to help you," and "I know you are new to the community." S/he informs the group of the safer-sex kits available at the nurse's office.
- The outreach worker lets the group of newly hired workers know that they can speak to him/her anytime during the course of their employment and thereafter, get more information on HIV, or set up an appointment for free testing or medical services.
- The outreach worker allows a few minutes for questions, then hands out pamphlets about the agency's services. Extra pamphlets are displayed in holders in the training room where employees can access them later.

Preparation for Outreach During Work Shifts

- The outreach worker and plant safety coordinator determine the outreach schedule, identifying the most useful days, times, and places for the outreach workers to be on the plant premises. It is important that the service in no way interfere with work productivity.
- Shift changes and cafeteria hours are usually identified as ideal times for outreach. Plant-floor exits and paycheck disbursement areas are usually identified as ideal locations. Coordination with other activities, such as free food events and health fairs, can be advantageous.
- The outreach worker e-mails the plant management informational posters to print and post around the plant letting the employees know when and where the agency will set up and be available.
- Each outreach intervention requires an education display board, pamphlets on HIV infection, information about testing and care services available at the agency, and promotional gifts such as pencils and pens.
- Two outreach workers staff the booth (usually a table with chairs) at the designated area. If the outreach workers do not speak both English and Spanish, they arrange for an interpreter to be present.

A Typical Scenario During General Work Shift Outreach

- A group of four or five women walks up to the outreach table, which is set up outside the plant cafeteria. "What are you doing?" they ask the outreach workers.

- The outreach workers explain who they are and tell the women about the services the agency offers, such as free HIV testing, medical care, and referrals to other community resources. One of the outreach workers hands each of the women a business card and a brochure.
- The outreach workers offer the group other materials they have at the table and ask the women if they would like to ask any questions about HIV.
- The outreach workers answer all the questions. The conversation lasts as long as the workers stay engaged.
- If an outreach worker senses that someone may want to ask a more personal question or that "something's going on," s/he casually takes the person aside for a more private conversation.
- During this conversation, someone might reveal a need for HIV testing or mention someone in the family who has been diagnosed with HIV or has unidentified health problems. The outreach worker encourages the person to follow up with a telephone call or by making an appointment at the agency clinic for testing, medical care, or more information. The outreach worker always stresses that the services provided by the agency are free.
- When a group visiting the booth returns to work, each member has a card with the outreach workers' names and telephone numbers, and the agency address. Over time, many men and women working at the plant start to recognize the outreach workers, trust them, and eventually ask for information.

PROMOTION OF ACTIVITY

- Food Processing Plant Outreach exists as part of the mandatory, new-hire orientation.
- The activity is promoted with bilingual (English and Spanish) posters appearing in locations throughout the plant, including the area where paychecks are distributed, the cafeteria, and on the door of the nurse's office. The posters advertise free testing and medical care.
- The consistent presence of the same outreach workers fosters familiarity among the plant workers who eventually feel free to speak to them about health issues.

II. Logistics

STAFF REQUIRED

- Two HIV outreach workers
- A translator or interpreter, as necessary

TRAINING & SKILLS

- The outreach workers have basic HIV training (i.e., Red Cross and state-funded HIV training) as well as counseling and testing education and training.
- The outreach workers must have an intimate knowledge of the community.
- The outreach workers must have an open, friendly, and caring approach and the ability to communicate simply, clearly, and discreetly.

PLACE OF ACTIVITY

- During new-hire orientations, the outreach is done in the training room.
- General worker outreach takes place in the cafeteria, at the work floor's exit, and in other areas of the plant with high personnel traffic.

FREQUENCY OF ACTIVITY

- New-hire orientation happens twice monthly, or as needed.
- General worker outreach takes place once every two or three months for two hours at a time.

OUTSIDE CONSULTANTS

None

SUPPORT SERVICES

Translation for languages spoken by workers at the plant but not by the outreach workers

CONDITIONS NECESSARY FOR IMPLEMENTATION

- In order for this activity to be successful, the agency must maintain a strong, positive relationship with the company and its plant management personnel.
- The activity should take place during full shifts at the plant in order to reach as many people as possible.

III. Strengths and Difficulties

STRENGTHS

- Employees can receive preliminary information and education about HIV and health care services without having to make a trip to the agency.
- The outreach workers' open, friendly, and caring attitude makes them very "approachable" to the workers.
- Because the outreach activity goes to a work location, it can reach men who might otherwise not seek care.
- The outreach workers are very observant: if they sense a person wants to talk more or is "keeping something inside," they are able to draw out personal issues by taking the person aside for a more individualized and private needs assessment.
- When plant employees see that someone from their own community is speaking about health, they recognize and begin to trust the person.

WEAKNESSES

- During new-hire orientation, the activity is "wedged" into an intense series of sessions, where the new employee may not be able to absorb very much information.
- During outreach to general employees, the outreach workers cannot speak to people for as long they would like, and the public nature of the space makes private conversations more challenging.

DIFFICULTIES FOR CLIENTS

- In the orientation, the new employee often feels anxious about a new job and receives more information than can be reasonably processed.
- It can be difficult for employees at the plant to get answers to all their questions or to get all the information they want about HIV because they are reluctant to raise personal issues in a common area.
- Some employees may feel that breaks in their shift schedules don't allow adequate time to talk with the outreach workers.
- Because of the difficulty in securing legal working papers for immigrant populations, some newly hired employees do not complete the entire orientation process and, therefore, are not linked to agency services through this activity.

DIFFICULTIES FOR STAFF

- Communication barriers for plant employees who speak languages other than Spanish or English
- The outreach workers cannot commit sufficient time to each employee.
- Plants in rural areas are often far apart, requiring outreach staff to drive long distances.

OBSTACLES FOR IMPLEMENTATION

- Some companies might not let outreach workers enter their plants. Some company personnel might be reluctant to get involved in HIV outreach, or might believe that HIV isn't present in their community.
- There is often a general reluctance among people to accept that HIV exists in their community.

ACTIVITY NOT SUITED FOR

N/A

IV. Outcomes

EVALUATION

- The agency keeps quantitative data on the number of people with whom staff has talked at outreach events at the plant, and the number of brochures and business cards handed out.
- The agency administers intake assessments to all new clients. Among many questions, it asks the referral source for new clients.
- The agency keeps records on client awareness of HIV status, number of HIV tests, and the number and source of referrals.

EVIDENCE OF SUCCESS

- The outreach workers receive positive feedback from the employees.
- The outreach workers report that employees at the plant begin to recognize them, trust them, and ask more questions about health issues related to HIV.
- A primary source of agency referrals is the food processing plant.
- Since the initiation of outreach work at the plant, HIV testing at the agency has increased by 100%.
- Employees who have participated in outreach report that family and friends with whom they have discussed agency services go to the agency to get tested or to ask for medical care referrals.
- Since the initiation of the outreach activity, there have been increases in the following: the number of phone calls requesting information for an HIV+ family member/friend, the number of visits to the agency, and the number of requests for agency services.
- The intake assessments for new clients at the agency reveal an increased community awareness of the agency's services and an increased use of medical services as a direct result of outreach efforts.
- The agency intake assessments report an increase in walk-in clients who were informed about the agency at their place of employment.
- Employees contact the outreach workers after plant visits to ask for more information or for appointments for particular health services. The outreach workers have documented an increase in the number of people who go to the agency for HIV testing or care after having spoken with them at the plant.

UNANTICIPATED BENEFITS

- Word of mouth referrals to people who do not work at the plants occur as a result of the outreach.
- The host corporation begins to trust the agency and recognizes its important role within the community.

"CONNECTING TO CARE" ELEMENTS OF ACTIVITY

- Workers understand that all the agency services are available at no cost, regardless of one's legal working status. Promoting free services helps to link certain immigrant populations who are accustomed to free health care in their country of origin.
- The male and female Latino working population receives HIV education and information about care services in Spanish.
- People don't have to go to an "HIV clinic" to receive initial health information; they receive it at work. The activity "comes to them," which allows the agency to reach people who may be initially afraid of going to any official health provider, particularly one that is associated with HIV.
- The outreach workers' open, friendly, and caring attitude makes them very "approachable" to the workers.

KEEP IN MIND...

- Be aware of the employees' different education levels and the cultural differences among them.
- Be prepared for the environment of the plant: the onsite activities of a meat packing and food processing plant can be difficult to witness. There are also strong odors associated with food processing that might pose difficulties at first.
- Hearing HIV information in one's own language is very important.

Rural

TRAVELING HIV CLINIC 10

Traveling HIV Clinic is an individual level intervention that is designed to provide HIV care to people in rural areas who would otherwise face challenges to accessing HIV specialty care. The key characteristics of Traveling HIV Clinic are: collaboration with a local case manager who is known and trusted within the community served; the expertise of the participating health providers; and consistency in the staffing and schedule of the traveling clinic.

CURRENT ACTIVITY SETTING
University Medical Center, Internal Medicine, HIV Program

- ✔ Directly links the client to medical care
- ✔ Gets the client in a conversation about starting medical care
- ✔ Brings the agency closer to where HIV+ people are so that the conversation can begin

I. Description

OBJECTIVES

- To provide consistent quality HIV specialty care in rural areas

POPULATION SERVED

- HIV+ individuals residing in rural areas

ACTIVITY DESCRIPTION

Traveling HIV Clinic regularly provides HIV expertise, health care, and social services to individuals residing in a rural area.

QUICK NOTES:

"There will always be problems—most of my clients don't believe like I want them to—but you have to work with people's constructs."

— HIV SPECIALIST

Planning

- A clinic identifies an agency in a selected rural area to host a team of HIV medical care providers who will travel there and set up a clinic on a regularly scheduled basis. The host should provide general (not HIV specific) health care and be well-used and respected by the target population.
- The clinic identifies a case manager in the selected area. This local case manager will work closely with the traveling HIV specialist team.
- A year-long calendar is set for the Traveling HIV Clinic, which will take place every six to eight weeks.
- The clinic staffs the HIV specialist team. The team should consist of at least one physician specializing in HIV care, one nurse, and a phlebotomist, a medical resident, and medical case manager. Additional staff can be considered depending on the types of services planned and number of patients expected.
- Services and supplies provided include: specialist HIV care; seasonal and chronic vaccines; HIV rapid testing; laboratory testing and analysis; nutritional supplements; dental care assessment; distribution of safer sex kits (condoms, lubricant, and information on proper use in Spanish and English); and other multi-lingual, HIV related information.
- The HIV specialist team builds a relationship with the local case manager. They communicate regularly, sharing information on individual patients' health and social service needs.
- A protocol is established for the local case manager to do the following: identify HIV+ individuals in need of the team's services, schedule appointments, ensure clients have transportation to the appointment, and sign up clients for benefits and entitlements to provide for basic needs.
- The local case manager creates and manages the schedule of appointments for each Traveling HIV Clinic. (The team is able to see approximately 30 patients per clinic.)
- When the team is not on location, the local case manager troubleshoots any medical or social problems. In the event of a medical emergency, the local case manager coordinates patient care with the local hospital's emergency room and medical providers.
- If a patient of the HIV team has an urgent medical need, the local case manager may facilitate, with the help of the HIV specialist, the ordering of lab tests at a local hospital. The results will then be available for review by the HIV specialist during the next scheduled clinic.

Preparation for the HIV Specialist Team's Clinics

- The host agency allocates one or two members of the nursing staff to work with the HIV team and to orient them to the site's resources.
- At the "home" clinic, a medical case manager reviews the patient appointments and generates a billing sheet for each patient. The billing sheets include insurance information and a stamp with five "reminder boxes," which the HIV team checks off to document that a service has been carried out.
- The medical case manager prepares the rapid HIV test kits for transport.
- S/he packs supplies for the traveling clinic, including pharmaceutical samples which, for the most part, cannot be provided through Ryan White CARE Act programs (e.g., Tylenol, medication for diabetes, hypertension, and opportunistic infections).
- The phlebotomist prepares the blood-drawing kit (dry ice, tubes, syringes, etc.).
- The morning of a clinic, the HIV specialist team meets at the transport site and loads the equipment and supplies on a small, private plane. The team flies to an airport near the host site where a van, arranged by the local case manager, meets them and brings them to the site.

Traveling Clinic Site

- An open, friendly tone is set for the clinic, and the host-site staff prepares cookies and tea for the waiting room.
- The host site's nursing staff conducts preliminary examinations, taking patients' weight, vital signs, etc. New patients have a complete intake and physical.
- The nurses prepare for the local case manager patient "shadow reports" which contain basic clinical information from each patient's medical file. The reports are then given to the traveling HIV specialist for further documentation.

- Patients are brought into each of the four examining rooms reserved for the activity. With the patient's permission, family members are invited into the examining room. Their presence allows the provider to learn more about the social and medical issues influencing the patient's health.
- When dividing up the appointments, members of the HIV specialist team work to ensure that patients see the provider they know best or have the best rapport with.
- During each appointment, a provider reviews with a patient his/her medical needs and current medications.
- The HIV specialist meets with patients as needed. For example, the HIV specialist might be "called in" to determine a course of action for a new patient, administer vaccinations, or write prescriptions. S/he fills out a lab ticket to request necessary laboratory tests and records all diagnoses on the patient's chart.
- The patient returns to the waiting room to see the local case manager and discuss other needs, such as public insurance, other entitlements, and nutrition.
- The phlebotomist will call patients into a separate room to draw blood for any lab tests that the HIV specialist has requested.

Follow-Up

- Once back at the home clinic, the phlebotomist transports the blood samples to a laboratory for analysis.
- The following work day, the medical case manager unpacks the bags and processes patient entitlement and insurance information to obtain compensation for the HIV specialist team's care services.
- The medical case manager reports the results of the lab tests to the patients by letter. Patients may also request to receive this information by telephone.
- The local case manager will arrange a relationship with a local primary care provider for any patient who does not have one. That way, each patient has a medical professional to see or contact between traveling clinics.
- Patients take any prescriptions they have received to a public or private pharmacy to have them filled. The pharmacist counsels the patient on adherence to medications.
- If a patient misses two appointments with the HIV specialist team, the local case manager places a call to encourage them to come in.

PROMOTION OF ACTIVITY

- Through AIDS Education and Training Centers, which provide HIV education to health care providers
- Word of mouth from patients and providers
- The local case managers inform their clients
- Local and state press

II. Logistics

STAFF REQUIRED

Clinic

- Physician specializing in HIV care
- Nurse
- Phlebotomist
- Medical case manager to coordinate the delivery of clinical care service and provide results of lab tests to patients
- Physician's assistant, medical resident, or other staff to provide selected services for the number of patients expected
- Licensed pilot of small aircraft

Outreach Site

- Local case manager to coordinate care, including psycho-social support, to help manage medical care benefits, to monitor patient health between traveling team visits, and to offer referrals to care providers
- Nurses (2 – 3)

TRAINING & SKILLS

- The local case manager must demonstrate persistence in follow-up with clients and possess social and clinical skills. This person must have knowledge of basic health assessment and the ability to recognize symptoms of HIV, and know what questions to ask and referrals to make.
- Medical providers must learn to work with each patient's unique situation and be open-minded and non-judgmental.

PLACE OF ACTIVITY

Donated clinic space with basic medical equipment and a room for every medical care provider at the designated host site location

FREQUENCY OF ACTIVITY

A clinic is held every six to eight weeks, from 11:00 a.m. – 5:30 p.m.

OUTSIDE CONSULTANTS

None

SUPPORT SERVICES

Interpretation services by bilingual (Spanish and English) staff at outreach site

CONDITIONS NECESSARY FOR IMPLEMENTATION

- The social and health service providers who staff the activity must be caring.
- The remote community must be willing to work with the service providers to ensure that the activity's objectives are met.
- State health departments, the medical community, and local community-based organizations must be able to achieve a high level of coordination in their efforts to bring HIV+ people into care.

III. Strengths and Difficulties

STRENGTHS

- Consistency in the delivery of care: the same providers visit the same place at regular intervals of time
- Quality of the medical care provided: expert HIV care is rare in rural areas
- High-level coordination between case managers and medical providers enables them to know each patient's particular situation.

WEAKNESSES

- As the activity grows, it becomes more difficult to raise sufficient funding.
- Lack of intensive care for the very sick; acute care is difficult to deliver to patients in rural areas
- Lack of staff specializing in substance abuse

DIFFICULTIES FOR CLIENTS

- The length of time between visits
- Distance of travel and problems scheduling reliable transportation
- Frequent inability for HIV team medical providers to be present in medical emergencies

DIFFICULTIES FOR STAFF

- Lack of local ancillary services (which are necessary for truly comprehensive care)
- Demands of work and travel schedule: it is exhausting and emotionally draining
- Risks of flying in a small aircraft
- Lack of substance-abuse and mental-health counselors on the team

OBSTACLES FOR IMPLEMENTATION

None

ACTIVITY NOT SUITED FOR

Populations with existing HIV specialist nearby

IV. Outcomes

EVALUATION

- The clinic surveys 25 randomly selected patient charts each month to assess clinical indicators (e.g., changes is CD_4 counts and viral loads) and the quality of medical care (i.e., how the HIV specialist fared in the delivery of the five required services).
- The medical case manager monitors clinical-indicator and quality-of-care trends in these surveys and discusses challenges with clinic providers.
- The outcomes of HIV+ women who are pregnant are tracked through a review of their medical charts, including their viral loads and CD_4 counts.

EVIDENCE OF SUCCESS

- The number of HIV+ people in continuous care has grown significantly over ten years.
- People receiving care from the HIV specialist team are living longer and healthier lives, which is attributed to the team's ability to identify and prescribe the best medications for each patient.
- CD_4 counts increase and viral loads decrease when individuals become patients of the HIV specialist team.
- Fewer infants with HIV+ mothers are diagnosed with HIV infection.
- People who move out of the clinic region often reconnect to care with other outreach clinics.
- Although some individuals stop using the traveling clinic when their health improves, they return when they get sick.
- A recent needs assessment survey found that patients of the HIV specialist team were "very happy" with their medical care and case managers.

UNANTICIPATED BENEFITS

- This activity provides the only opportunity for many patients to interact with HIV care providers and other individuals living with the disease. So it serves as a type of support group.
- Providers derive personal satisfaction from the work.
- Providers have greater awareness of the need to identify patients and refer them to the Traveling HIV Clinic.
- People in care do their own outreach and bring other people into care.

"CONNECTING TO CARE" ELEMENTS OF ACTIVITY

- The involvement of a case manager from the designated area serves as one of the activity's cornerstones and facilitates the building of relationships between the traveling HIV specialist team and their patients. The case manager is a familiar, trusted, and comforting presence because s/he is known, established locally, and engaged by the community in activities that are not HIV specific.
- The traveling clinic reduces travel time and expenses for patients and eases problems with scheduling transportation.
- It eliminates the apprehension of navigating through an unfamiliar and sometimes intimidating urban area.

KEEP IN MIND...

- This is not an easy task and it may be slow at first; persistence pays.
- It is important to establish a good relationship with the community as a whole and to provide services only where the community perceives a need.
- You may need to make an effort to help community members understand the need for your work.
- Use all of the funding streams, organizations, and other resources that the chosen community has to offer.
- Funding for a charter plane can be solicited from pharmaceutical companies or local universities. Pharmaceutical companies may agree to fund the plane if the activity offers "provider education" about pharmaceuticals and drug management.
- As an alternative, a car, van, or bus can transport the HIV specialist team.

CALL-IN RADIO PROGRAM "VIH Y COMMUNIDAD"

11

Call-in Radio Program "VIH y Communidad" is a community level intervention that offers information and education about HIV infection, promotes free medical care services available in the community, and engages members of the community in health care. The key characteristics of the Call-In Radio Program "VIH y Communidad" are: the pre-established popularity of the Spanish speaking station; the ability to reach a large, rural listening audience; the collaboration of surrounding county health departments; the interactive nature of the program; and the high level of cultural sensitivity and understanding for the targeted population.

CURRENT ACTIVITY SETTING
Medical Clinic and Social Service Agency, Health Education

- ✔ Directly links the client to medical care
- ✔ Gets the client in a conversation about starting medical care
- ✔ Brings the agency closer to where HIV+ people are so that the conversation can begin

I. Description

OBJECTIVES

- To increase knowledge within the greater community about HIV and other STDs
- To refer members of the Spanish speaking community to HIV testing and care services
- To stimulate members of the community to ask questions about HIV infection, transmission, testing, and medical care

POPULATION SERVED

- Heterosexual identified, Spanish-speaking individuals living in rural communities
- Spanish-speaking women working in their homes

ACTIVITY DESCRIPTION

Through Call-In Radio Program "VIH y Communidad," rural Spanish-speaking listeners receive compassionate, supportive health messages about HIV and medical care resources in the community.

QUICK NOTES:

"Listening to music is one of the few sources of fun that people in rural areas easily access and enjoy. Everyone can do it."

— HIV PROGRAM COORDINATOR

Needs Assessment and Initial Planning

- After identifying a Spanish-speaking radio program that often presents social issues important to the targeted community, the agency contacts the show's director.
- The agency's health educator meets with the director of the radio program. S/he discusses the mission and services of the agency and proposes using the radio program, which has a wide listening audience, to actively engage the community in conversations about HIV and other health issues.
- They discuss how the radio broadcasts can inform the Latino community about available health care services they may not be aware of. They agree to the development of a health-related program format for use in the established program.
- The director and staff of the radio station consider the production of the program and the advertisements that will promote the broadcast.
- The agency secures funding for the advertisements and enlists the help of technical assistants from other organizations in the community to design the content of the aired advertisements and the structure of the radio broadcast.

Development of Radio Program

- Agency staff and consultants design a pilot program. The pilot format includes basic information on HIV infection, the services the agency provides, and a question and answer session with callers.
- After the pilot program is aired, interest is generated in the community, and new themes are suggested by the listeners. In response, the agency expands the program content to create the following shows: 1) *Prevention Facts;* 2) *STDs;* 3) *Women, HIV, and Pregnancy;* and 4) *HIV Testing.* As a way to encourage listeners to get tested, radio staff undergoes testing in program four.
- After the program content is developed, the health educator, who will co-host the show with the principal host, establishes a schedule for the HIV shows roughly three months in advance. These "special" programs are often scheduled in observance of such events as National HIV Testing Day and World AIDS Day.

Standard Show Format

- Each of the four HIV programs airs live and is entirely in Spanish.
- The health educator arrives at the radio station one-half hour before the show begins and provides all of the radio program staff with copies of the program's general "script." A script, divided into program segments, might run as follows:

Segment One, 5-7 minutes

- The radio host opens the program and introduces the health educator as a regular guest, then plays an interlude of popular Latino music.
- The educator introduces the agency, briefly describing its mission and providing the telephone number and address. The educator tells listeners the show's topic and states the call-in number several times, inviting the listeners to ask questions and share comments. S/he then thanks the program's sponsor. Upbeat music plays softly in the background, and the health educator's tone is friendly and light.
- The program pauses for a music break.

Segment Two, 10 minutes

- The educator explains the history and services of the agency and its relationship with and presence in the Latino community.
- The educator then discusses in more detail the agency's HIV services, explaining the process for being diagnosed with HIV and what type of care is available to a person living with HIV. S/he emphasizes that people can receive services free of charge, regardless of economic or immigration status, and repeats the agency's address and phone number.
- The program pauses for another music break.

Segment Three, 30-35 minutes

- The educator restates the program topic and gives a presentation on it. Listeners are invited to call in and ask questions about anything s/he has covered.
- The station doesn't screen calls from listeners. They are answered by the radio program host and transferred to the health educator.
- Callers ask for clarifications, further details, verification of beliefs about HIV, and advice for themselves, their friends, or family members.

- At the end of the presentation, the educator summarizes his/her main points and closes with information on HIV in the region to help the community fully understand the need for regular HIV testing and care.
- The program breaks again for music.

Closing Segment: 5 minutes:

- Encouraging listeners to consider getting tested for HIV, the educator repeats that the agency offers free, confidential testing and medical services. Individuals who test positive are entitled to free care services from the agency. The health educator repeats the agency address and phone number.
- After some community announcements, the educator closes with a sound bite like: "HIV can be prevented, but it depends on us."
- The host of the program comes on the air to thank the health educator. The host then invites the listening audience to seek services at the agency.

PROMOTION OF ACTIVITY

- Advertisements announcing the HIV show are scheduled during the radio station's regular broadcasting hours.
- Agency pamphlets and brochures listing the services along with the radio show's FM-dial number and airing time are provided to local health fairs, local clinics, community organizations, and the 24 county health departments that, in turn, advertise the materials in their client spaces.
- The program's call-in number is repeatedly given while the show is on the air.

II. Logistics

STAFF REQUIRED

- Health educator to design and present the program as a guest host and to organize the scheduling and advertisements
- Radio host from the station to manage the equipment, open and close the show, and field calls

TRAINING & SKILLS

- The health educator must be fluent in Spanish and familiar with the different dialects of Spanish spoken by the listening audience.
- The health educator must have a solid knowledge of HIV infection, transmission, and clinical care.
- The health educator must be skilled at public speaking and have the ability to present often complex and sensitive or even "taboo" themes comfortably, in a culturally acceptable and comprehensible manner.

PLACE OF ACTIVITY

The activity takes place in a radio station that broadcasts to over 100,000 people within a 160 mile radius.

FREQUENCY OF ACTIVITY

Every two to six weeks, depending on local community events and holidays

OUTSIDE CONSULTANTS

Staff skilled in media technology collaborates in program design and advertisement development.

SUPPORT SERVICES

None

CONDITIONS NECESSARY FOR IMPLEMENTATION

- Radio stations that produce Spanish-speaking programs
- An existing radio audience

III. Strengths and Difficulties

STRENGTHS

- Because the program is broadcast in Spanish, it reaches an audience that may not otherwise benefit from educational information produced by English-speaking media.
- The activity has a high level of cultural sensitivity and understanding for the targeted population.
- The interactive nature of the program allows people to ask questions from the comfort and privacy of their home or work environment, which fosters more direct communication and the "safety" of anonymity.

WEAKNESSES

The health educator must be very familiar with the cultural taboos of the target audience, taking care to avoid certain vocabulary considered inappropriate by listeners (e.g., language about genitalia, explicit references to sexual acts).

DIFFICULTIES FOR CLIENTS

Given the diversity of the listening audience, there may be differences in people's understanding of the health terms and explanations used.

DIFFICULTIES FOR STAFF

The program doesn't take place frequently enough to capture all potential listeners.

OBSTACLES FOR IMPLEMENTATION

Some target communities lie outside the broadcasting range of the radio station.

ACTIVITY NOT SUITED FOR

N/A

IV. Outcomes

EVALUATION

- During client intake, all new clients are asked how they found out about the agency and its services.
- The HIV testing services are logged, and referrals to this service are documented.

EVIDENCE OF SUCCESS

- Because the program is interactive, listener comments are evidence that people are listening, are interested in the topic of the show, and are learning from the information presented.
- There is a recorded increase in community participation. Calls are steadily increasing, and more people are asking about HIV.

- The program reaches a wide range of the target community. Young, middle-aged, and older people participate in the call-in segment of the program.
- There is an increase in radio call-ins from HIV+ people and from affected family members asking about medical services for HIV.
- Listeners are increasingly asking more "informed" questions, and there is a need to increase the level of information offered during the program.
- Since the beginning of the broadcasts, organizations in the community have been requesting presentations about HIV for their staff and clients.
- From 2001- 2005, there was an increase (from 60 to 600) in HIV tests. Approximately 45% of those getting tested during this period said they sought testing as a result of the show. Forty percent of people tested continued to receive health care services from the agency.
- Agency intake assessments reveal increases in the people using care services who report learning about them from the radio program.
- Intake forms at the agency show that new clients bring their spouses into the clinic with them as a result of what they learned on the show.
- Clients are reporting that they are mailing information from the show to friends and families in their countries of origin.
- There is an increase in walk-ins for HIV care services by people who received information about the agency from the program.
- Approximately 20% of all new clients to the agency in 2005 reported that they were coming in for services as a result of hearing the radio broadcast.

UNANTICIPATED BENEFITS

Non-HIV-related agency staff reports that people are coming in for other services as a result of the HIV radio broadcast (e.g., child health and diabetes services).

"CONNECTING TO CARE" ELEMENTS OF ACTIVITY

- The activity uses listening to music, a popular past time for the target community, to make receiving information on HIV enjoyable.
- Allowing for questions and answers over the radio allows members of the community to get answers to their questions anonymously.
- The program helps people to feel more comfortable speaking about HIV and other health issues.
- The activity allows people to participate easily and anonymously. While it is difficult for many people in the rural Latino community to use medical services (due to distance, immigration status, and lack of insurance), the call-in part of the radio show provides a comfortable way for people to participate and become more involved in their own health.

KEEP IN MIND...

- There may be variations in the words and expressions used by different audience members to communicate about health.
- Keep the program content simple and speak clearly so that it can be easily understood by as many people as possible.

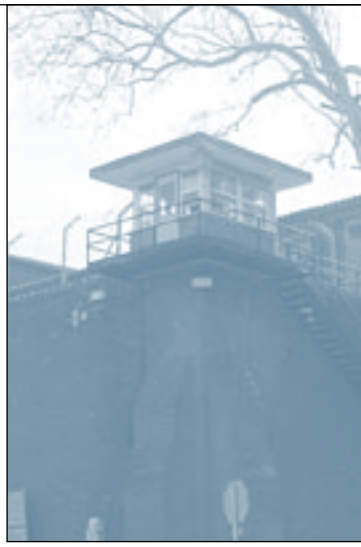
MEDICAL ADVOCATE DISCHARGE PLANNING

12

Medical Advocate Discharge Planning is an individual level intervention that aims to provide inmates nearing release with a plan for accessing medical and social services after discharge. The key characteristics of Medical Advocate Discharge Planning are: the compassion, dedication, and clinical knowledge of the discharge planner, who is also a registered nurse; the individualization of each interaction the discharge planner has with an inmate; and the trust that is built between each inmate and the discharge planner as they work together to ensure a healthy transition back to community life.

CURRENT ACTIVITY SETTING
Federally-Qualified Health Center, Medical Discharge Planning

- ✔ Directly links the client to medical care
- ✔ Gets the client in a conversation about starting medical care
- ✔ Brings the agency closer to where HIV+ people are so that the conversation can begin



I. Description

OBJECTIVES

- To ensure continuity of health care for individuals who are recently released
- To decrease the frequency of emergency room visits by formerly incarcerated individuals

POPULATION SERVED

- Soon-to-be-released inmates who have serious or chronic medical needs

ACTIVITY DESCRIPTION

Incarcerated individuals with serious or chronic health conditions see a medical advocate from a local community health agency who helps formulate a discharge plan designed to assist individuals in maintaining their health care while transitioning into community life.

QUICK NOTES:

"We're here to make change . . . gently."

— DISCHARGE PLANNER

Activity Preparation

- The medical discharge planner keeps a running list of inmates due for release in the next week or two.
- S/he reviews the medical records of the listed inmates, prioritizing any record that notes a history with chronic disease, HIV, substance use, sexual abuse, or mental disorders.
- The discharge planner consults a set of residential-assignment lists to locate the units where the inmates she needs to see are housed. S/he meets with each of them in their respective units at least three days before they are discharged.

Introductory Visit

- The medical discharge planner meets face-to-face with each of the high priority inmates first. During introductions, s/he gives the name of the sponsoring clinic.
- Then, the discharge planner asks if the inmate knows their date of discharge. If not, s/he tells the inmate the release date.
- S/he and the inmate discuss the inmate's medical needs. In this exchange, the discharge planner asks if the inmate is receiving appropriate medications and inquires about the medications' effectiveness. They also discuss nutrition as a part of general medical care.
- S/he continues with a "mini-depression screening." When necessary, s/he makes a direct referral to an organization providing mental health services in the jail.
- The discharge planner then goes over the inmate's options for clinical care after release and asks the inmate's preference.
- Once a clinic has been identified, the discharge planner explains how the inmate can access health care services at that clinic.
- S/he asks the inmate about insurance. If the inmate has none, the discharge planner discusses publicly-funded sources of health care coverage.
- S/he also helps the inmate fill out applications for food stamps and local food banks.
- When the applications are complete, the discharge planner shifts the conversation to changes that the inmate could experience post-release and how such changes can be managed.
- The discharge planner writes a clinic referral, attaching a list of the identified medical needs. For an inmate who is either pregnant or co-infected with HIV and Hepatitis C, s/he writes a referral to an appropriate specialty clinic that provides comprehensive services in one place.
- S/he usually offers to notify the clinic that the inmate will soon be in touch. In some instances, s/he offers to schedule the first appointment for the inmate.
- Before ending the visit, the discharge planner asks, "Have I answered all of your questions?"

Follow-up Visit

- The inmate and discharge planner have one follow-up visit, which occurs right before the inmate's release.
- The discharge planner goes to the facility's holding area on weekday mornings to follow-up with any inmate who has begun the discharge planning process.
- S/he makes sure each inmate has their medical paperwork, including referrals, the health insurance numbers for their city and state, information on the clinic they have chosen, and the name of the doctor they will see.
- While in the holding area, the discharge planner may also have first-time visits with other inmates. Meeting them one-on-one, the discharge planner identifies a clinic near their respective homes and provides them with some basic information about its services.
- These visits are confidential. The discharge planner does not have to report any of the information discussed to the correctional staff.

Tracking Linkages to Care

- After each day of inmate visits, the discharge planner returns to the agency and enters inmate data, including the referrals made, into a computer database.
- Also, the discharge planner completes a summary sheet for each of the inmates she or he visited that day, including their demographic information, diagnoses, and the medications they are taking.
- This summary sheet is forwarded (by fax) to providers at the clinic where the inmate will be seen as a patient. When the inmate has followed up on a referral to a health provider, the discharge planner enters it into the agency database.

Advocacy Work

- In addition to helping inmates create a post-release plan, the discharge planner assists inmates who are having difficulty accessing health care services within the correctional facility. As a medical advocate, the discharge planner works with the correctional facility personnel to make sure the inmates get the care services and medications they need. The discharge planner also meets with the Department of Health's HIV Administration, the correction facility's mental health staff, other service providers working in the jail, and the deputy warden to discuss special concerns with inmate health and to advocate for individuals who need medical attention.

PROMOTION OF ACTIVITY

- Word of mouth within inmate population and from discharge planner
- Orientation program for new inmates
- Clinic pamphlet
- Clinic advertisement in a resource handbook distributed to inmates

II. Logistics

STAFF REQUIRED

- Medical discharge planner
- Medical assistant to help with administrative work, including the preparation of health-information packets for inmates and visits to inmates when the discharge planner is not available

TRAINING & SKILLS

- The medical discharge planner must be a registered nurse.
- Staff should have the following: an ability to draw out critical medical and personal information from an individual in a limited amount of time, a non-judgmental disposition, the ability to express compassion without "enabling" negative behavior, a willingness and capacity to be very flexible, a confident and "fearless" attitude in the correctional facility, and knowledge of HIV infection and transmission.

PLACE OF ACTIVITY

- A private corner in each correctional unit, with two chairs
- Sometimes, if the inmate's mobility is restricted, the activity takes place in the inmate's cell.

FREQUENCY OF ACTIVITY

- Available to male inmates on weekdays from 8:00 a.m. - 5:00 p.m.
- Available to female inmates two times per week

OUTSIDE CONSULTANTS

None

SUPPORT SERVICES

Bilingual (Spanish and English) translators

CONDITIONS NECESSARY FOR IMPLEMENTATION

- This activity must have backing from several sources:
  - The correctional facility in which the activity takes place;
  - The government at all levels, including the Office of the Mayor;
  - The clinic's full staff;
  - Community organizations, such as medical providers, faith-based groups, and agencies for the homeless.

III. Strengths and Difficulties

STRENGTHS

- The discharge planner's delivery of compassionate care
- The activity's ability to coordinate the efforts of government agencies with medical providers and non-profit, faith-based, community, and mental health organizations

WEAKNESSES

The demand for services overwhelms the capacity of providers to supply them.

DIFFICULTIES FOR CLIENTS

- Limited access to medical discharge planning services. At least six percent of the inmates released are never seen by the discharge planner.
- Not enough privacy during discharge planner visits
- Doesn't include the securing of post-release housing

DIFFICULTIES FOR STAFF

- Staff is unable to meet the demand for services.
- The correctional facility lacks education on preventive care.
- Some inmates do not show a "proactive attitude" in seeking out care.

OBSTACLES FOR IMPLEMENTATION

A lack of much-needed services for housing, substance abuse treatment, and treatment for the sexually abused can make it difficult for individuals to follow through on their discharge plans.

ACTIVITY NOT SUITED FOR

N/A

IV. Outcomes

EVALUATION

- The clinic stores and reviews patient information in a database.

- The clinic tracks the number of patient visits to a service provider and the location of visits.
- Every month, the clinic prepares a report on the number of people served by the activity, the top five diagnoses, and which former inmates met with service providers after their release.

EVIDENCE OF SUCCESS

- Correctional officers ask questions about the service's methodology, like, "How do you get them to talk to you?" Their questions suggest the discharge planner has earned the inmates' confidence and trust.
- Service provider feedback reveals that inmates who meet with the discharge planner bring others to their care visits.
- Community stakeholders report that trust has grown between this clinic and other agencies, because the clinic helps to communicate the individual health needs of the inmates to health care providers in both the correctional facility and the community.
- Preliminary data indicate an increase in the number of inmates who visit service providers after release, and a decrease in the number of visits that each makes to emergency rooms.

UNANTICIPATED BENEFITS

- This activity helps people to gain access to medications.
- It facilitates the building of relationships between community and government agencies.

"CONNECTING TO CARE" ELEMENTS OF ACTIVITY

- Care decisions rest with the inmate.
- The discharge planner attends to each inmate individually.
- Because the discharge planner does not work for the corrections system, it is easier for inmates to have trust and confidence in her or him.
- The staff shows true dedication in linking people to appropriate care.
- Discharge planning ensures that at least once during an inmate's incarceration someone has listened without judgment and offered to help.
- The activity receives support from many in the city health department and department of corrections, and in the correctional facility—from its director to its front line workers.

KEEP IN MIND...

- The activity cannot be performed without third-party reimbursement, so Ryan White CARE Act programs are important to the activity's success.
- The sponsoring agency should attend community events and meetings and also become recognized in the correctional system as a team player.
- It is essential to have support at all levels of the correctional facility's hierarchy.
- Learn what the needs are of those in charge of the correctional facility and offer to help meet them.
- Help the correctional facility see the positive effects of the program.

Notes page

RAPID HIV TESTING AT JAIL INTAKE

13

Rapid HIV Testing at Jail Intake is an individual level intervention that offers individuals, on a volunteer basis, an opportunity to learn or "re-learn" their HIV status while being detained in a correctional facility. The key characteristics of Rapid Testing at Jail Intake are: the inclusion of a conversation about HIV during the general medical intake process; the non-invasive nature of the HIV screening test; the incentive packages provided to encourage greater participation; the individual attention inmates receive from counselors; and the opportunity to link promptly to care.

CURRENT ACTIVITY SETTING

Community-Based Medical and Counseling Services Agency, HIV Prevention and Education for Inmates and Ex-Offenders

- ✔ Directly links the client to medical care
- ✔ Gets the client in a conversation about starting medical care
- ✔ Brings the agency closer to where HIV+ people are so that the conversation can begin

I. Description

OBJECTIVES

- To provide voluntary HIV screening services to individuals housed in a local correctional facility
- To help build HIV awareness among underserved, incarcerated populations
- To provide people previously diagnosed with HIV who are not in care with the opportunity to become "newly aware" of their status in a setting that offers direct access to medical care

POPULATION SERVED

- Detainees entering a local department of corrections facility

ACTIVITY DESCRIPTION

Incarcerated individuals who may or may not be aware of their HIV status have access to non-invasive, rapid HIV screening, subsequent counseling, and direct links to medical care.

QUICK NOTES:

"At one time, inmates didn't even want to be seen with us HIV screeners. But now, they know us and call out, 'Hey, how do I get tested?"

— PROGRAM DIRECTOR

Development

- The agency collaborates with the correctional facility's intake department, medical unit, mental health unit, and the appropriate department of corrections staff to coordinate the activity's logistics.
- An agreement is reached on which phase of the intake process the counseling and testing will take place and on the location of the activity, which must be in proximity to the other medical exams being performed during intake.
- The agency and mental health unit of the facility ensure that a mental health professional is available during testing times to provide counseling to inmates being tested, especially those receiving HIV diagnoses for the first time.
- The agency determines the incentives to be offered to individuals volunteering for testing and receives the facility administration's approval of the items. An incentive package might include condom(s) and brand name hygienic items to which individuals do not have ready access during incarceration.
- The agency assigns staff roles, determines who will present the incentives to the inmates, who will escort them to the testing room, and who will perform the tests and counseling sessions.
- Final logistics are discussed with and approved by the medical team and intake staff.

Implementation

- Each day, the agency learns the number of inmates entering the facility to determine the number of incentive packages that will be needed. The incentive items are placed in clear plastic bags.
- Inmates are seated in the facility's medical intake holding area as they wait to complete the facility's required medical examinations.
- An HIV screener from the agency enters the medical intake holding area, introduces him or herself to the inmates, displays the incentive packages, and explains that anyone who voluntarily wishes to be screened for HIV will receive one.
- The screener describes the test process, stressing that it is a "non-invasive mouth swab," to eliminate fears associated with blood drawing.
- The HIV screener enters and asks for volunteers, who hand their medical intake card to the screener.
- Using the intake card to identify the volunteers, the screener escorts the inmates, one by one, to a confidential counseling and testing room.
- The HIV screener then begins the pre-test counseling process, first describing how long the process will take, then the confidentiality of the test and what the test entails. Continuing, the screener explains the possible results, the circumstances for a confirmatory test, and the questions volunteers will be asked during the screening. In this conversation, the screener works to dispel erroneous "myths" about HIV testing.
- Each inmate signs agency and department of corrections consent forms permitting the agency to conduct the test and access the inmate's medical records.
- Before performing the rapid test, the screener inquires about the inmate's knowledge of HIV and the kinds of behavior that put people at risk. The screener also asks about the inmate's recent sexual encounters, number of partners, etc. The screener makes sure to talk about sex in clear terms and to include behaviors that some people may not consider "sexual acts."
- The inmate and screener also begin to develop a risk reduction plan.
- The screener accesses the medical-records database to look for medical information on the inmate. If found, the screener looks for indication that the inmate already knows his/her HIV status or that an HIV treatment regimen was previously prescribed for the inmate.
- If the records show a previous diagnosis of HIV infection, the screener asks the inmate whether s/he has previously been in care. No matter what the screener learns, a test is performed.
- The screener prepares the test and shows the inmate, by example, how to perform the swab.
- S/he explains that its result will be available in 20 minutes and the inmate may "opt-out" of receiving the result.
- The screener determines whether the inmate stays in the room during the 20-minute wait based on the inmate's history of risk behaviors and the number of people waiting to be tested. If the inmate stays in the room, the screener will discuss risk behavior and use a condom from an incentive package to demonstrate correct usage.
- Prior to escorting the inmate from the testing room, the screener again explains that the test will remain confidential and hands the inmate the incentive package.

- Inmates who wait outside the room continue medical intake, while the next volunteer enters the testing room.
- Inmates are called back one by one from the medical bench to receive their results.
- Inmates receiving a preliminary positive screening result who have never received an HIV diagnosis are immediately referred to a mental health professional.
- The screener contacts the medical officer to draw blood for a confirmatory test, a CD4 count, and a viral load test.
- S/he continues the conversation with the inmate by asking health questions that might influence a treatment regimen, if prescribed.
- The screener offers the inmate a consent form to sign for treatment.
- S/he logs the test result and all pertinent information in the inmate's electronic medical file in the medical database.
- At this point, the only persons who know the preliminary HIV status of the inmate are the screener, the medical officer, and the mental health professional.

Follow-Up

- If the confirmatory test is positive, the screener who administered the rapid HIV test meets with the inmate to report the confirmed test result and provide post-test counseling.
- Next, the medical officer sees the inmate in the infirmary for a conversation about care and treatment options.
- If the inmate has previously been in treatment, the conversation addresses when and why it was discontinued.
- The medical officer reviews the inmate's latest CD4 counts and viral loads, compares them with the medical record on file (if any) and prescribes the appropriate treatment regimen if determined necessary.
- The inmate is referred to a case manager.
- Inmates who test positive and are within 120 days of release are assigned a discharge planner/transitional case manager. Inmates confined to the facility for longer than 120 days are connected with a facility case manager for treatment adherence, nutrition, and other support services.
- If the confirmatory test is negative, the screener who administered the rapid HIV test provides post-test counseling in the inmate's assigned housing unit. This discussion reinforces the risk reduction plan developed during their first meeting.

PROMOTION OF ACTIVITY

- Announcements of free testing and incentives to all entering inmates awaiting facility medical intake in the holding cell
- Word of mouth in the housing units

II. Logistics

STAFF REQUIRED

- The activity requires a minimum of four screeners: two for intakes during the day, two for intakes at night. The screeners conduct the test, do pre- and post-test counseling, and make referrals to the facility's medical and mental health staff.

TRAINING & SKILLS

- Staff must have training on HIV counseling and testing, cultural sensitivity, and knowledge of local resources.
- One staff member coordinating the project should be a peer: a formerly incarcerated, HIV+ individual.

PLACE OF ACTIVITY

Each screener has access to a private interview room in the correctional facility infirmary.

FREQUENCY OF ACTIVITY

Monday through Friday

OUTSIDE CONSULTANTS

Consultant to provide HIV counseling, testing, and ethics training to staff

SUPPORT SERVICES

Foreign language interpreters and signers

CONDITIONS NECESSARY FOR IMPLEMENTATION

- The screening must take place in the same area as the rest of the intake physical exams to ensure that those who test positive aren't easy to identify.
- The agency and the facility must share a common objective for the activity.
- The correctional facility staff members need to feel the activity will benefit them as well.

III. Strengths and Difficulties

STRENGTHS

- The staff has a non-judgmental attitude.
- The inmate and screener are able to develop a risk reduction plan.
- The inmate receives one-on-one attention at the facility, strengthening the message that their health is important to the agency.
- Inmates receive their HIV test results while still undergoing the intake medical exam.

WEAKNESSES

Participation is voluntary, and not all inmates participate.

DIFFICULTIES FOR CLIENTS

- There is a fear of being identified as HIV+.
- The time inmates are able to spend with the screener is limited.

DIFFICULTIES FOR STAFF

- Staff cannot ensure that all inmates follow up on the treatment recommendations.
- There is a lack of effective tracking of inmates through their medical and socialization process while incarcerated.
- Staff may lose touch with inmates upon their release.

OBSTACLES FOR IMPLEMENTATION

- Some community partners do not support HIV testing in correctional facilities.
- It is difficult to conduct the activity under high security conditions.

ACTIVITY NOT SUITED FOR

Some immigrant populations are afraid to test for fear of deportation.

IV. Outcomes

EVALUATION

- The medical records of all screening volunteers are reviewed to determine whether they've had treatment already.
- The agency and facility record the number of people tested and the results—both negative and positive—from preliminary and confirmatory tests.
- The agency makes quantitative comparisons of the number of people tested before and after initiation of the activity.

EVIDENCE OF SUCCESS

- Starting as a 90-day pilot project, the activity was considered highly successful by facility and agency staff, and it was officially incorporated as a permanent service before the pilot project ended.
- A comparison between the numbers of inmates tested before and after implementation of the activity shows an increase.
- A staff registry of tests administered reveals a steady increase in the number of people who have voluntarily participated in the activity.
- Other organizations request information on and capacity building for this activity.
- The counselors report that inmates show increased knowledge about how their behaviors affect certain aspects of their health, such as their sexual health.
- Individuals who have fallen out of care are re-linked to care with the "new" HIV diagnosis.
- Ninety percent of inmates who already know their HIV+ status disclose during the pre-test counseling and are able to immediately begin a conversation about care options.

UNANTICIPATED BENEFITS

- The inmates begin to educate their families and other facility inmates on HIV.
- There is an increased awareness of the agency's services within the greater community.
- Inmates build relationships with the facility's medical staff.

"CONNECTING TO CARE" ELEMENTS OF ACTIVITY

- The counselors begin a discussion with inmates right away about current health concerns and health care options.
- The incentive packages encourage voluntary participation.
- The test procedure, which does not require blood drawing, is described up front, making volunteer recruitment much easier.
- Inmates who are living with HIV receive the message, "Someone cares that I'm HIV+."
- When a result from voluntary HIV testing is positive, the inmate is immediately connected to medical care, and if so desired, gets a complete physical. The inmate receives a CD4 count within 72 hours.
- Post-test laboratory results of a positive inmate often stimulate the individual's conscious desire to actively engage in health care.

KEEP IN MIND...

- It's important to be open to different approaches for bringing people into care.
- There will be obstacles and barriers. Have perseverance.
- Develop a close relationship with the officers who work in the infirmary unit.
- Without incentives, the numbers of volunteers would drop dramatically.
- The people on your team should share the same vision.
- Assure inmates that their health matters to agency staff.

Notes page

TRANSGENDER POST-RELEASE CASE MANAGEMENT 14

Transgender Post-Release Case Management is an individual level intervention which links transgender HIV+ individuals soon to be released or recently released from a correctional facility to health services. The key characteristics of Transgender Post-Release Case Management are: face-to-face meetings with inmates in a local facility or collect call conversations from distant facilities; use of case managers who are from the primary target population; acceptance and non-judgment of the client; development of a risk reduction plan that includes HIV and health service goals; and tracking of the client's progress.

CURRENT ACTIVITY SETTING
Community-Based Organization for Ex-Offenders, Case Management Discharge Planning

- ✔ Directly links the client to medical care
- ✔ Gets the client in a conversation about starting medical care
- ✔ Brings the agency closer to where HIV+ people are so that the conversation can begin

I. Description

OBJECTIVES

- To help transgender individuals recently released from a correctional facility reintegrate into society and into health and social services
- To identify pre-release and recently released HIV+ individuals who are currently out of HIV care and to assist them in re-establishing their medical care

POPULATION SERVED

- The primary target population is transgender (male-to-female and female-to-male) individuals soon to be released or recently released from a correctional facility.
- The secondary target population is gay, lesbian, and bisexual individuals who are soon to be released or recently released from a correctional facility.

ACTIVITY DESCRIPTION

Transgender Post-Release Case Management offers support to transgender, gay, lesbian, and bisexual individuals living with HIV in establishing independence and health connections after release from incarceration.

QUICK NOTES:

"You have to prepare people to take control of their health. Until the client is ready, there's not much you can do."

— DISCHARGE PLANNER

- A new case is initiated in one of two ways: 1) a correctional facility notifies the agency of an inmate who self identifies as, or is believed to be, transgender, gay, lesbian, or bisexual; or 2) a client contacts the agency after being discharged.
- The case manager, who is also a member of the primary target population, schedules an assessment appointment to determine whether the client is eligible for agency services.
- If the client is in a local correctional facility, the case manager can hold the meeting there, with the permission of the facility administration. If the client is in a distant facility, the case manager can talk with the inmate by phone about needed services. In either instance, the case manager informs the client of the agency's service portfolio.
- In face-to-face meetings, the case manager's demeanor and attitude communicate acceptance and non-judgment of the client, who may have experienced discrimination or abuse because of their appearance, behavior, or gender identification.
- Clients wishing to receive services sign a consent form granting permission for the release of information to the agency.

Post-Release Meetings

- Upon release, the client meets with the case manager at the agency, where s/he finds posters, signage, reading material, and other features to encourage cultural identification, safety and acceptance. At this first meeting, the client signs a formal "informed consent to release" allowing other agencies to help with establishing a continuum of care services.
- The case manager gathers intake information that includes emergency contacts, medical care history, known medical conditions, current medications, sources of income, and a breakdown of monthly expenses. The case manager also requests photo IDs, a birth certificate, release papers, the name of the parole officer and the terms of the client's parole, if applicable.
- In the case of parole, the case manager may choose to inform the parole officer that the client is receiving services from the agency.
- The client and case manager do a behavioral risk assessment.
- After gathering the necessary information, the case manager and client develop a risk reduction plan. This plan includes safer sex goals, HIV risk reduction goals, and a list of needed support services. The client and case manager put together a comprehensive, 60-day life plan.
- Once satisfied with the plan, the client signs the document thereby committing to the plan.
- Depending on the information received from the client, referrals are made for specialized support services, general health care, mental health services, specialized health care, food banks, and social services.
- The case manager helps the client identify a medical provider and promptly schedules an appointment.
- The case manager then begins the task of completing an AIDS Drug Assistance Program application and a city health insurance application so that the client can initiate or re-initiate anti-retrovirals or HIV-related medications (assuming clinical assessments deem them necessary).
- This entire process takes four to five hours. The agency provides lunch to the client.
- On the following day, the client returns and receives copies of the completed paperwork.
- The case manager emphasizes to the client that the "ball is rolling" to get them the care they need.
- The case manager tracks progress by asking the client to call in after each appointment with a provider to report on the experience.
- If the client has no place to stay, the case manager helps to find emergency or transitional housing.
- After the 60-day life and service goals are met, the case manager establishes a meeting schedule consistent with the urgency of the client's needs. The case manager also remains in touch with the client's parole officer.
- The agency holds case management meetings to ensure that clients are receiving necessary services and to assess their progress in meeting goals.

PROMOTION OF ACTIVITY

- Outreach by community organizations
- Brochures distributed to correctional facilities
- Local media advertisements for the agency and the population served
- Advisory councils of people living with HIV
- Court referrals to agency
- Word of mouth

II. Logistics

STAFF REQUIRED

Two case managers who serve as discharge planners

TRAINING& SKILLS

Training in comprehensive cultural competency specific for this population

PLACE OF ACTIVITY

- A private office and drop-in area at the agency
- Meeting place in correctional facility

FREQUENCY OF ACTIVITY

As needed

OUTSIDE CONSULTANTS

Graphic design professionals to develop brochures

SUPPORT SERVICES

- Transportation vouchers
- Meals during long visits to the agency

CONDITIONS NECESSARY FOR IMPLEMENTATION

- Funding streams must be in place.
- Agency must have a strong working relationship with correctional facilities.

III. Strengths and Difficulties

STRENGTHS

- Demonstrates to clients that the agency comes through with promised services
- Establishes and maintains trust with the client
- Creates a climate of support, understanding, and safety for clients
- The agency staff members are also members of the targeted population

WEAKNESSES

Clients may leave care and treatment because of substance use relapses or mental health problems.

DIFFICULTIES FOR CLIENTS

- Lack of transportation to appointments can be a serious barrier since transportation assistance does not cover non-medical appointments.
- It is difficult for some clients to obtain a government-issued identification card, and legal employment is impossible without it.

DIFFICULTIES FOR STAFF

- It is sometimes extremely difficult to maintain the "full attention" of a client when discussing health care needs—especially if that person has other pressing needs or priorities.
- Some clients do not take their care seriously.
- The substance use relapse rate is high.

OBSTACLES FOR IMPLEMENTATION

There is a documented gap in funding for services targeted to the transgender population.

ACTIVITY NOT SUITED FOR

The identified heterosexual population, severely mentally ill clients, and active substance users.

IV. Outcomes

EVALUATION

- Case evaluations are managed through case management reports.
- The case supervisor monitors and tracks referrals through a database to determine the number of times per month a client accesses local services.
- Calls from clients at correctional facilities are logged.
- Client surveys provide feedback at different stages of service provision.
- The data from each annual report is compared to the data in past annual reports.

EVIDENCE OF SUCCESS

- Case management reports and referral monitoring show an increase in moving clients from post-release homelessness to independent living.
- Client tracking shows an increase in linking clients to HIV medical care.
- The number of clients served has increased over previous years.

UNANTICIPATED BENEFITS

Opens relationships between staff and criminal justice agencies, mental health agencies, and the police department

"CONNECTING TO CARE" ELEMENTS OF ACTIVITY

- The agency fills emergency needs first; the client feels cared for when assured they are not going to be homeless and that they will be linked to a full array of services.
- The message sent through the agency literature and promotion is that the agency "makes miracles happen every day." Clients identify with that idea.
- The case manager is a mixture of compassion, personality, and patience.
- Clients understand that the case manager is serious about the work, and that all interventions will have follow-through.
- The service is explicitly client-centered.
- The case manager commits to clients with a willingness to go "the extra mile" and a spirit of compassion that wins clients' confidence and trust.

KEEP IN MIND...

- It is important to have compassion and a mission to serve the transgender community.
- Moving people from homelessness to independent living is a key factor in getting and keeping transgender individuals in care.
- Focus on clients who demonstrate a serious desire to get and stay in care.

Notes page

Currently/Formally Incarcerated

WOMEN'S HALFWAY HOUSE HIV EDUCATION

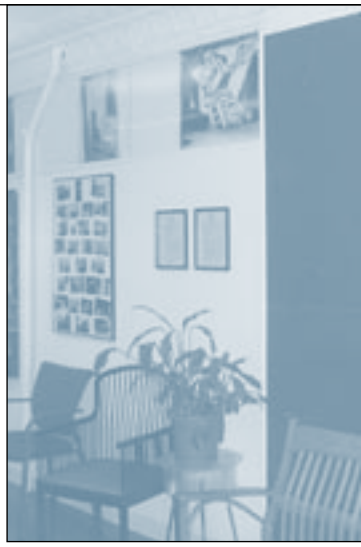
15

Women's Halfway House HIV Education is a group level intervention designed to provide information on HIV and other health care issues that are relevant to incarcerated women and to aid connections, or reconnections, to local health services. The key characteristics of Women's Halfway House HIV Education are: the direct connection to medical care it provides to participants; the professional and approachable demeanor of the staff; and the trusting relationship built between the client and the agency.

CURRENT ACTIVITY SETTING

Community-Based Service Organization for Women with Criminal Justice Histories, Community Outreach

- ✔ Directly links the client to medical care
- ✔ Gets the client in a conversation about starting medical care
- ✔ Brings the agency closer to where HIV+ people are so that the conversation can begin



I. Description

OBJECTIVES

- To link women to medical care
- To provide health education specifically on diseases and conditions that women with histories of incarceration are at higher risk for, including HIV, hypertension, and diabetes
- To increase awareness of agency services among currently incarcerated women

POPULATION SERVED

- Women who have been incarcerated, are still under court supervision, and are residing in a halfway house

ACTIVITY DESCRIPTION

Recently incarcerated women at risk for HIV and other health challenges gain hope and link to care through a voluntary, group educational program at their halfway house.

QUICK NOTES:

"My advice? Be nice to people! You could have all the training in the world, but if you're not nice to people, it's useless."

— AGENCY DIRECTOR

- The agency develops a relationship with a halfway house facility that houses the target population. A participant sign-up protocol is developed.
- Next, the agency identifies a nurse practitioner to lead the educational activity who will also attend agency staff meetings and participate in client case briefings.
- On the day of the scheduled educational activity, the nurse gathers a bag of demonstration models (of synthetic penises and condoms), simple, descriptive information on HIV and STDs, agency brochures, and forms to be completed by participants on their service needs.
- Beginning the class, the nurse and an agency case manager prepare the materials and briefly introduce themselves and the agency to the participants. They distribute a form that the participants complete on the medical and social services they need.
- The nurse discusses the goals of the presentation, which are to focus on health education and HIV prevention and to "hear what's going on with you."
- The nurse begins the presentation by asking if any of the participants have questions or issues to talk about. The nurse and case manager work as a team to respond to the questions and comments that follow.
- They make sure the participants know how to enroll in a health insurance program for the uninsured, providing as many details as needed along with handouts about the application process.
- The nurse asks if the participants have used a health care provider and whether they would like help in reconnecting. For those who do not have a provider in mind, the nurse offers to schedule an appointment at his/her clinic. (Interested participants can be seen within a week.)
- In the class, the nurse practitioner uses the demonstration models to show participants safer sex techniques.
- At the end of the class, the nurse and case manager speak with participants on an individual basis. A participant may disclose that she is HIV+ and in need of care, which may "trigger" additional involvement by the nurse and case manager.
- The participants then return their completed service request forms, which the case manager takes back to the agency.
- The case manager takes the next steps, advocating for the women and working with the halfway house to schedule medical appointments and assist the women in obtaining their medical records from the correctional facility where they were incarcerated.
- The nurse practitioner bases preparation for the next class on that week's discussion. During the next staff meeting and client briefing, s/he shares what was discussed during the class and suggests ways the agency can support the women.

PROMOTION OF ACTIVITY

- In pre-release classes in correctional facilities
- In an agency newsletter circulated to all correctional facilities that house women within the jurisdiction
- In promotional materials available at the agency's drop-in center

II. Logistics

STAFF REQUIRED

- Family nurse practitioner
- HIV case manager (historically an AmeriCorps staff member)

TRAINING& SKILLS

The nurse and the case manager must be very versatile and knowledgeable about women's health issues, particularly HIV and STDs. They must have technical HIV training and basic Red Cross training and certification.

PLACE OF ACTIVITY

Private room with chairs at the halfway house

FREQUENCY OF ACTIVITY

Weekly for 1 1/2 hours

OUTSIDE CONSULTANTS

Consultant to develop activity evaluation

SUPPORT SERVICES

None

CONDITIONS NECESSARY FOR IMPLEMENTATION

- The agency must have support from the halfway house administration.
- Women must have a willingness to accept the activity.
- The agency must have a clear understanding of, and be realistic about, the role its staff can play in the lives of the women.

III. Strengths and Difficulties

STRENGTHS

- The activity provides information that is valuable, useful, and accessible.
- It provides a sense of hope for women: they don't have to face difficult issues alone.
- The nurse practitioner is affiliated with the clinic where the women are linked for medical services. As a result, the women have the opportunity to see a familiar, trusted face when they go for appointments.
- The agency staff members conduct the activity with humor, intelligence, and professionalism.

WEAKNESSES

Because the staff is limited in the types of services it provides, it cannot meet every participant service need.

DIFFICULTIES FOR CLIENTS

- Class isn't long enough. At an hour and a half, it provides little more than a brief break from a very restrictive environment.
- Participation does not expedite women's discharge from the halfway house.

DIFFICULTIES FOR STAFF

- The staff is unable to meet all the needs that the women mention during the presentations.
- The staff has little control over the women's health provider connections because their health care is primarily coordinated by the administration and case managers of the halfway house.

OBSTACLES FOR IMPLEMENTATION

- Correctional institutions are closed systems and can be difficult to enter. They may not be welcoming to community providers.
- The missions of correctional systems and community providers are often seen as conflicting and contradictory.
- The activity should be peer-driven, but some local laws prevent people who have felony convictions from providing services in halfway houses.

ACTIVITY NOT SUITED FOR

N/A

IV. Outcomes

EVALUATION

- At staff meetings, the nurse practitioner reports on the number of women who were reached through the activity and have been connected to primary care, have health insurance, and are not using the emergency room for primary care.
- The agency's database tracks the number of clients who are connected to medical care.

EVIDENCE OF SUCCESS

- The participants are connected to health care services.
- Clients report a high level of satisfaction with the services they received through referrals from the nurse.

UNANTICIPATED BENEFITS

- The activity provides the participants with a "lifeline" that is respectful, caring, and highly professional.
- The agency is sensitized to the role the halfway house plays in the current life situation of the women. This allows the agency to provide the women with better complementary services.
- The agency gains a full appreciation of the struggle that women face reentering the community.

"CONNECTING TO CARE" ELEMENTS OF ACTIVITY

- The manner, openness, and care of the people who provide the educational experience
- The reputation and credibility of the agency as a trusted resource among the women

KEEP IN MIND...

- Stay focused on the activity and its mission.
- Make sure that people providing services are very well trained and can provide a level of service that is of a quality that any consumer would want to have.
- The people developing and providing the service (agency board of directors, leadership, and direct service staff) should reflect the community served.
- The formerly incarcerated should have the "loudest voice" and should be represented in positions at all levels of the agency.
- Don't get caught up in competition or in spending money and resources. Just do the work.

COMMUNITY RESOURCE VIDEOCONFERENCE

16

Community Resource Videoconference is a group level intervention that aims to help inmates, on a voluntary basis, develop a discharge plan as they near their release from federal prison. The key characteristics of the Community Resource Videoconference are: the motivation it provides for inmates to begin to think about, and plan for, post-release life; the opportunity for inmates to interact with community service providers "in real time"; and the time allotted after the videoconference for follow up questions and assessment with the facility case managers.

CURRENT ACTIVITY SETTING
Court Services and Offender Supervision Agency, General Program

Directly links the client to medical care
- ✔ Gets the client in a conversation about starting medical care
- ✔ Brings the agency closer to where HIV+ people are so that the conversation can begin

I. Description

OBJECTIVES

- To help individuals make a successful, post-release transition
- To provide inmates, prior to their release, with information from resource and health service providers in the community to which they will return

POPULATION SERVED

- Individuals who will be released from federal prison within six months and will be returning to a designated community under court supervision

ACTIVITY DESCRIPTION

In Community Resource Videoconference, the correctional facility and court supervision agency are able to support a comprehensive discharge plan for soon-to-be-released individuals housed in a remote correctional facility by connecting them with resources in the communities where they will live.

QUICK NOTES:

"Inmates tell me, 'this is what I've asked for from the beginning . . . if I only had this earlier, I wouldn't be back [in prison].'"

— DEPARTMENT SUPERVISOR

- The court supervision agency and correctional facility warden set a date for the videoconference.
- The agency invites community resource providers, including providers of HIV related services, to the videoconference as presenters. The presenters are asked to provide descriptions of their resources and services as well as "bureaucratic issues" relevant to recently released individuals (e.g., obtaining identification, and filling out forms and paperwork to secure needed benefits and services).
- The agency next develops an agenda for the full-day videoconference, allotting time for introductions, community resource presentations (30 to 45 minutes), an orientation to community supervision, and a question and answer period.
- The correctional facility screens and selects 200 inmates who have voluntarily signed up to participate. Participants must expect release from the correctional facility within six months, and their release status is verified by the facility.
- One week before the videoconference, each participating inmate receives a packet of materials from the court supervision agency. Materials include the videoconference agenda and information on the presenters and their organizations.
- The facility provides a large common room with seating for each of the participating inmates.
- The agency provides videoconferencing equipment (screens, audio devices, etc.) to the correctional facility. An IT specialist sets up videoconference equipment in a room at the facility.
- Another IT specialist sets up videoconference equipment at the agency, where the presenters will be located.
- The day of the videoconference, participating community agencies gather in a room at the court supervision agency. Facility staff, including the warden, case managers, and moderator, gathers in a room at the correctional facility. Inmates are escorted to the room.
- The videoconference begins with introductions. General supervision officers then give an orientation to supervision. A question and answer session follows, facilitated by a moderator at both ends. Throughout the day, agency re-entry officers are on-hand in the room to continue answering any questions on post-release supervision.
- A representative from each community resource agency speaks for 30-45 minutes on agency services. Q & A sessions follow each presentation. Any questions left unanswered during this session are taken down with the inmate's name. A response is promised either as soon as possible or during a follow-up videoconference (depending on the urgency of the requested information).
- Following the community presentations, there is a break for lunch.
- Lunch is followed by presentations from the remaining agencies.
- The moderator concludes the event, referring the inmates to the information in the packets they received.
- The facility case managers provide the inmates with additional information and application forms for identified health and social services.
- The warden shuts down the television set, and the inmates are escorted back to their housing units.

Follow-Up

- One month later, the follow-up videoconference takes place, which is a half day event. Selected presenters are asked to return and answer questions, speaking first to the group and then one-on-one with inmates who have questions needing confidentiality.
- Inmate attendance is voluntary.
- Again, IT specialists positioned at each end of the videoconference manage the equipment. Agency case managers attend to provide application forms and brochures for services that were not identified during the initial videoconference.

PROMOTION OF ACTIVITY

- Service organizations receive reminders of videoconference dates by e-mail.
- Inmates learn of the event from their case managers, the warden, and by word of mouth from other inmates.

II. Logistics

STAFF REQUIRED

Agency Site

- Co-moderator to open the videoconference, introduce the presenters, and provide concluding remarks
- Agency court supervision officers to detail post-release supervision requirements and expectations
- Agency case managers to provide service information and forms and to answer inmate questions
- IT specialist to set up videoconferencing equipment
- Community resource representatives to outline services and resources available in the designated community

Correctional Facility Site

- Co-moderator to open the videoconference and provide concluding remarks
- IT specialist to set up audio-visual equipment
- Facility representative (usually the warden) to promote Community Resource Videoconference events within the inmate population and to officiate at each event
- Facility case managers to record and answer questions
- Unit managers and corrections officers to escort participating inmates to and from the videoconference site
- Facility staff to assist in scheduling the room and setting up seating for videoconference

TRAINING& SKILLS

The agency does not require special training or skills for this activity.

PLACE OF ACTIVITY

Two videoconference-capable rooms: one at the agency and the other at the correctional facility

FREQUENCY OF ACTIVITY

The initial video conference, lasting seven hours, takes place four times a year. In each instance, a follow-up videoconference of four to five hours takes place one month later.

OUTSIDE CONSULTANTS

None

SUPPORT SERVICES

None

CONDITIONS NECESSARY FOR IMPLEMENTATION

- The agency's public affairs office and the correctional facility warden must commit a considerable amount of time to planning the activity.
- The agency must generate support from provider organizations in the designated community and secure speakers to present on services available.
- Service organizations must commit to serving inmates before and after their release.

III. Strengths and Difficulties

STRENGTHS

- Inmates receive general information on critical health and social services, often for the first time. The information provides them with a "road map" to successful reunification with their families and the possibility of "crime-free lives" through accessing appropriate resources and services.
- After a videoconference, inmates bring questions to their case managers within the facility and begin to ask questions about life after discharge. Many inmates begin to assess their service needs, which facilitates a smooth transition.

WEAKNESSES

- The limited number of participating facilities
- There is no individual follow-up with inmates after their release to make sure they are able to link to the services highlighted in videoconference.

DIFFICULTIES FOR CLIENTS

- The information from providers might be difficult for some inmates to comprehend and therefore act on.
- Inmates are unable to enroll in services at the time of the videoconference.
- Inmates may experience frustration navigating bureaucracies in order to access care.
- Since there could be as many as six months between the activity and a release date, there is a risk that an inmate will forget the information by the time they return home.
- The agency does not have funding for individual follow-up to make sure linkages to care and services are made.

DIFFICULTIES FOR STAFF

This activity is labor-intensive for all staff members involved and goes beyond the purview of their established job duties.

OBSTACLES FOR IMPLEMENTATION

Due to community mistrust of individuals with criminal justice involvement, the larger social service system tends to direct its outreach efforts toward individuals who are perceived to be at "lower risk" for re-incarceration.

ACTIVITY NOT SUITED FOR

N/A

IV. Outcomes

EVALUATION

- The agency tracks the recidivism of individuals receiving community supervision. The staff reviews this tracking data to determine the difference in recidivism between activity participants and non-participants.
- The agency also maintains records on attendance at videoconferences and participant overflow.
- The agency staff documents questions and concerns raised by inmates during the videoconference.

EVIDENCE OF SUCCESS

- All Community Resource Videoconference events are filled to capacity, even with minimal promotion, with active participation from attending inmates.
- Questions asked to service providers and facility case managers show active participation and genuine interest from the inmate population.
- Returning inmates report that they would not be back in prison if this activity had been available to them at an earlier time.
- Anecdotal evidence suggests that the activity supports a significant improvement in the inmate-discharge process.

UNANTICIPATED BENEFITS

- This activity has benefited children by helping their incarcerated parents think about their post-release life, which increases their chances of a successful transition back into the community.
- The agency gains increased awareness of other organizations that serve the same community.

"CONNECTING TO CARE" ELEMENTS OF ACTIVITY

- The human connection: Participants receive introductions to individuals who may be the same people who eventually provide them with HIV, health, and social services.
- The community providers show a compassion for the HIV+ clients which isn't always demonstrated by community supervision.

KEEP IN MIND...

- The activity requires much coordination; start on a modest scale and build it up gradually.
- If a correctional facility lacks IT infrastructure (equipment and staff to conduct videoconferencing), information packets on community resources can still be offered to inmates who are nearing discharge.
- New technological developments (involving Web-based videoconferencing) may eliminate technological barriers, reduce costs, and ease staff efforts.
- Discharged inmates are more likely to stay "on the right track" with appropriate support, but they need to know which community services they can access.

Notes page

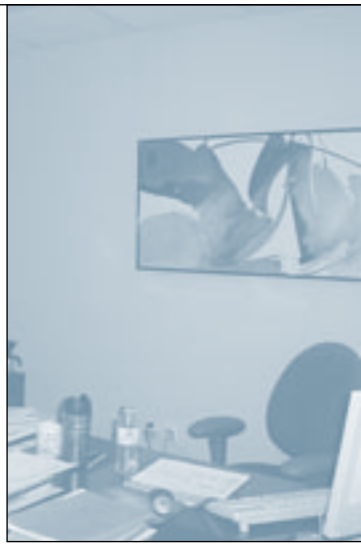
SUBSTANCE USE DISCHARGE LIAISON

17

Substance Use Discharge Liaison is an individual level intervention designed to help meet the immediate health and social service needs of HIV+ men and women with histories of substance use upon release from incarceration. The key characteristics of Substance Use Discharge Liaison are: the relationship built between the agency and correctional facility; the continuity of care that begins inside the facility and continues after release; the development of a treatment plan that identifies the client's goals and plan of action; and the substance-use intake assessment that matches a program to client needs.

CURRENT ACTIVITY SETTING
Lesbian Gay Bisexual Transgender (LBGT) Mental Health Service Agency, Early Intervention Program

- ✔ Directly links the client to medical care
- ✔ Gets the client in a conversation about starting medical care
- ✔ Brings the agency closer to where HIV+ people are so that the conversation can begin



I. Description

OBJECTIVES

- To help HIV+ clients link to health care and substance use treatment upon release from correctional facilities
- To actively involve formerly incarcerated HIV+ individuals in their own process of sobriety and well-being

POPULATION SERVED

- Inmates co-diagnosed as substance using and HIV+
- Men and women being released from a correctional facility

ACTIVITY DESCRIPTION

Substance Use Discharge Planning supports individuals returning to life outside a correctional facility by helping them to increase their attention to health and well-being, and also to participate actively in the process of sobriety.

QUICK NOTES:

"It's important to let the client identify what their needs are and not assume that HIV comes first."

— SUBSTANCE USE DISCHARGE PLANNER

Development

- The agency gains permission from selected correctional facilities for a liaison to carry out discharge planning for HIV+ inmates with histories of substance use who are within 90 days of release.
- The agency staff requests security clearances for the liaison.
- The correctional facility administration determines which units the liaison can visit within each facility.
- In each facility, agency staff builds a relationship with a department (e.g., the medical department) that is willing to host the discharge liaison.
- The "host department" selects a time for the liaison to visit inmates in the facility on a regular basis.
- The agency staff builds relationships with other departments in each facility that can help to identify inmates with histories of substance use and connect them to the liaison. These departments may include the medical department/infirmary, the chaplaincy, or the education department. The agency asks that these departments refer inmates to the discharge planner liaison for a meeting.
- The agency staff sends all pamphlets, brochures, consent forms, and other written materials for use in the liaison meetings to the State Department of Corrections for approval.

Discharge Planning Meeting Scenario

Preparation for the Meeting

- Participating departments of the facility make request forms available to inmates for discharge planning. An inmate may submit this form, when completed, to the facility administration. Alternatively, inmates who find out about the liaison through word of mouth may write a letter directly to the liaison to request a meeting.
- The host department then prepares a list of approved inmates with whom the liaison will meet and sends it to the liaison.
- The discharge liaison calls the correctional facility to make sure the approved inmates have not been unexpectedly transferred or released.
- On the day of the predetermined visit, the inmate is given a pass by the medical department for an escort to the medical area.

Meeting with the Inmate

- The liaison and inmate have their first meeting in a private space in the facility.
- The liaison greets the inmate and describes the services the agency provides. Because of the sensitive nature of disclosing HIV and substance use, s/he focuses the first meeting on establishing rapport and begins by discussing the inmate's general needs.
- The liaison expresses a willingness to help the inmate before and after their release from the facility.
- S/he then asks the inmate to identify specific health and life needs. The liaison does not assume that the inmate will identify HIV care or substance use treatment as the most important need. Instead, the liaison asks broad questions, like "You have requested a meeting with me, which suggests you may have some health needs. Can you tell me about them?"
- As the inmate shares his/her needs, the liaison responds, "And how can I help you with that?" If the inmate does not disclose substance use or HIV infection, the liaison probes with questions like, "Did you ever engage with people who used drugs?" or "Are you taking any medications?"
- If an inmate discloses a history of substance use, the liaison requests more information. If an inmate discloses HIV infection, s/he asks when they were diagnosed and about their last doctor visit.
- Noting the inmate's release date, the liaison discusses the public benefits and services the inmate can access once discharged. S/he always asks which services interest the inmate because they will have to commit to each service's individual requirements. The inmate signs eligibility paperwork for the AIDS Drug Assistance Program, food pantries, housing, and other services.
- The liaison asks the inmate to sign consent forms in order to access his/her confidential information from the facility administration.
- S/he asks the inmate to meet three to five more times before release in order to get all the paperwork organized. That way, services will be available to them when they are released.
- The liaison and inmate then discuss other services that interest the inmate.
- As the meeting winds down, the liaison reminds the inmate of the date of their next meeting and offers informational literature on the agency.
- The liaison requests information from the facility administration about the inmate, such as their HIV status and medications.

- After the meeting, back at the agency, the liaison creates a client file and sends the inmate's application paperwork to the appropriate service agencies.

Follow-Up Meetings at the Facility

- At subsequent meetings with each inmate, the liaison further explores substance use and HIV issues and the best service options for each individual.
- In the final meeting before release, the liaison verifies that the inmate has completed all the appropriate paperwork for the chosen post-discharge medical, housing, and support services. The liaison provides a packet of information on these services along with referral letters to medical and social service resources, a copy of the inmate's identification card, documentation of their HIV diagnosis, proof of residence and income, and a list of their medications and dosages.
- The liaison invites the inmate to attend a "walk-in" meeting at the agency any afternoon immediately following release. Walk-in meetings are more convenient for newly discharged clients since arranging transportation and other issues at release can interfere with keeping an appointment.

Post-Release Meetings

- When the liaison and client have their first post-release meeting at the agency, the liaison enters the client's eligibility verification information into a city-wide computer database accessible by many social service agencies throughout the city. This saves the client the needless effort of duplicating paperwork for every service provider and reduces the occurrences of conflicting information.
- The meeting focuses on the immediate needs of the client. It may include a suggestion to explore substance use treatment programs.
- The liaison then requests a second, post-release meeting to follow-up on the client's needs.
- By the second meeting, the agency has helped to stabilize the client's life; this builds the client's confidence in the agency. The liaison and client follow up on options for addressing the client's history or pattern of substance use. The liaison assigns the client a case manager to help them access health and social services.
- The liaison then schedules the client (often the same day) to meet with a licensed clinical case manager for a formal substance use intake assessment. This case manager assesses the client's suitability for one or more of the following programs:
    - Individual Case Management - Clients have ongoing meetings with a case manager to arrange for dental, nutritional, housing, and health care needs.
    - Individual HIV and Chemical Dependency Counseling - Clients have weekly, individual counseling sessions with a chemical dependency therapist on HIV and substance use issues.
    - In-patient Substance Use/Chemical Dependency Treatment - Clients are referred to a 12-step, in-patient substance use program at another agency.
    - Intensive Out-Patient Substance Use Treatment Program - Clients meet for a group training five nights a week for eight weeks. Licensed therapists provide psychological education and support (including a "family night"), relapse prevention, and information on substance use and HIV.
- Case managers work with supervisors from each of these programs to review and determine which counselors, groups, and programs the client will be referred to.
- Once a program schedule is established, the case manager and client create an individualized "treatment plan" together. The plan states the client's goals and action steps for health, which often address substance use. When appropriate, the plan sets out a course for the client to access HIV care.
- Every week, the staff members from all four programs meet to review the substance use treatment process of each client and discuss how they can further help clients manage their HIV health care.
- Clients who successfully complete the intensive out-patient substance use treatment program attend a graduation ceremony. They can then choose to enter a six-month "after-care recovery group" or individual counseling to receive support in setting new substance use treatment and HIV care goals.
- Once clients achieve their treatment goals and have transitioned into stable sobriety and health care, they leave the agency or their cases are closed.

PROMOTION OF ACTIVITY

- Discharge planner describes planning services at public meetings attended by correctional facility staff.
- Community health agencies discuss agency services in meetings.
- HIV educators give pamphlets and brochures to inmates.
- Word of mouth both in and out of the facility
- State conferences on substance use

II. Logistics

STAFF REQUIRED

- Criminal justice discharge planner liaison
- Clinical case manager
- Licensed social worker or counselor to perform chemical dependency intake assessment and individual counseling
- Licensed therapist to facilitate group therapy
- Program coordinator or supervisor to develop treatment plan and determine appropriate level of care services

TRAINING& SKILLS

- The staff must show respect and be non-judgmental, constant, and consistent in its service.
- The staff must demonstrate professional follow-through on each agreement made with the client.
- The staff must be sensitive to prison culture and to gay identity in the context of prison culture. It must also recognize that men may have sex with men in prison without necessarily identifying themselves as gay.
- The staff must understand HIV infection and have knowledge of STDs, TB, and universal safety precautions.
- Key staff must be trained in nonviolent crisis intervention.

PLACE OF ACTIVITY

- Incarcerated clients: within correctional facility in a private space
- Released clients: wherever the client chooses to meet (agency clinic, client's home, or public place)

FREQUENCY OF ACTIVITY

- Three to five visits with client inside correctional facility within 90 days of anticipated release
- Three more visits, post-release, over eight to ten weeks

OUTSIDE CONSULTANTS

None

SUPPORT SERVICES

- Interpretation for hearing impaired, Spanish-speaking, and French-speaking clients
- Transportation support such as bus vouchers

CONDITIONS NECESSARY FOR IMPLEMENTATION

- The agency must maintain a positive relationship with correctional facilities and community service providers.
- All levels of agency staff must commit to providing this service.

III. Strengths and Difficulties

STRENGTHS

- Immediate health and social service needs of clients are met upon release.
- The agency provides an accessible, welcoming, and safe space for clients who return after dropping out of the program.

WEAKNESSES

- The activity cannot always prevent substance use relapse by clients.
- The rigidly structured format of substance use treatment can be too inflexible for some clients.

DIFFICULTIES FOR CLIENTS

- Clients may encounter obstacles in accessing needed services.
- They often find the extensive paperwork and documentation overwhelming.
- They sometimes perceive the substance use treatment programs as rigid and unaccommodating.

DIFFICULTIES FOR STAFF

- Agency staff experiences frustration with "no show" clients.
- Agency staff reports a high relapse rate for substance users.
- Principal resources within the community change their service portfolios or terminate programs without notification.
- Staff must deal with situations where clients have heard of programs that have since ceased to exist.

OBSTACLES FOR IMPLEMENTATION

- Lack of motivation and willingness on the part of the client to change established life patterns and social networks
- If too few clients enter into outpatient treatment, the money allocated for such services goes unspent and may be subject to cuts.

ACTIVITY NOT SUITED FOR

- Clients who are actively psychotic
- Clients whose lives are too chaotic for a substance use treatment plan
- Clients whose circumstances preclude commitment to an eight week program (e.g., employment schedule, transportation difficulties, or financial hardship)

IV. Outcomes

EVALUATION

- Agency staff meets quarterly to review and discuss case-manager reports for each client.
- Supervisors for specific treatment programs review each case with clinical managers.
- During the course of a treatment program, providers review "treatment plans" that spell out client goals and action steps.

- The substance use treatment program provider closely monitors client engagement in medical care for HIV infection.
- The staff from all four substance use treatment programs meets weekly to review the progress of each client with respect to substance use and HIV care.
- Client files are color coded, depending on which program(s) they join, for easier tracking.

EVIDENCE OF SUCCESS

- Over 50% of clients establish and maintain connections to HIV care during the course of their substance use treatment.
- Since beginning this program, the agency has observed an increase in clients linked to medical care for HIV infection.
- Since beginning this program, the agency has observed an increase in clients who complete their substance use treatment plans.
- Seventy-five to 80% of clients from correctional facilities go to first agency meeting.
- Over 50% of the clients whose process was initiated at the correctional facility stay in the agency case management service for the entire program.
- Clients report feeling healthier and having a better quality of life.

UNANTICIPATED BENEFITS

- As a result of successful completion of substance use treatment programs, clients become more productive and many obtain employment.
- Many clients whose health improves are able to obtain employment and they can often switch from restrictive, state-sponsored health plans to more beneficial employer-sponsored plans.

"CONNECTING TO CARE" ELEMENTS OF ACTIVITY

- The agency-client relationship begins inside the correctional facility and continues post-release.
- The staff continuously builds trust and rapport between the client and the agency.
- By providing referral documents and support material, this activity provides inmates with information on the array of services available in the community and prepares clients to access needed resources upon release.
- The full activity provides continuity of care: the same staff member who begins to meet with the client during incarceration also sees the client after release to connect the client to substance use treatment programs and HIV care.

KEEP IN MIND...

- Once you pass through the security at the correctional facility, you are under its authority and must abide by facility rules.
- Remember that you are a "guest" of the hosting institution.
- A liaison must understand and show sensitivity to prison culture.
- Be willing to travel.
- Allow for flexibility in the treatment programs for HIV+ clients with mental health issues.
- Keep your word; show up when and where you say you will.

GETTING STARTED INTAKE CASE MANAGEMENT 18

Getting Started Intake Case Management is an individual level intervention for HIV+ individuals to help ease their transition from life within a correctional facility to life beyond it. The key characteristics of Getting Started Intake Case Management are: the holistic approach taken by the case manager in assessing clients' needs; the support and health education offered to clients through participation in support groups and case management meetings; and the provision of "staple-item" incentives which help clients meet basic needs in hygiene and apparel.

CURRENT ACTIVITY SETTING
AIDS Service Organization, Client Services

- ✔ Directly links the client to medical care
- ✔ Gets the client in a conversation about starting medical care
- Brings the agency closer to where HIV+ people are so that the conversation can begin

I. Description

OBJECTIVES

- To link HIV+ individuals with criminal justice involvement to medical and social case management services
- To enroll HIV+ individuals in the AIDS Drug Assistance Program (ADAP) and help them secure housing

POPULATION SERVED

- Currently incarcerated men and women soon to be released

ACTIVITY DESCRIPTION

Getting Started Intake Case Management allows incarcerated individuals to create a post-release plan with the help of a case manager who supports an assessment of their social, housing, and health care needs.

QUICK NOTES:

"Six months is our goal. If you're in care that long, you're much more likely to continue."

— CEO

Planning and Needs Assessment

- The agency selects a group of inmates living with HIV or chronic hepatitis C who will soon be released from a correctional facility and conducts a two-survey needs assessment of the group.
- The first survey is administered while the group members are incarcerated, and the second takes place once all the members of the group have been released.
- The agency uses the assessment results to inform its selection of community organizations for clients to use for their health and social-service needs.
- The agency secures funding to implement the activity.

Implementation

- The agency establishes a partnership with a correctional facility that houses inmates who will be returning to the community served by the agency.
- A medical checklist is developed and placed in HIV+ inmates' medical files. It includes a prompt for initiating discharge planning three to six months before an inmate's release date. The agency asks the facility's medical personnel to insert this checklist in the medical files of inmates living with HIV.
- Working with the medical personnel, the agency's case manager contacts inmates who are HIV+ and nearing their release date to inform them of the agency's services.
- In consultation with correctional facility officials, the agency designs an informational brochure on its services for use within the correctional facility.
- To encourage wider distribution of the brochure, the agency contacts the HIV services planning council, which prints a directory of recommended service organizations within its community. The agency arranges for the council to provide brochures to inmates who request a copy of the directory.
- The informational brochure has a section that inmates can detach and mail to the agency, postage free, with a message or a request for more information.
- Following their release, they may either mail in the brochure's detachable section or contact the agency to schedule an appointment.
- When a client schedules an appointment, the activity proceeds as follows:

Client Intake

- A client arrives at the agency and meets with a case manager.
- The case manager and client begin to develop a service plan to guide the client's transition. The plan develops in accordance with the client's needs and personal goals and the organizations from which s/he will receive services.
- Together, they consider the client's housing, nutritional, and transportation needs and discuss how to best meet these needs.
- The client signs a consent form, which lists service organizations available to him/her. The client's consent authorizes the agency to communicate with the client's parole or probation officer as well as the listed organizations. Before the client signs the consent form, s/he can decline to provide information or refuse to accept services from any resource listed by crossing them off the form.
- The case manager and client explore the client's need for mental health services. The case manager asks about any previous psychiatric diagnoses and medications.
- S/he also explores any history the client has of substance use and whether or not the client would benefit from a 12-step or out-patient program. Classes for support and substance use are identified and scheduled.
- The conversation then shifts to medical care, in general, and HIV care in particular. The case manager asks if the client has identified a medical facility from which they would like to receive care.
- When the client indicates a preference, the case manager provides a referral to that facility. On the referral form, the case manager writes the client's medical needs. S/he then gives the client a business card for the referred medical care professional. Knowing the doctor's name personalizes the process.

- The case manager advises the client on the details of this first medical appointment and provides them with a seven-day bus pass for transportation to the appointment. The client receives a 365-day bus pass from the health care provider for use thereafter.
- The case manager explains that over the next six months, the agency will monitor the client's medical and ADAP participation. If, at the end of six months, clients are able to verify their participation through receipts, prescriptions, and other documentation, the agency will give them a $50 clothing voucher.
- The client receives the service plan developed during intake. The dates and times of all scheduled appointments, identified support groups, and follow-up visits to the agency are clearly noted.
- Each client who completes intake receives a backpack of gender- and race/ethnic-specific items, including T-shirts, personal hygiene kits, and condoms.

Intake Follow-Up

- The case manager and client review what has happened since their last meeting. They cover the client's first medical visit, any referrals that the medical provider made, and any parole meetings that have taken place.
- In one of the initial meetings, the client completes a pre-test on his/her knowledge about HIV infection, STDs, and safer sex practices.
- The case manager and client next complete the ADAP application, which the case manager files on behalf of the client.
- They review the service plan and discuss any additional support groups or services the client might benefit from.
- For the next six months, the case manager and client continue to meet and discuss the client's progress and address any needs that arise.
- The client completes a post-test around the six-month mark to gauge his/her increase in knowledge following the completion of the service plan.
- Every quarter, the agency holds a commencement ceremony for individuals who are marking the sixth month of their relationship with the agency. The ceremony includes a keynote presentation, a discussion of risk reduction, lunch, and the distribution of certificates of completion.
- Clients often continue to access agency services after their commencement.

PROMOTION OF ACTIVITY

- Brochures circulated in partnering correctional facilities
- Referrals from the Department of Criminal Justice
- Peer educator program in operation at 67 correctional facilities
- Agency's case manager at client intake
- HIV services planning council
- Word of mouth

II. Logistics

STAFF REQUIRED

A case manager to assist in the development of client service plans, provide medical provider and support group referrals, and present clients with incentives for continued participation

TRAINING & SKILLS

- The case manager must have extensive working knowledge of HIV services in the community.
- Staff members should understand prison culture.

- Staff should also be skilled in putting people at ease so they feel comfortable opening up and expressing their needs.
- Staff should be trained in data collection and documentation.

PLACE OF ACTIVITY

- Individual client meetings are held in a private office at the agency.
- Support groups attended by clients take place in meeting spaces in the community.

FREQUENCY OF ACTIVITY

Daily for new clients

OUTSIDE CONSULTANTS

None

SUPPORT SERVICES

None

CONDITIONS NECESSARY FOR IMPLEMENTATION

- In order to ensure that the informational brochures are distributed and that agency staff can do outreach in the correctional facility, the agency must have a solid relationship with facility officials or, at the very least, with personnel assigned to the individual units of the facility.
- It is beneficial for the agency to have a good rapport with probation and parole officers since they usually see, and may refer, former inmates within 24 hours of release.
- The agency must have good working relationships with other service organizations in the community to make appropriate referrals for clients.

III. Strengths and Difficulties

STRENGTHS

- The activity helps clients to meet their most basic needs, which is a critical first step to linking them to other services, including health care.
- The incentives keep clients motivated.

WEAKNESSES

In the agency's needs assessment survey, housing is cited as the number one concern, yet there is not sufficient funding to fully support clients with this need.

DIFFICULTIES FOR CLIENTS

The type and nature of some clients' offenses impose legal restrictions on the kinds of services the agency is able to offer to them.

DIFFICULTIES FOR STAFF

- The agency lacks funding for emergency housing, and clients have trouble adhering to a service plan when they lack housing.

- Securing and packaging items for use as incentives in order to link clients to care is time intensive.
- The agency cannot process the entire population of men and women coming out of the correctional system.

OBSTACLES FOR IMPLEMENTATION

None

ACTIVITY NOT SUITED FOR

- Individuals with acute psychiatric disorders
- Individuals with cognitive impairment

IV. Outcomes

EVALUATION

- Client evaluation form
- Pre- and post-tests administered to clients

EVIDENCE OF SUCCESS

- Within two weeks of intake, 90% of clients are enrolled in medical and health benefit programs, including ADAP.
- In the first six months, 80% of clients adhere to their service plan, including scheduled medical care visits.
- After six months, 70% continue to receive care and 40% remain involved in agency groups and activities, including its annual AIDS Walk.
- Post-test results reveal clients' increased knowledge of HIV and community resources.

UNANTICIPATED BENEFITS

- Clients raise their self-esteem and have an increased sense of self-worth.
- Clients gain knowledge of STD transmission, prevention, and risk reduction methods.
- Clients improve their knowledge of basic hygiene and how to stay healthy.

"CONNECTING TO CARE" ELEMENTS OF ACTIVITY

- The case manager smooths the way for the client's first contact with a health care provider by making an informed referral, communicating the client's needs to the health care provider, scheduling an appointment for the following day, and providing the client with a means of transportation.
- The incentives serve as tangible reinforcements for accessing social services and medical care. Providing supportive services helps to link clients to medical care and keep them in care.
- Some staff members have either worked in correctional facilities or were incarcerated themselves, which makes it easy for them to relate to clients' situations.

KEEP IN MIND...

- The brochure promoting the activity should be appealing to the eye, and the inclusion of HIV on the cover should be subtle.
- Community resources may offer reduced prices or bulk rates for incentive items.
- One agency can't "do it all"; partnerships are essential to the success of this activity.
- Commitments made by agency staff must be carried through to completion; otherwise, clients will lose confidence in the agency and drop out.

Notes page

LUNCH AND LEARN

19

Lunch and Learn is a group level intervention designed to enable correctional nurses to provide up-to-date, high-quality medical care to HIV+ inmates. The key characteristics of Lunch and Learn are: the Continuing Nursing Education (CNE) credits offered to participating caregivers; the integration of care for HIV infection into primary medical care; the information network built between the nurses and experts in health-related fields and the focus on the relationship between nurses and their HIV+ patients.

CURRENT ACTIVITY SETTING
University Hospital Medical Center, Education Program

- ✔ Directly links the client to medical care
- ✔ Gets the client in a conversation about starting medical care
- Brings the agency closer to where HIV+ people are so that the conversation can begin

I. Description

OBJECTIVES

- To strengthen correctional nurses' involvement in HIV care
- To provide correctional nurses with tools to better diagnose opportunistic infections
- To create and cultivate a network of professional support for correctional nurses

POPULATION SERVED

- Correctional care nurses working in state and federal prisons and jails

ACTIVITY DESCRIPTION

Lunch and Learn grants nurses who work in correctional facilities continuing education credit for attending educational seminars that provide accurate, up-to-date information on HIV infection, care, and treatment.

QUICK NOTES:

"The nurses really care about the patients. It makes sense to provide them with tools to teach people how to live with [HIV] disease."

— ASSOCIATE PROFESSOR OF MEDICINE

Development and Implementation

- The team, consisting of an infectious disease doctor, nurse coordinator, and experts in health related fields, conducts a needs assessment among corrections nurses in HIV care.
- After reviewing the responses, the team determines the corrections nurses' learning needs and which identified topic areas will be covered in the activity.
- The team designs the Lunch and Learn curriculum and divides it into 12, one-hour seminars.
- Each luncheon seminar addresses a different health care topic where HIV is integrated into other important medical fields (e.g., cardiology or primary care).

Accreditation

- The nurse coordinator applies for curriculum accreditation, so that the one-hour seminars qualify for CNE credits. Each seminar completed counts as one credit.
- The application for accreditation involves identifying the objectives, content, display of information, and evaluation of each seminar.
- The accreditation process requires a lead time of three to four months before the Lunch and Learn seminars begin.
- Once approved, the accreditation is valid for two years and allows some adaptation of the material.

Logistics

- The nurse coordinator from the team determines the date and time of the luncheon seminars and reserves a convenient location in the host hospital's correctional unit for the 12 upcoming seminars.
- Also at this time, s/he reserves audio/visual equipment (e.g., laptops and a video screen) for each seminar so it's available for presenter use.
- The infectious disease doctor and nurse coordinator select speakers for each seminar. Speakers include qualified professionals who can provide up-to-date information on the selected subject matter. Speakers are offered a $50 gift certificate as an honorarium.
- The doctor and nurse obtain funding to pay for each monthly lunch.
- The team develops an evaluation form that asks participants for feedback on the quality of the presentation and the knowledge gained through the seminar. The form also serves as an "ongoing needs assessment" by asking participants what they will need to learn about the subject in the future.
- The nurse develops promotional material for each seminar. It includes the date, time and location of the seminar, the topics covered, and pre-registration requirements. It also states that the CNE credits and lunch are provided for free.
- Each seminar is publicized four weeks before its scheduled date.
- The nurse e-mails reminders to registrants just before the event.
- The nurse reviews the submitted registration information and orders lunch accordingly.
- Just before each seminar, the nurse prepares information packets for the participants, including copies of the speaker's Power Point presentations (obtained in advance), supplementary information on the subject matter, and an evaluation form to assess the seminar. The packet also includes a request form for CNE credits that the nurses complete on the day of the seminar.

Scenario for a Lunch and Learn Seminar

- The nurse coordinator arrives early to make sure the buffet style lunch, the audio/visual equipment, and registration table are properly set up.
- The participants enter, register, and pick up material packets. They are invited to serve themselves lunch from the buffet table and find a seat.
- The team welcomes the participants and requests that they introduce themselves.
- The speaker is introduced.
- The speaker establishes an informal atmosphere by dressing casually and by emphasizing that the seminar is interactive. S/he invites participants to ask questions or make comments and encourages them to correct any mistakes they catch during the presentation.

- S/he presents on a health subject for 40 minutes, using flip charts, Power Point, videos, and other visuals to keep the participants engaged. Subjects may include bilingual HIV education tools for incarcerated patients, opportunistic infections (emphasis on diagnosis), discharge planning and continuity of care for patients being released, reproductive health of HIV+ women, hepatitis C and HIV co-infection, bio-terrorism, and HIV in Africa.
- Following the presentation, the speaker opens the conversation up for a question and answer session.
- The infectious disease doctor joins the conversation and helps relate the information that the speaker presented to the realities of corrections nursing.
- The nurse coordinator closes the seminar by asking participants to take a few minutes to complete the evaluation forms in their packets.
- The participants usually complete their CNE-credit request forms and submit them to the nurse coordinator before they leave the seminar to ensure quick processing. If time does not permit a participant to complete the form immediately after the seminar, s/he can mail it to the nurse coordinator later.
- The nurse coordinator reviews the evaluation forms with the medical director and often with the speaker. Future seminars may be modified based on the feedback received.
- The nurse coordinator submits the CNE credit requests, along with copies of the seminar-content description and registration sheet, to the education department in person for fast processing. S/he follows up on the requests to ensure that none is lost or delayed.

Two-Way Video Broadcast Option

While a luncheon seminar is taking place in the hospital's correctional unit, it can also be broadcast interactively to nurse participants in the correctional units of other facilities. Implementing a broadcast luncheon includes the following:

- The team selects two pilot sites that are correctional units willing to allow nurses to participate in the luncheon seminars via videoconference. It then identifies a coordinator at each site to organize participation and logistics.
- The nurse verifies that the units have the telecommunications infrastructure to support the broadcast seminar.
- The nurse sends flyers advertising the seminar to the selected remote coordinators who post them at appropriate locations in their respective correctional units. The flyers request that pre-registration be done through the remote coordinator who is onsite.
- Based on the number of attendees registered at the remote locations, the nurse coordinator prepares the appropriate number of participant packets and sends them to the remote coordinator four weeks in advance. (The packets contain the same information and materials outlined earlier, under Logistics.)
- S/he verifies with the remote coordinator that the equipment for the seminar is set up and working. Each remote site must have a video camera, satellite/T-2 line/telemedicine capability, and video screens with two-way capability.
- On the day of the seminar, all remote coordinators prepare their rooms and set up the food and packets.
- Participants enter, sign-in, receive their packets, help themselves to lunch, and take their seats for the seminar.
- At the end of the seminar, remote coordinators collect and mail to the nurse coordinator the "day-of" registration sheet and the CNE-request and evaluation forms.
- The nurse processes this paperwork in an identical fashion to a non-broadcast luncheon seminar.

PROMOTION OF ACTIVITY

- Brochures and flyers announcing the topic and speakers are sent by e-mail and post to correctional units and hospitals.
- Online advertising through hospital's online network
- Periodic mailings to correctional units

II. Logistics

STAFF REQUIRED

- An infectious disease doctor to develop the curriculum, co-facilitate presentations, and help relate information presented by

non-corrections speakers to the work of corrections nurses

- A nurse to serve as seminar coordinator, helping to develop the curriculum, obtain seminar accreditation, and manage logistics of the seminars
- A planning committee to aid in the development of the curriculum. The committee includes the nurse coordinator, infectious disease doctor, and experts on topics to be covered in the seminars
- Two remote coordinators to handle class logistics at remote sites for broadcast seminars

TRAINING & SKILLS

- The infectious disease doctor should understand nursing and education.
- The nurse coordinator must have a keen understanding of nursing education and be knowledgeable in HIV infection and care.
- Someone on the team must have experience working in corrections systems.
- Presenters must understand nurses and nursing.

PLACE OF ACTIVITY

The seminar takes place in the conference room of a university hospital providing correctional health care. Broadcasts are received in correctional facility conference rooms or other appropriate spaces at remote sites.

FREQUENCY OF ACTIVITY

Monthly

OUTSIDE CONSULTANTS

Guest speakers

SUPPORT SERVICES

Audio visual (videoconferencing) support for live broadcasts to off-site locations

CONDITIONS NECESSARY FOR IMPLEMENTATION

- The team must have the support and collaboration of the warden and correctional staff at the host institution where the seminar is broadcast.
- The team must be able to obtain CNE accreditation for the seminars.

III. Strengths and Difficulties

STRENGTHS

- The seminar establishes a relationship between people who take care of patients and experts in the disciplines that the seminars feature.
- The teaching program helps to ensure that patients receive complementary information from different health providers.
- Coordinating such an educational effort strengthens the medical professional teams of participating facilities.
- At no cost, participating nurses can receive CNE credits, which are offered less frequently than other continuing education credits.

WEAKNESSES

The nurses' varying levels of training make it difficult to design a curriculum that meets everyone's educational needs.

DIFFICULTIES FOR CLIENTS

None

DIFFICULTIES FOR STAFF

- The team may discover that not all nurses are equally prepared to master the technical information covered.
- The team may encounter challenges getting correctional units to "sign on" because participation adds to their work load.
- The wait time for accreditation is lengthy.

OBSTACLES FOR IMPLEMENTATION

- Correctional units with existing education programs can be resistant to change or to adopting new programs.
- There is sometimes a need to justify the dedication of extra resources to HIV training. Within the correctional facility culture, staff members may perceive the activity as "special treatment" because they are unaware of how much training is needed to successfully manage HIV disease.

ACTIVITY NOT SUITED FOR

N/A

IV. Outcomes

EVALUATION

- Evaluation forms are collected after each seminar.
- Informal feedback from nurses and correctional staff
- Tracking by the infectious disease doctor of calls received from nurses following a seminar
- Periodic analysis of HIV+ inmates' health records

EVIDENCE OF SUCCESS

- Following a seminar, the number of calls to the infectious disease doctor from nurses seeking advice on caring for HIV+ inmates or reporting a health related problem increases.
- Nurses report thinking more critically about patients and their care.
- At participating facilities, the death rate has decreased in the prison population and more HIV+ inmates are achieving undetectable viral loads.
- Correctional facility personnel report improvements in HIV care.

UNANTICIPATED BENEFITS

The activity helps to create a coordinated team across the state and within the correctional units of participating facilities.

"CONNECTING TO CARE" ELEMENTS OF ACTIVITY

- The nurses apply the information they learn to their work and are able to provide better care and information to HIV+ inmates.
- The CNE credits, offered at no cost to attendees of the seminar, are a strong incentive that greatly increases nurse participation.
- The activity fills a gap in HIV medical education for correctional nurses.
- The seminars are tailored to nurses working in a correctional facility environment who have a constant need for the latest information on HIV medical care.
- Nurse participants begin to think critically and to look holistically at HIV care and the patient.

KEEP IN MIND...

- Make sure the seminar is CNE accredited before advertising it as such.
- Be persistent if you only have a few participants at first.
- Start out with seminars every two to three months to get used to the amount of work each involves.
- Be sure you are not stepping on others' perceived turf.
- Be prepared to justify your additional spending on HIV.

BUS ROUTE TO CARE

20

Bus Route to Care is a community level intervention that aims to remove a common barrier to health care in the United States: a lack of transportation. The key characteristics of the Bus Route to Care are: the collaboration among area service providers; the helpful and friendly demeanor of the caseworkers staffing the bus; and the emphasis placed on allowing people to make their own decisions about the care they receive.

CURRENT ACTIVITY SETTING
Health Service Organization for Homeless Individuals, General Program

- ✔ Directly links the client to medical care
- ✔ Gets the client in a conversation about starting medical care
- ✔ Brings the agency closer to where HIV+ people are so that the conversation can begin

I. Description

OBJECTIVES

- To provide clients with transportation to health and social services
- To maximize opportunities for people to exit homelessness and increase their access to community services

POPULATION SERVED

- HIV+ and HIV- homeless individuals
- African American, Latino, and Caucasian populations

ACTIVITY DESCRIPTION

Bus Route to Care uses community collaboration to provide homeless individuals with free transportation to social service organizations and health clinics.

QUICK NOTES:

"We want to make the road to health care a little easier for homeless people."

— EXECUTIVE DIRECTOR

Needs Assessment and Development

- The agency conducts a survey of area residents who are homeless to learn which service providers they would be interested in using if they had transportation.
- Survey responses are reviewed and the locations of the selected service providers are plotted on a map.
- The agency narrows the selections to a corridor of 18 service organizations that could be easily reached on a single bus route. Agencies with HIV specific services are included on the route.
- The agency surveys the 18 organizations and learns their hours of operation to ensure the route's practicality and feasibility.
- It determines the bus stops and timetable.
- Next, it submits the bus-route schedule to transportation companies and requests their bids for operating a bus along the route.
- The agency consults with its consumer advisory board (consisting of homeless individuals and service providers) on the types of behavior to expect from clients and the best ways to monitor people's seating and belongings on the bus. The agency also asks about the best way to market the activity.
- The agency determines the staffing needs for the bus.
- Approaching "friendly" members first, the agency appeals to the city council for funding. It provides data on homeless people and their needs and outlines the ways Bus Route to Care will benefit the city.
- After securing funding for the activity, the agency contracts staff for the bus route using the human resources of participating organizations. The agency selects two caseworkers every six months to rotate staffing on the bus.
- The agency attorney reviews the bus-route activity to identify legal liabilities and possible risks, and to assess the agency's need for insurance coverage.
- It develops a policy for the distribution and use of bus passes. Under this policy, the participating service providers distribute single-use ride passes to eligible clients.
- The agency establishes a secure Web page with a database that enables participating service organizations to:
  - Register new clients electronically,
  - Review a list of "banned" clients (see Bus Policy below), and
  - Prepare and print bus passes for on-site distribution to clients. (The agency codes the bus passes by client name in order to track the number of clients served, providers used, and rides given.)
- The agency trains staff from all of the participating service organizations to use the Web-based database.
- Caseworkers who wish to provide passes to clients must take a ride on the bus beforehand.
- The agency trains the bus staff to collect passes and documentation of homelessness for the service and to record in the database who has ridden the bus. The agency also trains the caseworkers, who are assigned to ride the bus, to give clients service-provider information and referrals.
- The caseworkers meet weekly with their supervisor. In these meetings, caseworkers receive support, supervision, and further training.

Bus Route

- The bus runs from 7:30 a.m. to 5:30 p.m., Monday through Friday.
- The bus route begins at the largest of three homeless shelters.
- As clients board the bus, the caseworkers greet them. If it is a client's first time riding the bus, a caseworker will approach them and ask if they'd like to talk about available services.
- When filled to capacity, the bus heads to the first service organization on its route.
- It then continues on to the 17 other provider stops.
- After completing this first loop, the bus returns to the homeless shelters, fills, and delivers clients along the same provider loop.
- The bus route repeats until clients from all three homeless shelters have been delivered to their providers.
- The bus route then shifts to a more narrow loop around the social and health service providers to take clients from agency to agency.
- As 5:30 approaches, the bus repeats its first loop, transporting clients from the provider stops to their respective homeless shelters.

Bus Policy

- No weapons are permitted aboard the bus.
- Physical altercations and heated verbal arguments are prohibited.
- Caseworkers on the bus have discretion to ban a client from the bus for policy violations. Ban duration depends on the severity of the offense.

How Clients Obtain Bus Passes

- There are four ways for a client to obtain a bus pass:
  - Placing a request at one of the 18 participating agencies.
  - Participating in a meeting with agency outreach workers anywhere in the community. If an outreach worker determines in conversation with a client that the bus would be useful in helping the client reach his/her goals, the outreach worker may give the client a bus pass with a provider referral. Later, the outreach worker registers the client in the Web-based database.
  - Placing a request with staff while staying at a homeless shelter in the city.
  - Visiting one of 30 to 40 non-participating agencies throughout the city—including health, social, and HIV specific organizations, agencies of the federal and local governments, and non-profit organizations.

PROMOTION OF ACTIVITY

- Word of mouth from the clients and staff of other service organizations
- Monthly presentations by a national homeless coalition include promotion of Bus Route to Care.
- Agency newsletters and service brochures
- Agency case worker referrals

II. Logistics

STAFF REQUIRED

- Caseworkers (2) to provide service information, referrals, and a welcoming presence on the bus
- Bus driver
- Caseworker supervisor to oversee the caseworkers and other Bus Route to Care staff
- Administrative support

TRAINING& SKILLS

- Bus driver should have or receive basic training in the prevention and management of conflict, aggressive behavior, substance abuse, mental disorders, and other conditions associated with homelessness.
- Staff members (bus driver excluded) must learn to use the Web-based database.

PLACE OF ACTIVITY

- Inner-city homeless shelters and health and social service organizations
- 40-passenger bus

FREQUENCY OF ACTIVITY

Monday-Friday, 7:30 a.m. - 5:30 p.m.

OUTSIDE CONSULTANTS

The agency contracts the bus driver through a private transportation company.

SUPPORT SERVICES

Caseworkers on the bus call the agency via a cell phone to request a translator or signer when necessary.

CONDITIONS NECESSARY FOR IMPLEMENTATION

- The local political environment must be receptive to implementation of this activity.
- Funding for the activity must be secured at the onset.
- Travel corridor must be compact for route to be viable.
- Riders with persistent coughs must wear a mask as a TB prevention measure.

III. Strengths and Difficulties

STRENGTHS

- Addresses one of the top barriers to care: the lack of transportation
- Uses client-driven care planning
- Fosters true collaboration among service providers
- Offers an entry portal into a larger system of care

WEAKNESSES

None

DIFFICULTIES FOR CLIENTS

- The bus doesn't stop at each and every service organization that clients would like to use.
- On occasion, clients must be turned away because the bus has reached its capacity.

DIFFICULTIES FOR STAFF

- Caseworkers rotate every six months, necessitating periodic training.
- The forms collected to verify clients' homelessness are cumbersome for staff.

OBSTACLES FOR IMPLEMENTATION

Street detours due to road construction may result in frequent alterations to the bus route.

ACTIVITY NOT SUITED FOR

- Individuals who exhibit violent or threatening behavior
- People who are uncomfortable wearing a mask when they have a persistent cough

IV. Outcomes

EVALUATION

- The agency conducts quarterly, client-satisfaction surveys and semi-annual focus groups to assess the activity.
- There is an annual review of the route through satisfaction surveys given to clients (30% of whom are formerly incarcerated).

EVIDENCE OF SUCCESS

- Clients report they feel "very good" about the activity.
- Clients report that the activity makes it easier to keep appointments.
- Ridership is high, and the bus often fills to capacity.

UNANTICIPATED BENEFITS

- Clients' self-esteem improves when they know that people want them to receive care.
- A sense of camaraderie develops on the bus.
- Bus Route to Care has been a financially efficient way for the agency to meet its goal of bringing people into care. As a result, the agency saves money.

"CONNECTING TO CARE" ELEMENTS OF ACTIVITY

- The caseworkers aboard the bus are warm and gracious and create a welcoming environment for clients.
- The caseworkers provide information and referrals to any client who asks.
- It is the clients who make the decisions about their care.
- With transportation assured, clients have easier access to the care they choose.
- The bus stops are marked by signs bearing the same logo, which is well recognized by the target population.

KEEP IN MIND...

- The selection of stops has to be client-driven in order to avoid backlash from service providers that have not been selected.
- The activity is a good way to identify service providers that clients feel are truly useful to them.

Notes page

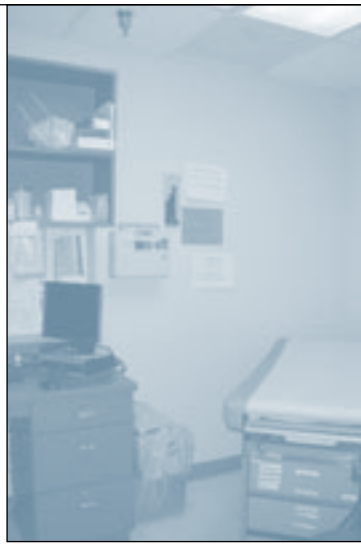
TREATMENT ADHERENCE NURSE

21

Treatment Adherence Nurse is an individual level intervention designed to actively engage formerly incarcerated individuals who are HIV+ in the planning and follow through of their medical care. The key characteristics of the Treatment Adherence Nurse are: the utilization of a nurse who specializes in HIV care; the staff's knowledge of the population served; the formal relationships established between the agency and local medical providers; and the client's involvement in the development of the treatment adherence plan.

CURRENT ACTIVITY SETTING
Community-Based Service Organization for Formerly Incarcerated Individuals, Health and HIV Services

- ✔ Directly links the client to medical care
- Gets the client in a conversation about starting medical care
- Brings the agency closer to where HIV+ people are so that the conversation can begin



I. Description

OBJECTIVES

- To educate clients about the importance of HIV treatment and the medications available
- To ensure that clients adhere to their treatment regimens
- To link clients to care and help keep them in care
- To help clients negotiate the health care system and adapt their role and behaviors as patients

POPULATION SERVED

- HIV+ African American, Caucasian, and Latino men and women with criminal justice histories

ACTIVITY DESCRIPTION

In Treatment Adherence Nurse, the nurse works with clients individually, talking with them about engaging in treatment and helping them adhere to their regimens. The activity also offers an agency team that supports the client in successfully transitioning back into the community after incarceration.

QUICK NOTES:

"You can case manage someone great or put them in housing, but if they're not taking their meds and sustaining physically, all else will fail."

— DIRECTOR OF HEALTH AD TRANSITIONAL SERVICES

First Steps

- To initiate the activity, the agency and treatment adherence nurse create strong linkages with several hospitals and medical providers in different areas of the city where agency clients may seek care.
- The nurse travels to meet the doctors and nurses in person to build trust, make agreements for treating agency clients, and establish a relationship that will allow for close discussions about client cases.

Client Intake

- The client arrives at the agency and goes through intake and assessment to determine their HIV status, immediate needs, and eligibility for agency services.
- The client is escorted to the clinical supervisor for psychosocial assessment.
- The psychosocial report is sent to staff in housing and case management as well as to the treatment adherence nurse and director of health services.
- The clinical supervisor evaluates the client and refers him/her to an agency case manager.
- The case manager explains to the client the role of the treatment adherence nurse and the services offered. If the client is interested, the case manager walks the client to the nurse's office.

Treatment Adherence Nurse and Client Relationship

First Meeting

- The treatment adherence nurse greets the client and makes clear that the client need not see others in the agency to be eligible for the nurse's services. Private appointments can be scheduled just between the two of them. The nurse describes his/her role in detail and what their relationship can be. The nurse will be the client's medical contact at the agency and will work closely with the client on all medical needs.
- The adherence nurse opens a conversation about what it means to be in care and helps to define what medical care is for the client.
- The nurse completes a medical assessment through conversation rather than a "question and answer" format. The client's medical history and past relationships with medical providers are thoroughly discussed.
- If there is a provider that the client would like to reconnect with or if it is determined that a new referral is required, the nurse describes how s/he can help.
- Together, the nurse and client establish an agreement about next steps and define roles for their relationship.
- Once the plan is developed, the client and nurse discuss how the client will adhere to the plan in light of possible obstacles, such as an uncertain housing situation or transportation difficulties. They come up with ways for the client to continue to take medications and stay in care. If the client is already taking medications or may be soon, the nurse outlines the client's medication delivery or pick-up options.
- If the client has a doctor in mind with whom to re-establish care, the nurse calls that doctor's office and schedules an appointment for the client. If the client does not have a provider, the two of them discuss options for a referral.
- The nurse then makes an appointment with the provider the client chooses. S/he asks if the client feels comfortable going alone to the appointment. If not, the nurse arranges for a peer escort.
- Once the medical appointment is scheduled, the nurse and client discuss what the client should expect during the visit. Subjects covered include what to do if the client has to wait past the appointment time, the forms the client will be asked to fill out, and questions to ask the provider.
- To help the client remember some of the key items to discuss with the provider, the nurse writes them on the back of his/her business card, which the client takes to the appointment.
- After the client is comfortable with the medical appointment details, the nurse discusses the steps to take if the client gets a prescription or a referral.
- The client and nurse schedule their second appointment for immediately after the client's medical appointment. The client brings any prescriptions received and information about specialist referrals from the doctor to that next appointment.

Second Meeting

- The client and nurse begin the meeting with a discussion of what happened during the medical appointment. They talk about the importance of new prescriptions and appointments to meet with specialists. The client is counseled on how to answer questions from the specialists about being HIV+.
- If the client is prescribed medications but has no place to safely keep them, the nurse offers to store them in her office, which is equipped with a refrigerator.
- The nurse urges the client to schedule the next medical appointment.
- If the client will be starting or continuing treatment, the conversation turns to the medications: what they are and at what times they must be taken. The nurse discusses in detail the prescribed medications and the importance of treatment adherence.
- S/he spends time reviewing what drug resistance means, how it happens and how to avoid it. This information is reinforced at each meeting. Nutrition may also be discussed at this time.
- Together, they develop a plan for the client to take the medications. The nurse asks, "What do you need from me to help you remember or help get you to a point where you can adhere?" The client begins to consider how to incorporate the medications into his/her life.
- The nurse identifies other issues and activities in the client's life that may influence their attention to, and engagement in, medical care.
- At the end of the second meeting, the client and nurse schedule their third meeting for the following week.
- Following this second meeting, the nurse contacts the client's medical provider to discuss issues the client may have raised or simply to inform the office of his/her involvement in the client's care.
- If a peer escorted the client to the medical appointment, the peer shares with the nurse or the client's case manager his/her perspective on how the appointment went.

Third Meeting

- By this time, most lab work is back and the doctor might have prescribed new medications. The nurse and client review the lab results and any new drugs.
- If the client has already begun the medications, the two talk about "how it has been going" for the client. If the client has yet to start taking the medication, they discuss the client's life situation and establish a regimen.
- By this third meeting, the client begins to feel more confident. The nurse nurtures this confidence consistently with positive reinforcement and recognition for the steps taken.
- The nurse and client discuss other services offered by the agency.
- They agree on a time for the next appointment. Depending on the client's need, they may revisit the frequency of their established meetings and decide to meet bi-weekly or monthly.

Ongoing Meetings

- The length of sessions get shorter as the client follows through on the established plan. In all of the sessions, the nurse and client continue to review and discuss the client's medical appointments and regimen, and problem-solve any needs.
- The nurse discusses the relationship of the client with the medical providers. Sometimes s/he suggests role playing to help the client communicate needs.
- The client and the nurse regularly discuss the effects that legal and illegal substances can have on prescribed treatments.
- The nurse communicates with the client's case manager and other agency staff working with the client. These case reviews help with the coordination of other important services for the client, such as rescheduling parole appointments to accommodate the client's medication schedule or medical appointments.
- The relationship between the nurse and the client ends when the client becomes confident interacting with the medical-provider network, taking medications, and managing life under medical care.
- The client can, however, make appointments with the nurse on an as-needed basis if medications change or problems arise that may disrupt regimen adherence.

PROMOTION OF ACTIVITY

- All agency clients are introduced to the activity at intake.
- Clients hear about the activity from their discharge planner or through word of mouth from other clients.
- Clients are referred by other local agencies including those for parole or probation.

II. Logistics

STAFF REQUIRED

Treatment adherence nurse

TRAINING& SKILLS

- The nurse should have counseling skills, a clear understanding of criminal justice issues, HIV specific training, and knowledge about HIV medications. Computer literacy is needed for data entry.
- The nurse is trained in cultural competency for this population to help "get past roadblocks."

PLACE OF ACTIVITY

The activity takes place at the agency, in the nurse's office. The office is a private and comfortable space equipped with a refrigerator, that allows the nurse to keep medications for clients when necessary.

FREQUENCY OF ACTIVITY

- Clients initially meet with the nurse weekly and progress to bi-weekly or monthly meetings depending on their need.
- Most clients meet with the nurse for approximately six months.

OUTSIDE CONSULTANTS

None

SUPPORT SERVICES

Volunteers as peer escorts to services

CONDITIONS NECESSARY FOR IMPLEMENTATION

- A team approach at the agency is necessary to ensure that the activity and clients are supported on every level and that clients receive a consistent message from all agency staff about the importance of involvement in their own medical care.
- The activity relies on a strong linkage agreement with medical providers: medical providers agree to perform high quality, efficient care for clients and ensure that these clients will neither wait for hours nor be turned away.
- The broader medical service network must be aware of the importance of the treatment adherence profession.

III. Strengths and Difficulties

STRENGTHS

- The client and treatment adherence nurse are doing the work together. From the beginning, the client is involved in making change.

- Having a medical background equips the nurse to understand the clinical dimensions of HIV care and treatment in a way that non-medical professionals may not be able to do.

WEAKNESSES

None

DIFFICULTIES FOR CLIENTS

- Having to begin a new relationship with medical providers
- The length of the wait before a client can see the agency's only treatment adherence nurse

DIFFICULTIES FOR STAFF

- One person is not enough to address the demand.
- The nurse doesn't always have time to follow up with all the clients who drop out.

OBSTACLES FOR IMPLEMENTATION

None

ACTIVITY NOT SUITED FOR

N/A

IV. Outcomes

EVALUATION

- The treatment adherence nurse prepares weekly reports on client progress for inter-service team meetings.
- The agency regularly conducts client surveys.
- Client charts are reviewed in follow-up meetings and outcomes are documented to measure the number of clients who start and maintain care, follow prescribed treatment regimens, make and keep medical appointments, and bring requested lab work to the nurse.

EVIDENCE OF SUCCESS

- Staff reports that clients are adhering to their treatments more and are in better health than they were when they first began accessing agency services.
- Regular reviews of client charts reveal an increase in the number of clients in care, an increase in maintenance of care, an increase following prescribed treatment regimens, an increase in appointments made and kept with medical providers, and an increase in the number of clients bringing lab work back to the treatment adherence nurse.
- Clients report that the nurse is an integral part of their medical care.
- Medical providers express appreciation for the services of the treatment adherence nurse and stress the important role these services play in helping patients to access medical services.

UNANTICIPATED BENEFITS

The activity has helped clients stay drug free.

"CONNECTING TO CARE" ELEMENTS OF ACTIVITY

- Clients are able to have a real discussion, in some cases for the first time, with a health professional about their care.
- The nurse teaches clients to take full control of their health and coaches them on interacting with medical providers.
- The level of accountability established empowers clients; they want to follow their regimen.
- Clients trust that the nurse will refer them to a place of care that is safe.
- The nurse helps clients build trust in a medical relationship where trust has been absent before.
- The nurse initiates the process of care before the client asks for help, which is sometimes perceived as a sign of weakness by some formerly incarcerated clients.

KEEP IN MIND...

- The activity should not stand alone; it should be part of a client's continuum of care services.
- Remember to include the nurse in team case conferencing to ensure that the complex needs of clients, including those impacting medication and treatment adherence, are addressed holistically.
- Don't make the activity Medicaid reimbursable because it would greatly limit the time the nurse can spend with each client.
- Remember to "support" but not "enable" the client.

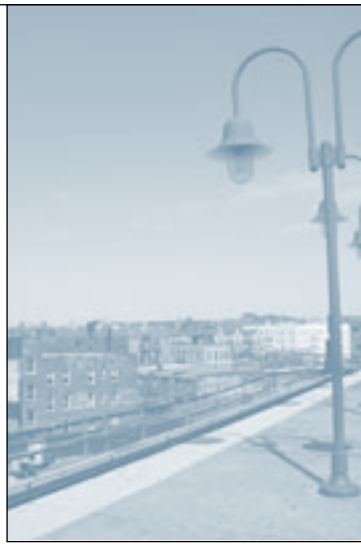
PEER MENTOR ESCORT TO CARE

22

Peer Mentor Escort to Care is an individual level intervention designed to help current clients—women recently released from a correctional facility, including HIV+ women—to successfully navigate the community network of health and social services. It also provides temporary employment and job preparation to former clients who serve as peer mentors. The key characteristics of Peer Mentor Escort to Care are: the immediate connection established between the agency and clients upon their release; the training and support system offered to the peer mentors; and the trusting relationship that develops between the client and peer.

CURRENT ACTIVITY SETTING
Community-Based Service Organization for Women with Criminal Justice Histories, Reentry Services

- ✔ Directly links the client to medical care
- ✔ Gets the client in a conversation about starting medical care
- Brings the agency closer to where HIV+ people are so that the conversation can begin



I. Description

OBJECTIVES

- To ensure that clients don't relapse or disengage from health and social services during the critical time after release
- To help clients make healthy life choices
- To provide greater support of clients' case management goals
- To help formerly incarcerated women obtain employment and gain work experience as peer mentors in a supportive environment

POPULATION SERVED

- Women with criminal justice involvement

ACTIVITY DESCRIPTION

Formerly incarcerated women gain work experience by supporting other women who have been recently discharged from a correctional facility as escorts to and from appointments for medical and social services.

QUICK NOTES:

"This intervention puts someone at the gate, so clients won't have to return to an unhealthy environment."

— PROGRAM OPERATIONS DIRECTOR

Development / First steps

- The agency identifies funding sources and a program manager for Peer Mentor Escort to Care.
- The program manager develops a nine-month-long training institute, which has three aims:
  - To provide peer mentors with a working knowledge of community resources and the health and social issues faced by agency clients
  - To provide support and professional development to former agency clients
  - To staff a peer escort service for newly released clients that will help them engage in health and social services within the community.
- The program manager prepares a job description for the peer mentor positions and interviews applicants.
- Selected applicants are offered a nine-month paid position with a 20 - 30 hour work week.
- The program manager, on an ongoing basis, interviews interested agency clients, some of whom apply after using the Peer Mentor Escort to Care themselves.

The Training of Peer Mentors

First Two Weeks: Orientation

- The curriculum covers rule establishment and administrative expectations, such as filling out timesheets properly, appropriate dress code, and professional behavior.
- A supervisory relationship between peer mentors and the manager is established.
- The program manager introduces peers to the agency's services and discusses the local network of social service agencies.
- Peer mentors then visit agencies (e.g., shelters, vocational services, and housing and family programs) to familiarize themselves with the resources available to clients.
- At the end of orientation, peer mentors are introduced to a clinical consultant who will meet with them on a weekly basis. Independent and group supervision meetings are established.

Beyond Orientation: Support Training and Supervision for Peer Mentors

- Aided by the program manager, peers select and enroll in brief training courses that appeal to their strengths and interests and may help them reach their program goals. The trainings are offered by the agency and other local service providers. Course topics may include computer literacy, case management, harm reduction, HIV confidentiality, and domestic violence.
- The agency also trains the peers to use the agency-wide database in which staff logs the services provided to clients.
- Administrative supervision of peers by the program manager is ongoing and includes medical advocacy training, conflict resolution and negotiation, "Medical 101," (a course specific to HIV+ women's health) and the peer's role as an advocate.
- Problem solving in the workplace is also covered.
- Clinical supervision occurs weekly with the clinical consultant. The sessions include mental health training, problem-solving "on the job" difficulties, and discussions about "triggers," transference, and counter-transference.

Escort Training

- Peer mentors begin to escort clients after completing the two-week orientation. The types of escorts vary and may require different skills. Peer mentors receive orientations to each new type of escort by "shadowing," or accompanying, another peer mentor who is experienced in that kind of escort on assignment.
- After completing the escort, the newly oriented peer mentor returns to the agency to discuss the experience with the program manager. Together, they determine whether or not the peer mentor is ready to conduct an escort alone.

Peer Mentor – Client Escort Scenario

- An agency staff member fills out an official request form and gives it to the program manager. The request documents where the client is going and the time of the appointment(s).
- The program manager reviews the request, determines the appropriate number of peers for the appointment (some may need two if the location or time of the appointment is unsafe for solitary women), and delegates the assignment. Escort assignments

include meeting clients when they are released from a correctional facility, supporting clients while they obtain medical benefits or go to appointments with parole/probation officers, medical providers, apartment viewings, family court for family visitation, or the Department of Motor Vehicles to obtain photo identification.

- The peer mentor learns more about the client's situation (release date, medical history, housing, etc.) from the staff member who made the request.
- The peer mentor has a "case conference" with the program manager to assess what will be needed for the escort. When necessary, transportation and lunch money are provided for the peer and client.
- After the case conference, the peer sets up a time and location to meet the client.
- Throughout the escort, the peer demonstrates an attitude of positive encouragement and may serve as an advocate for the client in certain situations (helping, for example, to facilitate communication with clinicians and service providers).
- After completing the assignment, the peer mentor writes "progress notes" from the escort in the agency's database. The client's case manager places a copy of these notes in the client's confidential file.
- The peer reports to the program manager on the dynamics of the escort: what went smoothly, what was challenging, etc.
- The peer may discuss certain escort situations with the clinical supervisor during their weekly meeting.

Peer Mentor Professional Development

- While peers are gaining skills as mentors, the case manager provides professional development counseling for job placement. This counseling includes:
  - Discussing the peer's transition out of the program at the end of nine months
  - Drafting a resume and set of cover letters that document the skills and experience acquired through the peer mentor training
  - Encouraging the peer to review job postings, attend job interviews, and select appropriate job attire
- As peers near the end of their nine-month training, their clinical support is increased to help prevent behavior-related relapses.
- Each peer participates in an exit interview with the manager before leaving.

PROMOTION OF ACTIVITY

- Incarcerated clients find out about the service from their discharge planner.
- Post-release clients learn of the service from their case manager or counselor.
- The agency offers a weekly "new client orientation session" for recently released clients.
- Word of mouth from other clients

II. Logistics

STAFF REQUIRED

- A director of reentry services is responsible for securing funding and contracting management.
- A program manager of peer mentor services administers support and supervision to the program, recruits peers, and serves as the ongoing professional development coordinator.
- Peer mentors

TRAINING & SKILLS

- Agency staff must have supervisory experience, strong communication skills, and knowledge of correctional systems and community resources. All involved staff must be flexible and patient.
- Peer mentors must have criminal justice histories. They also need to demonstrate the requisite stability to fulfill the

requirements of employment and an interest in doing social service work. The mentors must complete a two-week orientation and participate in ongoing training.

PLACE OF ACTIVITY

- The professional development takes place at the agency, where the peer mentors have access to workstations and computers.
- The escort routes and destinations are established and determined by individual client needs.

FREQUENCY OF ACTIVITY

- Each peer mentor works Monday - Friday, 20 - 30 hours a week.
- The mentors attend weekly and bi-weekly supervision meetings.
- Agency clients request escorts about ten times in their first post-release month, then once a week, on average, for nine - 12 months.

OUTSIDE CONSULTANTS

Clinical consultant

SUPPORT SERVICES

Training resources provided by the community

CONDITIONS NECESSARY FOR IMPLEMENTATION

- Well-structured agency support system for peer mentors
- High-functioning agency administrative system
- Approval from funding sources
- Existence of relevant training resources in the community that the mentors can use

III. Strengths and Difficulties

STRENGTHS

- The client places high value on the relationship with the peer mentors.
- The mentors support clients in a way that other direct service staff cannot.
- Clients feel supported and want to give support back.
- Clients respond well to the sensitivity and understanding of the peers.
- Peer mentors are provided with a unique experience in job readiness.

WEAKNESSES

- There is high mentor turnover due to new employment, the nine month position cycle, and burnout.
- Training the mentors while they do their job is difficult for the agency to manage.
- Since the peer mentors are learning on the job, they may occasionally be unprofessional or allow a client to miss an appointment.
- Agency staff may afford the peer mentors graces that aren't common in the workplace, which may leave some with unrealistic expectations.

DIFFICULTIES FOR CLIENTS

- The peer mentors often have limited formal education experience.
- Personal and professional boundaries are sometimes not clearly established between the peer mentor and the client.

DIFFICULTIES FOR STAFF

- Working with peer mentors requires the staff to make difficult decisions in order to strike a balance between treating them as clients (who need a great deal of support) and as employees (who are held to certain expectations).
- It is difficult to draw clear, professional boundaries between the agency and peer mentors during the professional development process.
- There is high turnover of peer mentors.

OBSTACLES FOR IMPLEMENTATION

Insufficient funding for the director, manager, and consultant positions

ACTIVITY NOT SUITED FOR

N/A

IV. Outcomes

EVALUATION

- The agency conducts quarterly client-satisfaction surveys and program evaluations and solicits feedback through client advisory boards.
- Case manager collects feedback from peer mentors on each client case.
- The case manager logs requests for service by the clients.
- The peer mentors complete progress notes following each escort.

EVIDENCE OF SUCCESS

- Clients who use peer escorts have increased their use of services at the agency and within the broader community more than clients who do not use peer escorts.
- Client feedback suggests that the peer mentor program is integral to their success in navigating the health care system.
- Client evaluations have shown that, after receiving peer mentor services, clients are better connected to primary medical care and gynecological care, less reliant on emergency room care, and better prepared to self-advocate during medical appointments.
- Both clients and peers report an increase in clients' capacity to stay at appointment sites when they are scared, tired, and want to leave.
- There is an increase in client requests for the service.
- There is an increase in the number of current, full-time staff members at the agency who are former peer mentors.

UNANTICIPATED BENEFITS

- Currently incarcerated individuals who have not had previous contact with the agency are increasingly requesting peer mentor escorts when they are discharged.
- Clients benefit from seeing someone who had been incarcerated holding a successful position as their peer mentor.

"CONNECTING TO CARE" ELEMENTS OF ACTIVITY

- The peer mentor physically brings the client to care during a critical time in the client's transition back into the community.
- The advocacy that the mentor provides helps to facilitate the client's transition from a correctional facility to a healthier life in the community.
- Clients benefit from seeing someone who, like themselves, has been incarcerated and is now in a successful position as their peer mentor.
- The peer mentor, who is trained in medical advocacy, knows what questions to ask or how to coach the client to ask of medical providers.
- The connection with the peer mentor occurs before the client can return to a potentially unhealthy environment.
- Having a peer mentor with experience navigating the system of social service and health care and the ability to prepare the client for what to expect during appointments is really helpful in alleviating fears of the client.
- Clients begin to "see themselves in the peer mentor." The peer mentor is someone who "has done it and is successful."

KEEP IN MIND...

- The more you support the peer mentors, the better the delivery of services to the clients.
- Be clear in your expectations of the peer mentors.
- Remember that the quality of the mentors depends on the quality of the supervision they receive.
- Be client-centered when developing the peer mentor training curriculum.
- Assume nothing!

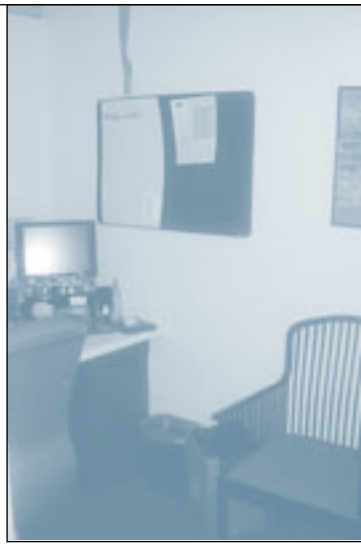
FAMILY MAPPING

23

Family Mapping is an individual level intervention designed to help people first to understand characteristics of their families and then to draw on the identified strengths of the family in order to engage in health care, including care for HIV infection. The key characteristics of Family Mapping are: the respect paid to the family as it is defined by the client; the creation of a visual account of a family's relationships, achievements, and resource network; and the non-judgmental, participant-driven nature of the activity.

CURRENT ACTIVITY SETTING
Family-Centered Social Service Agency for People with Criminal Justice Involvement, Family Case Management

- ✔ Directly links the client to medical care
- ✔ Gets the client in a conversation about starting medical care
- Brings the agency closer to where HIV+ people are so that the conversation can begin



I. Description

OBJECTIVES

- To enable clients to identify the "negative" and "positive" patterns that exist in their families
- To help clients recognize and draw on the strengths of their family
- To provide a structured mechanism to help formerly incarcerated clients develop a plan to remain in the community, gain access to service providers, and improve their well-being and that of their families

POPULATION SERVED

- Individuals with a history of criminal justice involvement and their families, including:
  - Individuals with low income from African American and Puerto Rican communities
  - Current and former injection drug users
  - Public housing residents

ACTIVITY DESCRIPTION

Family Mapping uses a creative, visual model that allows insight, facilitates problem solving, and supports an overall balanced life for HIV+ individuals newly released from correctional facilities. It is a process that begins during the first meeting, but can take more than one visit to complete.

QUICK NOTES:

"Families may be part of the problem, but they are also part of the solution."

— AGENCY DIRECTOR

- Clients arrive at the agency through a variety of channels. Parole/probation supervision officers may directly refer to the agency an individual recently released from a correctional facility, or an agency case manager attends a home visit with the officer to meet with the family of a soon to be released inmate. During such a home visit, the case manager talks with the family about the resources the agency can provide.
- If a family member does not contact the agency after the visit, the case manager follows up with them. S/he may also contact the inmate before discharge to extend an invitation to visit the agency upon release.

First Meeting at Agency

- A client and a family member arrive at the agency, where a receptionist greets them and asks if they have a scheduled appointment. If they don't, the receptionist offers them an impromptu meeting with a family case manager.
- The family case manager provides an introduction to the agency and begins to learn about the client's situation. The case manager's interview style is affirmative; it builds rapport and gives positive reinforcement. S/he watches for body language that signals discomfort or nervousness and adjusts the questions accordingly.
- The discussion addresses the client's needs and how the agency can help meet them.
- To begin the family mapping process, the case manager inquires about family members who live in the area.
- The case manager mentally maps the client's family network and verbalizes the strengths of the family. In addition, the case manager encourages the client and family member to talk to each other and work together to identify family dynamics.
- Before the initial visit ends, the client signs necessary agency forms.
- The first visit sometimes ends at this point, with a follow-up visit scheduled. Other times, the visit continues with Family Mapping.
- It is best to begin and complete a family map within the first two weeks of meeting the client.

Identifying the Family

- The case manager introduces the process of Family Mapping by observing, "We are all affected by the dynamics of our families and networks," and then asking, "Could we take a minute to put down on paper what I'm hearing from you?"
- Using the information that the client and family member have already shared, the case manager starts to draw a family tree, placing the client at its center.
- The case manager then probes for further information to flesh out the map. Possible questions include, "Who is in your household?" and "Do you have any brothers or sisters?"
- On the sheet of paper, the case manager draws circles around the family members who live together and notes the gender and ages of everyone on the family tree.
- The case manager asks about other people who are not related by blood but may be a part of the client's family, such as a frequent child care provider or godparents.
- A discussion about the quality of family relationships begins.

Charting Strengths in the Family

- Inquiring about these relationships, the case manager might ask, "Who do you feel closest to?" S/he marks these close relationships on the map.
- During this conversation, the case manager continues to identify and highlight the strengths apparent in the client's family network. S/he may also invite the client to bring in other family members for support: "Can you bring your daughter in with you sometime? I'd love to meet her."
- The case manager places symbols on the family map to indicate people's strengths and accomplishments, such as graduating from high school, being a nurturing figure in the family, or achieving sobriety.

Charting Tensions in the Family

- The case manager asks about any tensions or issues the family is dealing with. How, for example, the family responded to the client's incarceration and return home.
- The case manager places symbols on the family map to indicate conflicts or tension with other family members, and relationships affected by separation, divorce, or death.

Identifying Positive and Negative Patterns in the Family

- When the client's needs and problems surface, the case manager finds out if these issues are part of a larger pattern in the family. For example, s/he may ask if anyone else in the family is HIV+, has used substances, has been incarcerated, or has mental health issues. Together, they will mark the family map with lines and colors to signify the needs and issues discussed.
- Looking at the family map, the case manager asks the client to identify any positive or negative patterns in the family, including those for level of education, criminal justice experience, substance use, etc. The case manager can assist the client in this discovery by asking such questions as, "What do you see in this map?" and "What do you notice about substance use in your family?"
- The observations the client and case manager make while looking at the whole map help them to understand patterns in the family that may have contributed to the client's current life situation. What's more, it can stimulate new thinking and actions that promote the client's health and well-being.
- The case manager also assists the client in discovering positive patterns, such as people helping or supporting each other, that will be helpful to the client in making desired changes in health, housing, and life.
- Important in this discussion is asking how the client helps or supports family members: "Who do you help?" or "What kinds of things do you do for your family?" The case manager reinforces the ways the client is a positive support in the family in order to build the client's self-esteem.

Identifying Needs

- The next step in the discussion is to focus in more detail on the client's life situation and identify needs. The case manager asks specific questions about the client's experience being recently discharged from jail/prison and with substance use, lack of housing or employment, and HIV and other health concerns.
- The case manager explores the family's relationship with the health care system by asking the client and family member specific questions: "When's the last time you've had a good check-up?" "Where do you go for health care? Do you like your doctor?" The case manager may then ask the client, "Do you have any specific health issues you want help with?"
- As the conversation continues, the case manager, who is trained to identify symptoms of HIV disease (i.e., symptoms of opportunistic infections), observes for any physical signs of health concerns.
- When a client volunteers an HIV+ status, the case manager draws the client into further discussion to learn whether s/he received treatment in the correctional facility, is currently on a treatment regimen, and how the client feels about other family members knowing his/her HIV status. The case manager may offer to speak to the client privately, or may ask the client's family member how they feel about the client's HIV infection.
- When a client is not taking medications, the case manager explores the client's difficulties in accessing or adhering to treatment and how the agency can help.
- The health concerns of family members and the medical care they receive are reviewed.
- The family member is encouraged to support the client in obtaining HIV health care (and other services). If a client is not in care, the case manager will offer to connect the client to a health clinic.

Follow-Up Visits

- When the case manager feels that the family network and its positive/negative patterns have been sufficiently documented and immediate client needs have been identified, an appointment for a follow-up meeting is schedule to develop a plan to link the client to needed services.
- Follow-up work includes the development of a Family Action Plan to help family members identify, and be accountable for, any steps necessary for linking to services and care.
- It also includes eco-mapping, which builds on the family map by having clients identify and illustrate the network of health care, social, family, educational, and spiritual resources used by the family. This allows the client to identify relatives who may be able to help with accessing medical care or supportive services.
- The case manager documents the next steps the client and his/her family will take and any referrals or appointments that have been made for the client.

- The family map is filed for continued mapping with the client and family members.
- The case manager follows up with the client on any services that they discussed previously and they continue to meet in the office, over the phone, or on home visits.
- The client or his/her family members can return to the agency to meet with the case manager, either by appointment or on a walk-in basis. As new information surfaces, the agency places it on the family map. If another family member is eligible for and requires agency services, s/he becomes a client and a new version of the family map is created.

PROMOTION OF ACTIVITY

- Word of mouth
- Crisis referral
- Referrals from service agencies, probation or parole officers, police, needle exchange centers, and child welfare offices

II. Logistics

STAFF REQUIRED

- Family case manager
- Receptionist to welcome clients and connect them with a family case manager

TRAINING& SKILLS

- Staff members must share common values with respect to criminal justice and substance use.
- They must have the capacity to listen carefully to clients and support them in a way that is empathetic, non-judgmental, and non-controlling.
- The staff should know and have connections to the community and its health and social resources.
- The family case manager must be skilled in motivational interviewing.
- The staff should have basic training in understanding and recognizing symptoms of HIV disease.

PLACE OF ACTIVITY

- A private office at the agency
- Client homes

FREQUENCY OF ACTIVITY

- For a given client, the activity takes place during the first two weeks of a relationship with the agency. The agency makes adjustments for families, as needed.
- A family case manager will usually focus up to a year on a client and family.

OUTSIDE CONSULTANTS

- Outside consultants provide clinical support to, and supervision of, staff

SUPPORT SERVICES

- The agency accepts collect-call charges from correctional facilities and provides food vouchers, public transportation cards, and escorts to court for clients.

CONDITIONS NECESSARY FOR IMPLEMENTATION

The agency must be located in the area where the clients reside.

III. Strengths and Difficulties

STRENGTHS

- The participatory nature of the family mapping exercise
- Its ability to render in a single image cross-generational family patterns in behavior, relationships, and health
- Its empowerment of clients to see the range of support available to them in their family network and to develop an action plan that uses them well

WEAKNESSES

- The difficulty in storing and accessing the hand drawn maps on a computer
- The difficulty this process has interfacing to other health systems' intake processes
- The general population's lack of familiarity with genograms (i.e., the "family map")

DIFFICULTIES FOR CLIENTS

- Family Mapping is unlike other case management tools and is new to most clients.
- Creating a family map is time intensive.
- The client-driven nature of the activity takes some adjustment for formerly incarcerated clients, who are used to "being told what to do and how to do it."

DIFFICULTIES FOR STAFF

Some clients may not cooperate in creating the family map because they do not initially appreciate its value.

OBSTACLES FOR IMPLEMENTATION

There can be resistance from law enforcement professionals to services for formerly incarcerated individuals.

ACTIVITY NOT SUITED FOR

N/A

IV. Outcomes

EVALUATION

- Participant charts are reviewed as a quality assurance measure.
- Client cases, including family maps, are presented and reviewed by staff on a weekly basis.
- The case manager monitors outcomes through client self-reporting and tracking of medical appointments attended.

EVIDENCE OF SUCCESS

- Case reviews indicate improvements in the physical health of clients after six months of agency services.
- Increases in client use of neighborhood HIV resources
- Increase in the development of HIV related family action plans
- Increases in clients' health care referral follow-through

UNANTICIPATED BENEFITS

The agency is able to provide government agencies with a model that gives people insight into the resources within their own family network and empowers them to take the steps necessary to improve their own lives as well as the lives of their families.

"CONNECTING TO CARE" ELEMENTS OF ACTIVITY

- Family Mapping demonstrates respect for the family as it is defined by a client.
- It helps clients to see positive and negative family patterns and to understand the health needs within the family. This, in turn, leads them to create an action plan, which builds on the family's strengths and supportive relationships, to access necessary services including HIV health care.
- It's a non-judgmental, participant-driven tool of engagement that enables people "to own" their experience. Family Mapping reveals the health needs and behavioral patterns in a family and, because it's visual, enables people to expose truths without having to state them.
- The activity helps people to see "the quality of their lives." The family case manager asks clients what they need, rather than telling them, and gives all clients respect: something that formerly incarcerated clients don't always receive in the corrections system, but need to function to their full potential in society.

KEEP IN MIND...

- The focus should be on the strengths and positive patterns of the family, not on its deficits.
- It is important for supervisors to treat staff members as professionals, to listen to what they have to say, and to support them in their work.
- Staff members can use questions they have about their own families as a guide for their inquiry work with clients.
- Family Mapping works best when done in conjunction with eco-mapping because the two diagrams together show the internal relationships within the family and the relationships between family members and external systems of service and care.

"GET THERE TOGETHER" HIV EDUCATION

24

"Get There Together" HIV Education is a group level intervention designed to help formerly incarcerated, HIV+ men and women improve their health and relationships with medical providers by providing them with information on HIV infection and treatment. The key characteristics of "Get There Together" HIV Education are: the participant-driven, flexible course curriculum; the holistic approach to HIV education; the comfortable, non-judgmental environment; and the participants' sharing of personal stories and knowledge.

CURRENT ACTIVITY SETTING
Community-Based Service Organization for Formerly Incarcerated Individuals, HIV Education Programs

Directly links the client to medical care
✔ Gets the client in a conversation about starting medical care
Brings the agency closer to where HIV+ people are so that the conversation can begin

I. Description

OBJECTIVES

- To help de-stigmatize HIV within the participant population
- To provide current and accurate HIV information for individuals, families, and communities who are living with or are at risk for HIV infection
- To provide clients with a better understanding of HIV related medications
- To empower participants to improve their relationships with medical providers
- To decrease HIV incidence

POPULATION SERVED

- HIV+ individuals using substances, HIV+ individuals who are homeless and/or formerly incarcerated
- HIV+ gay/bisexual/transgender individuals
- Caregivers of HIV+ individuals

ACTIVITY DESCRIPTION

"Get There Together" HIV Education is an eight week intensive course for HIV+ individuals who have been recently released from incarceration. It provides participants with accurate, up-to-date information on living with HIV and a support system in a peer learning environment.

QUICK NOTES:

"Many times people project their own beliefs on others. We think, 'They're not going to like this or that,' but we can be very wrong."

—DIRECTOR OF OPERATIONS

Curriculum Development

- Through focus groups and discussions with currently and formerly incarcerated individuals living with HIV, the agency determines the greatest informational needs within the target population.
- The staff (including executive, transitional services, and case management staff) develops a 24-class curriculum based on a review of the gathered information. Class topics include HIV infection, treatment, and disclosure, substance use relapse prevention, safer sex practices, stress management, domestic violence, and the use of meditation.
- The staff establishes a schedule for both day and evening classes and selects trainers. Trainers can be selected from qualified agency staff members, the local and state health departments, and various community agencies.
- Each session has its assigned trainer, plus a few peers (often course graduates). For particularly challenging topics, such as domestic violence, additional staff attends.
- Each class cycle, with meetings on Mondays, Wednesdays, and Thursdays for eight weeks, includes ten 45-minute break-out sessions. In each break-out session, facilitated by attending peers, participants discuss the course material most recently covered and what they have learned.

Participant Recruitment

- The agency sends an announcement, via fax, to other service agencies in the community. The announcement details the program and eligibility for enrollment and requests that the agencies refer eligible clients who could benefit from the classes.
- Follow-up calls are placed to agencies to confirm receipt of the information and to further encourage referrals of clients.

Registration

- Registration for the classes is offered in the morning and afternoon.
- On the day of registration, former graduates and peers greet arriving participants and answer general questions.
- Refreshments are provided in the registration room.
- Participants receive numbers upon arrival indicating their order for registration.
- When called, participants register with one of two staff members.
- In the interest of privacy, registration occurs at a distance from the participant waiting area.
- Registrants complete a demographic information form and specify their preference for day or evening classes. They must provide documentation of their HIV status. Those who do not bring this documentation at the time of registration must bring it by a later specified date.
- Participants receive course instructions and schedules.

Course Expectations

- All participants are permitted one absence during the course cycle. If participants miss two classes, they are required to complete a "make-up" assignment, such as writing an essay on an HIV or other health-related topic, to qualify for graduation.
- If participants miss three classes, they are dropped from the course. Dropped participants or those whose circumstances force withdrawal from the course may re-enroll in the next cycle.
- This attendance policy is made clear to all participants at the start of the course.

Opening Class

- The first class opens with meditative music followed by an official welcome by an executive staff member from the agency.
- Next, the staff member discusses the services offered by the agency, describes the course, introduces the curriculum, and explains the ground rules for participation.
- Participants are each assigned a counselor with whom they can discuss issues addressed in class.
- Participants receive nametags and binders for course materials.
- The trainer then initiates an icebreaking "name" game to facilitate introductions among participants.

General Format of Classes

- Each class lasts two hours, beginning with three minutes of music and dance to "shake off the outside stuff."
- The next three minutes are dedicated to voluntary, quiet meditation. The executive staff member introduces participants to a thought for reflection and provides instructions on how to do the meditation. This exercise helps participants center themselves, build trust, and feel safe.
- Agency announcements follow the meditation.
- The first hour of class begins with the trainer presenting the theme for the day, after which participants have a 15-minute break.
- When the class reassembles, participants are divided into breakout groups of six to eight people. Facilitated by a course graduate, each group takes a separate room for thirty minutes of discussion about the material covered. Participants talk about what they have learned so far and how this new knowledge will affect their lives.
- All participants return to the main classroom. One person from each breakout group presents highlights from their group conversation.
- The class closes with a three-minute meditation.
- Fare cards for public transportation are distributed to participants who require them.

Special Classes

- Based on the comfort level of participants, special activities are developed for certain classes. For example, there is a sexual health "carnival."
- The classroom is decorated and booths are set up with games and information to update participants' sexual health knowledge.
- Participants obtain a carnival "passport" by checking in with their respective counselors, who update the information collected during registration.
- In the last 45 minutes of class time, participants break into groups by gender to discuss issues like self-esteem, grooming, and accepting responsibility for family, sexual behavior, and partner disclosure.

Preparing for Graduation

- During week six of the program, participants are allotted time to begin developing skits, which they will perform at the graduation ceremony.
- During week seven, participants are reminded about graduation and receive volunteer sign-up forms to complete if they wish to become peer facilitators for future classes. Interested participants submit the sign-up form and, in subsequent weeks, are interviewed by agency staff.

Closing Class

- At the beginning of the final class session, all agency staff, peers, and volunteers form a circle around the participants and thank them for their participation and perseverance with the following statement: "We're here to thank you, to surround you with love and support." Encouraging words emphasize that this final class marks a beginning for everyone to keep themselves healthy.
- The lights are dimmed for a brief meditation.
- As the lights come back up, the staff plays "Ain't No Stopping Us Now" to lead the class into dance. Afterwards, participants hug and thank each other, affirming a festive and supportive atmosphere.

Graduation

- An appropriate location is selected and reserved for the graduation ceremony.
- Guest speakers are invited.
- All agency staff members are invited to the ceremony, and those who express interest in attending are encouraged to deliver a spoken message to the graduates.
- Participants perform their skits, which cover a variety of topics including HIV prevention, substance abuse and relapse prevention, and domestic violence.
- Previous graduates attending the ceremony are recognized.
- Lastly, each graduating participant receives a "Certificate of Completion" in a formal graduation ceremony. Participants with perfect attendance receive special recognition on their certificates.

PROMOTION OF ACTIVITY

- Agency outreach to community-based organizations through faxes, phone calls, and linkage agreements
- Discharge planners in correctional facilities talk with inmates about the classes.
- Brochures and flyers in correctional facilities and hospitals
- Health fairs in correctional facilities
- Street outreach
- Word of mouth

II. Logistics

STAFF REQUIRED

- Executive staff to develop the curriculum and to participate in first class session
- Licensed social worker to review the curriculum
- Three counselors to provide support to the participants
- Three department directors and two assistant directors to serve as trainers and to assist with the curriculum development

TRAINING & SKILLS

- All facilitators must have excellent skills in training and communications. They should possess a high school diploma and demonstrate an understanding of the challenges faced by the target populations and an acceptance of all client situations.
- All staff must be well-versed on HIV infection, medications, and treatment adherence.

PLACE OF ACTIVITY

The activity takes place at the agency, primarily in a classroom setting. Team breakout sessions require smaller rooms with a classroom style set-up.

FREQUENCY OF ACTIVITY

Five, eight-week course cycles are offered each year.

OUTSIDE CONSULTANTS

Guest speakers or presenters (occasionally paid)

SUPPORT SERVICES

The agency provides fare cards for public transportation to all participants.

CONDITIONS NECESSARY FOR IMPLEMENTATION

- A strong community referral process and community network must exist for stakeholders to know about the program and refer their clients.
- A pool of trainers and guest speakers knowledgeable about HIV as it relates to the criminal justice system must be available.
- The agency must have up-to-date HIV information.

III. Strengths and Difficulties

STRENGTHS

- The activity provides a setting that is comfortable and serene, which encourages bonding among participants.
- The sharing of personal stories and knowledge among participants promotes peer learning.
- Strong participant-trainer relationships are formed.
- Participants receive accurate and up-to-date information about HIV infection and treatment.

WEAKNESSES

- The curriculum needs constant reviewing and frequent revision to fit the complex social dynamics and particular needs of each cycle's participants.
- The information presented can be too complex for some participants.

DIFFICULTIES FOR CLIENTS

- The course is too long for some participants, too short for others.
- Some of the information, though very basic, is still too technical for some participants.
- The time commitment for the eight week course can limit participation. A participant may have to withdraw from the class because of unanticipated circumstances or conflicting appointments.
- Some participants may feel "closed" to other participants' sexual identities or life experiences.

DIFFICULTIES FOR STAFF

- Frustrations over overscheduled clients who must drop the class
- Some participants who are more knowledgeable may try to dominate the class.

OBSTACLES FOR IMPLEMENTATION

- The relationship between substance use and HIV infection is not fully appreciated within the community.
- The implications of HIV infection within the criminal justice system is not fully understood by the community.
- Many agency clients lack an understanding of primary medical care.
- The benefits of alternative therapies such as meditation and acupuncture are not widely known and consequently go under-funded.

ACTIVITY NOT SUITED FOR

- Participants exhibiting aggressive behavior are escorted out of the class and may not return until the next class.
- Violent participants are expelled.

IV. Outcomes

EVALUATION

- Past participants give testimonials during subsequent cycles.
- Agency staff observes changes in the behavior of participants who join the agency as peers.
- Observation of participant information sharing and peer encouragement throughout the course

- Through regular meetings, counselors track and report on participant engagement in care, CD4 counts, and viral loads.
- The agency employs an intake and mid-cycle assessment tool. The mid-cycle instrument includes a participant feedback form.
- Agency staff conducts periodic follow-up with graduates.

EVIDENCE OF SUCCESS

- Participant testimonials often mention increased success in managing the health care system and greater overall stability of life.
- Client surveys show that participants are more comfortable discussing and seeking care. They are connecting to doctors and medical care "they can stay with."
- Periodic follow-up with graduates reveals that some participants enroll in additional HIV related classes.
- Participants exhibit a better understanding of HIV.
- Increases in participants' CD4 counts
- Few participants return to jail or prison.
- Participants obtain stable housing and maintain a more stable life.
- Participants manage their anger and anxiety better.
- Participants learn to take medications properly.
- During class, participants share information with others on their medical care, such as the positive experiences they have had with a certain hospital or provider.
- Graduates of the program return to the agency and share their success stories.

UNANTICIPATED BENEFITS

The graduation certificate has proven helpful to participants in their search for permanent employment.

"CONNECTING TO CARE" ELEMENTS OF ACTIVITY

- Participants receive new tools to successfully manage their relationships with medical providers.
- People learn about HIV, other diseases, and the consequences of not engaging in medical care.
- Disclosure of trainers helps participants open up.
- The peer-to-peer component gives participants a new, unthreatening avenue to understanding HIV disease, helps them to build skills, and allows them to safely share their experiences and knowledge about HIV.
- Participants are able to think in a new way about their life situations in the safe and tranquil space the classes offer them.
- The activity provides a roadmap for participants, which helps them to build and maintain relationships with the medical establishment.
- Participants learn about drug-use relapse prevention, one of their most critical needs.

KEEP IN MIND...

- Don't project your own beliefs on the participants. Be receptive to their ideas and opinions.
- Be open to all the ideas and suggestions from staff members, including counselors, case managers, and outreach workers who have the strongest connection with clients.
- Consider pursuing funding from private donors for the elements of the course that other funding streams cannot or do not support.
- Hold the classes in a space that is easily accessible to participants; provide for transportation.
- Accept clients for who they are and accept their current choices.
- Inform and educate the community about the agency's objectives for the program.
- Make sure that agency staff has a clear understanding of course objectives.

"MIDNIGHT HOUR" OUTREACH

25

"Midnight Hour" Outreach is a community level intervention that seeks to link individuals with significant health needs to agency services by strategically positioning outreach teams in key areas of the city during "unconventional" hours. The key characteristics of the "Midnight Hour" Outreach are: the client-driven mapping of outreach locations; meeting the client "where they do business"; the staff's familiarity with the community and site locations; and the distribution of incentive gift bags and individual outreach-worker calling cards.

CURRENT ACTIVITY SETTING
Multi-Service, Community-Based Organization, Community Outreach

- ✔ Directly links the client to medical care
- ✔ Gets the client in a conversation about starting medical care
- ✔ Brings the agency closer to where HIV+ people are so that the conversation can begin

I. Description

OBJECTIVES

- To offer community outreach services at unconventional hours
- To identify and converse with persons who have significant health service needs
- To help link people to health care and to encourage people to know their HIV status
- To help people who are engaged in drug and sex work to move toward better health care and healthier lives

POPULATION SERVED

- Young, African American and Latino men and women who have intensive service needs and precarious or unstable housing
- Men 15 - 22 years old with limited education, one or more former incarcerations, and possible psychiatric disability or cognitive impairment
- Substance users, sex trade workers, and people who engage in petty crime

ACTIVITY DESCRIPTION

The "Midnight Hour" Outreach is an activity through which the agency connects with hard to reach individuals and begins to link them to social and health care services.

QUICK NOTES:

"Even in the summer, this city can be a cold place if you don't have money."

— DIRECTOR OF COMMUNITY FOLLOW-UP PROGRAM

Development and Needs Assessment

- In order to map the most useful areas for outreach activities, agency staff members ask clients during intake about their current living conditions, the areas where they spend time, and the times that they gather in those areas. In such intakes, the general lifestyle of clients is explored, as well as their sexual activity and income sources.
- Community members, such as the police, business owners, and residents, inform the agency of where street crimes that are sexually related or against gay people typically occur.
- The agency uses this information to identify and map locations for outreach.
- The targeting of new or unique sites also occurs throughout the year based on civic-event and holiday schedules and client feedback that point the agency to a new area or site.
- Two to three outreach workers make up each team. They are assigned according to their knowledge of the community around the site, how well they identify with the client profile of that particular site, and their skills, abilities, comfort level, age, and race.

Outreach Scenario

- The outreach workers prepare small incentive gift bags and bring them to the site. Each gift bag includes a mini-flashlight, male and female condoms, brochures on the agency and on HIV, movie tickets, public transportation passes, gift certificates, and snack food.
- In the pre-outreach meeting, the staff agrees on appropriate dress for the selected site.
- To ensure safety, the outreach staff sets a specific time and "concrete" meeting point for the team, so that no one is alone at the site in the dark. The most common outreach times are between 2:00 and 5:00 a.m.
- When the team arrives at the outreach location, they greet anyone they see and initiate easygoing one-on-one discussions. They are friendly and talkative, initiating casual conversations as they walk with the people at the location.
- The outreach workers may identify a specific person or group to engage by offering a soda, coffee, or donut that has been purchased at a nearby, all-night convenience store.
- Using culturally appropriate vocabulary, the outreach workers probe to see if the person uses drugs by asking if they have a hit of coke, blast, etc. or if they know where to get drugs. The client responses to these questions help the outreach workers to see "the map of the person's experiences."
- In order to start a conversation about health, an outreach worker may say, "I don't feel well. Where can I get some aspirin?" or "My stomach hurts . . . I haven't been to a doctor in a while." This technique is based on the idea that if the client begins to "help" the outreach worker with a health concern, it sets the client up as the "expert," inverting the provider and client roles. Outreach workers have the possibility for a more open, less hierarchical discussion about health, including HIV testing and care.
- To better define a person's experience and service needs, the outreach worker engages him/her in a discussion of criminal justice experience. For example, they may talk about prior incarcerations, about the law, or any legal problems that the individual has had.
- The outreach workers begin to piece together client "maps" or "profiles," i.e., their age, race, and prison background, as well as their sexual activity and substance use in and out of prison. Back at the agency, the outreach workers document this information and use it in follow-up with the individuals.
- Frequently, as outreach workers are winding down conversations and offering gift incentive bags, people discreetly ask for the business card of an individual staff member. The outreach workers provide their cards on request and invite individuals to make an appointment at the agency, communicating simple messages like, "I can help you. Come see me, and I can give you a subway card."
- If an outreach worker receives any kind of unwelcoming message during the course of the activity or feels uncomfortable about their own safety, they leave.

Post-outreach

- At the agency, the outreach workers document the information they gathered for use in follow-up with clients.

- When an HIV+ outreach participant calls an outreach worker at the agency, the outreach worker offers to explore the possibility of linking them to services for medical care, food, transportation, and emergency housing.
- If a participant visits the agency, the outreach worker assesses his/her interim needs. Once this assessment is complete, the outreach worker explains that applying for services requires disclosing certain medical information. This leads to scheduling a medical appointment for a TB test, which can be an important first step toward HIV care.
- During subsequent visits to the agency, the outreach worker helps the client to get any needed benefits. Confidentiality and trust have been established with the client, and the outreach worker is able to engage the client in a further discussion of their medical history, including any medications taken in the past.
- The outreach worker then refers the client to a case manager within the agency. The case manager helps connect the person to a transitional living program or other services, as needed.
- From this point on, the outreach worker maintains a relationship with the client on a social basis, greeting them at the agency and chatting with them to maintain a sense of familiarity and trust. The outreach worker also joins the case manager and client in celebrations of accomplishments, such as new housing, which affirms for the client that people care about their well-being.
- Working closely with the agency staff builds a strong connection for clients that, in turn, may increase their willingness to undertake new programs and services.

PROMOTION OF ACTIVITY

- Word of mouth
- Clients can observe the outreach workers at the location.

II. Logistics

STAFF REQUIRED

Two to three outreach workers per team per outreach site

TRAINING & SKILLS

- It is important that the staff be personable, knowledgeable about the targeted community, trained in outreach, articulate about health issues, skilled in defusing aggression, and able to document outreach activities.
- In addition, the staff must have a high degree of professionalism and must understand HIPAA confidentiality regulations.

PLACE OF ACTIVITY

On the street, in public venues

FREQUENCY OF ACTIVITY

Two to four times a month depending on weather, time of year, and special-event schedules

OUTSIDE CONSULTANTS

Community advisory boards provide input and knowledge of outreach service needs.

SUPPORT SERVICES

None

CONDITIONS NECESSARY FOR IMPLEMENTATION

- In-kind donations or money for incentive gift bags
- Diversity in the ethnicity of outreach workers

III. Strengths and Difficulties

STRENGTHS

- The outreach workers' ability to draw out information in a friendly, relaxed manner helps clients feel safe sharing information.
- A "comfort zone" and relationship are built between the agency outreach workers and the clients.

WEAKNESSES

The inability to provide immediate referrals during the outreach activity for emergency housing—almost always the most critical need of clients

DIFFICULTIES FOR CLIENTS

It is sometimes difficult to establish an appropriate level of comfort in public venues at night. Clients may feel they can't or don't want to "open up" about their personal health needs or problems.

DIFFICULTIES FOR STAFF

- The late-night hours of outreach
- The physical and emotional vulnerability of the outreach staff

OBSTACLES FOR IMPLEMENTATION

It may sometimes be too dangerous for outreach staff to work at a particular site (e.g. after a rash of crime or violent activity).

ACTIVITY NOT SUITED FOR

The outreach activity should not target populations who aren't reflected in agency staff or who the agency doesn't know well.

IV. Outcomes

EVALUATION

- Clients self-report their progress to the agency.
- Conferences with medical providers about specific cases occur monthly.
- The outreach workers and case managers keep reports on each client's progress.
- Outreach workers document the number of people contacted during each outreach.

EVIDENCE OF SUCCESS

- Outreach workers monitor and report "healthy transformations" in clients after they begin participating in agency services.
- Client engagement in agency services tapers off after about two months because of increased stability—the result of obtaining services with the help of agency staff.

- There is an increase in outreach clients who use an escort service provided by the agency to medical appointments and Medicaid sign-up.
- The number of clients obtaining current medical documentation of HIV status has increased.
- Client feedback indicates an increase in clients' health and well-being.
- There is an increase in the number of clients who initiate substance use programs after beginning services at the agency.
- There is an increase in the number of clients who re-establish HIV medical treatment after outreach activities.
- There is an increase in the number of clients in transitional, congregate, scatter-site housing or living independently.

UNANTICIPATED BENEFITS

Clients ask if they can become outreach workers.

"CONNECTING TO CARE" ELEMENTS OF ACTIVITY

- Many formerly incarcerated people who have been in and out of correctional facilities numerous times find themselves "doing business" on the street and in sex-trade bars because they have nothing else to exchange for money. The outreach workers offer them options and care to help them meet their needs.
- The activity goes to "where the client is," and the outreach workers talk to clients in their language and in their space.
- Food and housing incentives bring people to the agency where staff can help them to connect or re-connect to medical care.
- The outreach workers offer hope and the sense that someone cares about the client's life.

KEEP IN MIND...

- When at an outreach site, be mindful of your surroundings.
- Trust your intuition; do not hesitate to leave if you feel uncomfortable.

Kansas

Topeka AIDS Project
Care Renewal by Post
708 S.W. 6th Avenue
Topeka, KS 66603
Telephone: 785-232-3100
http://www.topekaaidsproject.org

University of Kansas Medical Practice Association
The Housing Plan
1010 N. Kansas
Wichita, KS 67214
Telephone: 316-293-3592

New Jerusalem Mission
HIV Ministry Emergency Shelter
209 East Broadway
Newton, KS 67114
Telephone: 316-282-2101

United Methodist Mexican American Ministries
Food Processing Plant Outreach
Call-In Radio Program: "VIH y Communidad"
224 North Taylor
Garden City, KS 67846
Telephone: Garden City
620-275-1766 ext. 240
Telephone: Liberal 620-624-6865

University of Kansas School of Medicine—Wichita
Traveling HIV Clinic
1010 N. Kansas
Wichita, KS 67214
Telephone: 316-293-1844

New York

The Fortune Society
Treatment Adherence Nurse
53 W 23rd Street, 7th floor
New York, NY 10010
Telephone: 212-691-7554 ext. 886
http://www.fortunesociety.org

Women's Prison Association
Peer Mentor Escort to Care
175 Remsen Street, 9th floor
Brooklyn, NY 11201
Telephone: 718-637-6802
http://wpaonline.org

Family Justice, Inc.
Family Mapping
625 Broadway, 8th Floor
New York, NY 10012
Telephone: 212-475-1500
http://www.familyjustice.org

Exponents
"Get There Together" HIV Education
151 West 26th Street, 3rd floor
New York, NY 10001
Telephone: 212-243-3434 ext 119
http://www.exponents.org

Palladia, Inc.
"Midnight Hour" Outreach
177 East 122nd Street
New York, NY 10035
Telephone: 212-360-7116
http://palladiainc.org

North Carolina

Eastern Triad HIV Consortium
Home-Based Treatment Coordinator
537B Huffman Mill Road
Burlington, NC 27215
Telephone: 336-586-0062

Western North Carolina Community Health Services
Triage Counseling
10 Ridgelawn Road
Asheville, NC 28806
Telephone: 828-285-0622

Lincoln Community Health Center
"Managing Our HIV" Workshop Series
414 East Main Street
Durham, NC 27701
Telephone: 919-560-7689
http://www.lincolnchc.org

Western North Carolina AIDS Project
Holiday Social
30 Orchard Street
Asheville, NC 28801
Telephone: 828-252-7489 ext. 11
http://wncap.org

Hertford County Public Health Department
HIV Advisory-Support Group
828 South Academy Street
Ahoskie, NC 27910
Telephone: 252-332-6650
http://www.hertfordpublichealth.com

Texas

Montrose Counseling Center
Substance Use Discharge Liaison
701 Richmond Avenue
Houston, TX 77006
Telephone: 713-529-0037 ext. 326
http://www.montrosecounselingcenter.org

AIDS Foundation Houston
"Getting Started" Intake Case Management
3202 Weslayan Annex
Houston, TX 77027
Telephone: 713-623-6796
http://www.aidshelp.org

University of Texas Medical Branch
Lunch and Learn
301 University Blvd
Galveston, TX 77555
Telephone: 409-772-8293
http://www.utmb.edu

Healthcare for the Homeless
Bus Route to Care
2505 Fannin Street
Houston, TX 77002
Telephone: 713-276-3056
http://www.homeless-healthcare.org

Washington, DC

Unity Healthcare
Medical Advocate Discharge Planning
3020 14th Street NW, Suite 401
Washington, DC 20009
Telephone: 202-745-4300
http://unityhealthcare.org

Family and Medical Counseling Services
Rapid Testing at Jail Intake
2041 Martin Luther King Avenue, SE
Washington, DC 20020
Telephone: 202-889-7900
www.fmcsinc.org

Miracle Hands
Transgender Post-Release Case Management
2127 Queens Chapel Rd. NE
Washington, D. C. 20002
Telephone: 202-832-5352

Our Place DC
Women's Halfway House HIV Education
801 Pennsylvania Avenue, SE
Suite 460
Washington, DC 20003
Telephone: 202-548-2400
http://www.ourplacedc.org

Court Services Offender Supervision Agency
Community Resource Videoconference
633 Indiana Avenue, NW
Washington, DC 20004-2902
Telephone: 202-220-5320
www.csosa.gov

THANK YOU

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- AIDS Foundation Houston, Houston, TX
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- Center for AIDS, Houston, TX
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- Court Services & Offender Supervision Agency, Washington, DC
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- Kansas Association for Community Action Programs, Topeka, KS
- Kansas City Health Department, Kansas City
- Kansas Statewide Farmworker Health Program, Topeka, KS
- Legacy Community Health Services, Houston, TX
- Lincoln Community Health Center & Early Intervention Clinic, Durham, NC
- Mental Health Association of Greater Houston, Houston, TX
- Miracle Hands, Washington, DC
- Montrose Counseling Center, Houston, TX
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- Osborne Association, The, New York, NY
- Our Place DC, Washington, DC
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- Positive Directions, Wichita, KS
- Project AIDS Land Manor, Beaumont, TX
- Reality House, New York, NY
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- Texas Department of Criminal Justice Health Services Division, Huntsville, TX
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- Triangle AIDS Network, Beaumont, TX
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WE HOPE YOU BENEFITED FROM THIS WORKBOOK!

Please fill out the form and send it to AIDS Action as soon as possible.

1. How helpful will this workbook be in achieving your programmatic goals related to HIV?

- ❑ very helpful
- ❑ somewhat helpful
- ❑ not sure
- ❑ little helpful
- ❑ not at all

2. In what ways can this workbook be helpful to you?

- ❑ in rethinking our organization/agency's HIV related programs
- ❑ in restructuring our organization/agency's HIV related programs
- ❑ in creating/replicating similar HIV related programs covered in this workbook
- ❑ all of the above
- ❑ other please explain: _____

_____

_____

_____

_____

3. Have you shared this workbook with anyone else

- ❑ Yes, with _____
- ❑ Not yet, but I plan to share it with _____
- ❑ No, I have not and do not plan to share it.

4. Would you like to participate in technical assistance workshops on:

- ❑ Addressing Unmet Need
- ❑ Strategies for connecting people to HIV care
- ❑ Connecting to Care activities for special populations, please specify _____

5. What other types of technical assistance (e.g. meetings, training, written material, etc) on "Connecting to Care" would you like to be part of in the further stages of this project?

_____

_____

_____

_____

TYPE OF ORGANIZATION: _____ YOUR POSITION: _____

YOUR PROGRAM: _____ CITY: _____ STATE: _____

YOUR NAME (OPTIONAL): _____ YOUR E-MAIL (OPTIONAL): _____

FOLD HERE

Place
Stamp
here

AIDS ACTION
PO Box 65162
Washington, DC 20035

IMPORTANT:

CONNECTING TO CARE SURVEY ENCLOSED!

USE TAPE. DO NOT USE STAPLES

connecting *to care*

until it's over
AIDS ACTION

1730 M Street N.W., Suite 611, Washington, DC 20036
Web/ www.connectingtocare.net and www.aidaction.org E-mail/connectingtocare@aidsaction.org

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