



2008 HIV Needs Assessment Report

Ryan White Title I

Denver Transitional Grant Area

Supplement I – Provider Perspective

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HRSA Common Features of Engagement Programs

The HIV/AIDS bureau of the Health Resources and Services Administration (HRSA/HAB) developed a list of common features of engagement programs¹. We used that list to organize the strategies for engaging PLWH/As in care that were suggested by providers and by PLWH/As. HRSA identified three broad categories: client level features, provider/clinic features, and system features. Each of these contains multiple subcategories. Table C1 below provides a description of the HSRA identified common features that fit within the three broad categories. These categories have been used as a framework for structuring open ended questions about current and suggested activities for engaging PLWH/As in care.

Table C1. Description of Common Features Identified by HRSA that Fit Under the Client Level Features Category

HRSA Subcategory	Subcategory Description*
Intensive Services and Support	Help and support provided by agencies that is extensive and can be "staff-intensive and long-term".
Assessment of client needs	Find out what the person needs to stay in care.
Engender client trust	Develop a relationship and trust with the person. This often needs to happen before you can get them into care. Requires honesty and being non-judgmental.
Meet client priorities first	Recognizing that HIV care may not be the most important priority in a person's life. Help them meet their current priorities as a way of building a trusting relationship that will eventually enable you to get them into care.
Readiness for care	Assess how ready the person is to enter and participate in care. Create a plan to move them along the "readiness continuum".
Client health beliefs/health literacy	Assess health beliefs and health literacy so that strategies can be put in place to improve patient understanding, change beliefs or help the person see how care can be consistent with their beliefs.

*Description of the subcategory was drawn from HRSA/HAB (2006).

Table C2. Description of Common Features Identified by HRSA that Fit Under the Provider/Clinic Features Category

HRSA Subcategory	Subcategory Description*
Get out into the community	Go out into the community to the places where your target group can be found to deliver services and encourage people to get back into care.
Be welcoming and accessible	Create ways to make the service delivery welcoming and accessible. This can include things like co-locating, flexible hours, friendly and non-judgmental staff.
Break down physician resistance	Help physicians see the benefits of outreach efforts to gain their support. Reduce resistance to treating certain types of patients (e.g., substance users)
Staffing	"Flexibility and creativity in use of staff" to conduct outreach and to work with clients to help them get care.
Peers and community members	Engage HIV+ community members in outreach and care retention efforts.
Staff training	Training staff to learn new skills.
Measurable outcomes	Measure the impact of your interventions on clients using concrete outcomes such as the number of new clients identified or referred to care, clinical markers, referrals, % of medical appointments kept, or using measures of mental health and health literacy.

*Description of the subcategory was drawn from HRSA/HAB (2006).

Table C3. Description of Common Features Identified by HRSA that Fit Under the System Features Category

HRSA Subcategory	Subcategory Description*
Collaboration	Cross-agency collaboration such as linking outreach with case management and with medical care.
Multi-level collaboration	Cross-agency collaboration that requires agency management involvement such as formal data sharing agreements. More formalized than simply the sharing of information by staff at different agencies.
Data sharing	Formal sharing of data across agencies such as sharing of databases that track service usage.
Community and provider education	Education providers and the community about the goals of outreach or engagement efforts. May also need to educate about staffing issues and the actual methods used in the effort.

*Description of the subcategory was drawn from HRSA/HAB (2006).

Provider Survey Data

Service provider agencies that currently receive Ryan White funding were invited to have their staff participate in the provider survey. The current survey had two objectives

- 1) Have providers rank order the priority for funding the Ryan White service categories
- 2) Allow service providers at multiple levels within the provider agencies the opportunity to help us understand why some people with HIV are not in medical care.

Agency facilitates clients seeking and staying in medical care.

Service providers almost universally stated that they *actively* encourage PLWH/As to seek and stay in medical care and that they *actively* help PLWH/As seek and stay in medical care. Only one out of 39 providers stated that their agency did not actively promote access to and continuity in receiving medical care.

Data from PLWH/A focus groups suggest that experiences of PLWH/As are very diverse in how they perceive support from service providers to seek and stay in medical care. Comments range from positive (“I know they always try to do the best for me”) to negative (“They are moving the services away from the people they are supposed to be serving”). Focus group participants indicated that until their top priorities (i.e., housing, food) are met, it is difficult for them to seek and stay in medical care. The complexities of accessing services (i.e., insurance, paperwork for CICP and Medicaid), the lack of coordination of services (i.e., not getting appointments soon, in the same location or for the same day, not being seen as a whole person with multiple needs), and the barriers faced in accessing other essential services make patients feel that service providers are not facilitating their seeking and staying in medical care. PLWH/As also have a very negative opinion of counselors and case managers who do not provide them with accurate and complete information about the services for which they qualify. Patients interpret this lack of information and inaccurate information as service providers not caring about their medical and other daily needs.

Why are people out of care?

Thirty-six of the 39 participants provided a response to this question. Most providers suggested multiple reasons for PLWH/As not receiving medical care. The most frequently cited reason for being out of care was substance abuse. Almost half of the providers thought that PLWH/As were out of care because their basic needs were not being met. Responses in this category included poverty, housing, and food. Categories of responses and their frequency are provided in the table below.

Data from focus group participants indicate that although PLWH/As refer to the same reasons for being out of care as those reported by service providers, they prioritize them in a different order. Cost of medical care, complexities to get in the system of medical care (paperwork for Ryan White, CICP, Medicaid), and meeting basic needs (housing, food) were frequently reported as critical barriers to medical care. Inaccessible location of services combined with transportation and with uncoordinated services, presented a big burden to accessing medical services. Getting tired of fighting the system and of side-effects of medications were also alluded to as reasons for being out of care.

Table D1. Reasons Providers Believe PLWH/As are Out of Care

Reason out of Care*	N	%
Substance abuse	22	56.4
Basic needs not met – poverty, housing, food	19	48.7
Mental health	17	43.6
Medical system – fear distrust, insensitive providers, paperwork, access	14	35.9
Denial or stigma	14	35.9
Health literacy – education, knowledge, belief that care is not needed when healthy	9	23.1
Transportation	8	20.5
Insurance or cost	7	17.9
Culture or language	5	12.8
Other – don't want to take medications, lack of social support, jail	8	20.5

*Percent of responses will not sum to 100 because participants could provide more than one response.

What effective strategies has your agency employed to help people get into and stay in HIV medical care?

Thirty-two of the 39 participants provided a response to this question. Responses to this question are organized using the HRSA common features of engagement programs framework. The rank column indicates how frequently a comment fitting the category was provided. Lower numbers mean there were more comments provided for the category. A full listing of the comments can be found in accompanying documents provided to the Council. Most comments provided fit under the strategies that address client level barriers.

Table D2. Current Client Level Activities Agencies Use to Engage PLWH/As to Get Them in Care or Keep Them in Care

Rank	HRSA Subcategory	Representative Comments
1	Intensive Services and Support	<ul style="list-style-type: none"> • “We have case managers that will immediately meet with people newly diagnosed and walk them through the steps of getting into care: financial screening, making the appointment, first set of labs.” • “We are providing transportation to and from appointments, medication pick up and help to keep a day planners for all their medical needs also home based services.” • “We have outreach staff that will find people for us if a person is more than 4 months from their last appointment. Through an escalating series of phone calls, letters, and home visits, we actively try to get people back into care.”
9	Assessment of client needs	<ul style="list-style-type: none"> • “We also utilize a wellness survey as a tool to assess clients' involvement and need for healthcare. Along with this, we outline goals on our wellness plans to address any issues in involvement with medical care.” • “There is also a comprehensive team dedicated to problem solving with a patient who is having difficulty or perceives a barrier to care. It is completely comprehensive it evaluates their enrollment status, copay issues, accessing meds appropriately, is a psych referral necessaryetc”
6	Engender client trust	<ul style="list-style-type: none"> • “Develop individual rapport and develop trust with a client. This can help bridge cultural gaps between individuals and an often intimidating medical system.” • “Asking them to meet a health care provider just to take their blood pressure so that the initial interaction is pleasant and low-stress.”

Rank	HRSA Subcategory	Representative Comments
4	Meet client priorities first	<ul style="list-style-type: none"> • “We have addressed issues based on their top 3 priorities and seeking ways to access resources available to the community based on where they are located in the metro area. If their basic needs are met such as housing, transportation, food, and clothing then it can be much easier to access healthcare and to stick to a health care regimen including meds, and appointments.” • “We try to get people stable with housing etc. so they are able to make it to doctor’s appointments on a regular basis as well as take medication properly. We check in on a regular basis and make it part of their wellness plans with the agency.” • “creation of Housing Plans”
8	Readiness for care	<ul style="list-style-type: none"> • “With the clients specifically, we utilize motivational interviewing strategies to assess their attitudes about medical care and encourage them to make a decision to become involved.” • “We work from where they are not where we think they should be and start there, to move them in a productive manner that they have ownership of their lives.”
2	Client health beliefs/health literacy	<ul style="list-style-type: none"> • “We address their cultural needs such as how does western medicine and holistic way work together and, try to get them to see that their beliefs are valuable and how they can work together for their health.” • “We provide workshops that help clients understand their treatment and how to advocate for themselves. Our prevention counselors also stress the importance of medical care.”

Table D3. Current Provider/Clinic Activities Agencies Use to Engage PLWH/As to Get Them in Care or Keep Them in Care

Rank	HRSA Subcategory	Representative Comments
9	Get out into the community	<ul style="list-style-type: none"> • “Presentations in community forums.” • “Staff involvement in CBOs and on the RW Planning Council.”
3	Be welcoming and accessible	<ul style="list-style-type: none"> • “Scheduling appointments for counseling on the same day as medical appointments.” • “Bi-lingual care providers. Hiring care providers and office staff who reflect the clientele racially and ethnically.” • “Psychiatric services provided through the clinic.”
NR	Break down physician resistance	No suggestions fit in this category.
6	Staffing	<ul style="list-style-type: none"> • “Implementing a position that addresses this issue directly.” • “Outreach teams which contact patients in house or actually seek known but lost to care patients.” • “Development of multidisciplinary team meetings, weekly, to discuss each patient who has been in house that week, as well as difficult patients.”
NR	Peers and community members	No suggestions fit in this category.
NR	Staff training	No suggestions fit in this category.
NR	Measurable outcomes	No suggestions fit in this category.

Table D4. Current System Level Activities Agencies Use to Engage PLWH/As to Get Them in Care or Keep Them in Care

Rank	HRSA Subcategory	Representative Comments
5	Collaboration	<ul style="list-style-type: none"> • "Collaborate with the bigger systems when participants drop out or do not continue care for their HIV." • "Another important effort involves our monthly case conferences with the clinics to discuss clients who are not as involved in care."
12	Multi-level collaboration	<ul style="list-style-type: none"> • "Pharmacy records to alert care providers to a patient's late pick-ups."
9	Data sharing	<ul style="list-style-type: none"> • "Collaborate with the bigger systems when participants drop out or do not continue care for their HIV." • "Another important effort involves our monthly case conferences with the clinics to discuss clients who are not as involved in care."
NR	Community and provider education	No suggestions fit in this category.

What new strategies would you like to try?

Twenty-five of the 39 participants provided a response to this question. Responses to this question are organized using the HRSA common features of engagement programs framework. The rank column indicates how frequently a comment fitting the category was provided. Lower numbers mean there were more comments provided for the category. A full listing of the comments can be found in accompanying documents provided to the Council. Most comments provided fit under the client level features.

Table D5. Suggested Client Level Activities Agencies Use to Engage PLWH/As to Get Them in Care or Keep Them in Care

Rank	HRSA Subcategory	Representative Comments
4	Intensive Services and Support	<ul style="list-style-type: none"> • "Organized retention in care efforts which would routinely identify when patients have missed appointments or been out of care, assess barriers as possible and re-engage clients. Various community outreach measures are critical in this regard as well." • "Appointment reminders and day after follow up calls for missed visits are used in many private settings: dentist, car service sites, and other medical practices. This should become standard of care."
NR	Assessment of client needs	No suggestions fit in this category.
5	Engender client trust	<ul style="list-style-type: none"> • "Invite participants to other programs within the organization that helps educate and support them so that they know that they are important and valued." • "more interaction with clients at the hospital level"
7	Meet client priorities first	<ul style="list-style-type: none"> • "Emergency shelter vouchers can be distributed directly to funded agencies in order to assist men coming out of prison. This would, in turn, move medical care and treatment up their ladder of priorities as they would not be consumed with the need to find shelter upon their release."
7	Readiness for care	<ul style="list-style-type: none"> • "I believe patients need more comprehensive counseling/coaching on life skills etc. that includes disease management. The barriers to patients accessing and maintaining medical care is mostly social, psychological and emotional. I believe we spend a lot of time improving our internal care delivery systems that have no connection to the real lives of populations living with AIDS or any other chronic disease for that matter."

Rank	HRSA Subcategory	Representative Comments
2	Client health beliefs/health literacy	<ul style="list-style-type: none"> • "I would like to see a strategy that is not combatant regarding healthcare assistance. Something like: "We just like to see how you are doing." Something which has as its aim the overall wellbeing of the client and that takes their decisions into consideration." • "Motivational Interviewing, health empowerment."

Table D6. Suggested Provider/Clinic Activities Agencies Use to Engage PLWH/As to Get Them in Care or Keep Them in Care

Rank	HRSA Subcategory	Representative Comments
7	Get out into the community	<ul style="list-style-type: none"> • "Organized retention in care efforts which would routinely identify when patients have missed appointments or been out of care, assess barriers as possible and re-engage clients. Various community outreach measures are critical in this regard as well."
1	Be welcoming and accessible	<ul style="list-style-type: none"> • "As the population of HIV positive African American women grows, I feel that in home care would be amazing. Many of these women have families and are unable to travel easily." • "the possibility of completing intakes at hospitals (so that clients associate medical case management with their health care rather than associating case management with financial assistance)" • "Portable services (similar to the Eye clinic or Mammography vans to the community clinics)"
5	Break down physician resistance	<ul style="list-style-type: none"> • "Education of primary care clinicians regarding barriers to care and how to address" • "Have the doctor be more involved"
NR	Staffing	No suggestions fit in this category.
3	Peers and community members	<ul style="list-style-type: none"> • "A CBO-based outreach program to encourage and incent patients into primary care." • "More community involvement from a grassroots level" • "I think having patients meet another patient in similar and worse situations would help, a buddy program."
7	Staff training	<ul style="list-style-type: none"> • "specific customer service training to the first person that someone sees upon entering a facility"
NR	Measurable outcomes	No suggestions fit in this category.

Table D7. Suggested System Level Activities Agencies Use to Engage PLWH/As to Get Them in Care or Keep Them in Care

Rank	HRSA Subcategory	Representative Comments
7	Collaboration	<ul style="list-style-type: none"> • "Collaboration with mental health services"
NR	Multi-level collaboration	No suggestions fit in this category.
NR	Data sharing	No suggestions fit in this category.
NR	Community and provider education	No suggestions fit in this category.

What single change to the system would you recommend to improve it?

Twenty-five of the 39 participants provided a response to this question. Responses to this question are organized using the HRSA common features of engagement programs framework. The rank column indicates how frequently a comment fitting the category was provided. Lower numbers mean there were more comments provided for the category. A full listing of the comments can be found in accompanying documents provided to the Council. Most comments provided fit under the client level features.

Table D8. Suggested Client Level Activities Agencies Use to Engage PLWH/As to Get Them in Care or Keep Them in Care

Rank	HRSA Subcategory	Representative Comments
3	Intensive Services and Support	<ul style="list-style-type: none"> • "Increase funding for case management so that case managers will have a smaller load and spend more time with individual clients."
NR	Assessment of client needs	No suggestions fit in this category.
NR	Engender client trust	No suggestions fit in this category.
1	Meet client priorities first	<ul style="list-style-type: none"> • "There really needs to be more access to housing specifically for individuals (men!) living with HIV who have a history of felonies or substance abuse. Case management and treatment should be built into the model, but if they continue to be excluded from housing because of their felonies or substance abuse treatment, they will not be in medical care or be able to take their medications and they will continue to need more acute care when they become ill." • "In home care would be great, but as the last question brought up it's not even in the top 5. Food, shelter, help for substance abuse problems, mental problems all come before HIV medical services. Because they need those things to live as a whole person even before their HIV treatments. Without these things first they most likely will not take their medications even if they had them." • "A program for undocumented persons living with HIV."
NR	Readiness for care	No suggestions fit in this category.
3	Client health beliefs/health literacy	<ul style="list-style-type: none"> • "A family centered approach. Take care of the whole family and not just the individual infected. Health outcomes are better when the client has a support system in place. We can teach someone all the info that they need to live a healthy and successful life but when they go home and they are not in a supportive environment everything that we just taught them gets left at the door. If they are in an environment where they cannot talk about it getting them into services that allow for that support"

Table D9. Suggested Provider/Clinic Activities Agencies Use to Engage PLWH/As to Get Them in Care or Keep Them in Care

Rank	HRSA Subcategory	Representative Comments
3	Get out into the community	<ul style="list-style-type: none"> • “Community/grassroots interaction from service agencies (increase funding)”
NR	Be welcoming and accessible	No suggestions fit in this category.
NR	Break down physician resistance	No suggestions fit in this category.
NR	Staffing	No suggestions fit in this category.
3	Peers and community members	<ul style="list-style-type: none"> • “Older gay community members must warn the new generation of the dangers of bath houses, unprotected sex and irresponsible partying. They did this efficiently when the first deadly wave of HIV/AIDS happened. The new generation has forgotten about this, and today we see the infection rate increasing because of the phenomenon of meeting sexual partners over the internet. I would like people who take meds to come out and tell others not only about the side effects of the HIV drugs, but of the psychological burden of depending on them. The new generation, partly because of the HIV Drug Companies, think the meds are as simple and easy as a daily cough drop, making them think that using them is an acceptable result for their dangerous practices.”
NR	Staff training	No suggestions fit in this category.
NR	Measurable outcomes	No suggestions fit in this category.

Table D10. Suggested System Level Activities Agencies Use to Engage PLWH/As to Get Them in Care or Keep Them in Care

Rank	HRSA Subcategory	Representative Comments
2	Collaboration	<ul style="list-style-type: none"> • “Increasing availability for therapy/counseling that is tied to primary care services. By this I mean all patients have assessments done at initiation of care, and counseling be provided prior to and along with HIV treatment.” • “Connect the various agencies providing support and care with a real collaborative effort.” • “Coordinated case management. The HIV community in Denver is small enough that we can work harder to coordinate services and do a better job for participants.”
3	Multi-level collaboration	<ul style="list-style-type: none"> • “Standardization so that everyone is operating with the same agenda.”
NR	Data sharing	No suggestions fit in this category.
NR	Community and provider education	No suggestions fit in this category.

Agency Background

Table D11. Ryan White Funding Category for Provider Participants

Service Category	N	%	Service Category	N	%
Case Management	23	59.0	Health Insurance	6	15.4
Mental Health Counseling	21	53.8	Nutrition	6	15.4
Substance Abuse Treatment	19	48.7	Home Delivered Meals	4	10.3
Medical Care	17	43.6	Home Health Nurse	0	0.0
Dental Care	13	33.3	Home Health Care Aide	0	0.0
Medicines	11	28.2	Child Care	0	0.0
Transportation	9	23.1	Don't Know	1	2.6
Housing	7	17.9			

Table D12. Provider Participant Agency Background Information

	N	%
Primary position in agency (%)		
Director/Administration	10	25.6
Case Manager	10	25.6
Nurse	4	10.3
Therapist/Counselor	4	10.3
Physician	4	10.3
Office Manager	1	2.6
Other	6	15.4
Direct contact with PLWH/As		
Less than once a month	2	5.1
At least monthly	7	17.9
Weekly		
Daily	9	23.1
	21	53.8

Table D13. Years Employed by Agency Serving PLWH/As

	Mean	Range
Years working at agency serving PLWH/As	7.8	.25 – 24.0

Provider Focus Group Data

Service provider agencies that currently receive Ryan White funding were invited to have their staff participate in a focused conversation about why some people with HIV are not in medical care. The conversation had two objectives:

- 1) Have providers relate their opinions about why people with HIV are out of medical care.
- 2) Have service providers suggest solutions for how to get people with HIV who are out of medical care either into care for the first time or back into care if they had received care in the past.

Why are people with HIV out of care?

Providers in the group suggested multiple reasons for PLWH/As not receiving medical care. Table 1 below lists the various reasons mentioned in order of those most frequently cited to those cited less often by fewer participants. The two most frequently cited reasons were the financial burden on clients to receive care and the multitude of system barriers that make it difficult for clients to access or stay in care.

Table E1. Stated Reasons for PLWH/As Being Out of Care

Category	Individual Reasons
Financial Burden	<ul style="list-style-type: none"> • "No insurance." • "High insurance co-pays." • "Difficult to apply for and obtain coverage through CACP." • "Working poor clients over-income and unable to qualify for financial resources." • "High bills that clients cannot pay and do not want to continue to accumulate."
System Issues	<ul style="list-style-type: none"> • "Insensitive to client needs (e.g., system not responsive to the day-to-day mentality of youth clients who do not plan in advance)." • "Hospital policies and requirements restricting who can receive care and what types of care they receive." • "Difficulties of navigating a complex system." • "Difficulties for undocumented and recently incarcerated clients to qualify for and obtain care."
Competing Priorities	<ul style="list-style-type: none"> • "Substance abuse and mental health issues have to be dealt with first." • "Women prioritize family needs over their own."
Individual Characteristics	<ul style="list-style-type: none"> • "Developmental disability and resulting inability to handle the responsibility of taking care of oneself." • "Disorganization, dysfunction- Lack of 'internal structure'". • "Overwhelm- hierarchy of needs, the need to find food, housing, deal with substance abuse and mental illness is overwhelming."
HIV as a Chronic Illness	<ul style="list-style-type: none"> • "Difficulty of taking care of oneself over a long period of time" • "Being out of care because they do not feel sick."
Other	<ul style="list-style-type: none"> • "Denial and fear" • "Lack of awareness/knowledge about HIV" • "Care fatigue" • "Transportation" • "Poor relationships between service providers, and between providers and clients"

What could help people with HIV get into or stay in care?

Responses to this question are organized using the HRSA common features of engagement programs framework. A full listing of the comments can be found in accompanying documents provided to the Council.

Table E2. Suggested Client Level Activities Agencies Use to Engage PLWH/As to Get Them in Care or Keep Them in Care

HRSA Subcategory	Representative Comments
Intensive Services and Support	<ul style="list-style-type: none"> “I’m thinking about the solutions for some of the people who are being released from the Department of Corrections and have these issues with organization and responsibility and that really is where they need to be linked up with an intensive case manager and medical case manager who can help alleviate those fears and those barriers because that is really what that job is, is to help you get linked into care and stay in care and understand how CACP works and understand the systematic barriers, understand the perceived barriers and help them overcome those. It’s getting the information out there in a way that is understandable.”
Assessment of client needs	No suggestions fit in this category.
Engender client trust	<ul style="list-style-type: none"> “Most people I know don’t want to be drug addicted...They don’t come and say I want drugs. They come and say I want help, but to engage in that help and develop the relationship there has to be trust and so if it takes getting high and coming to [Agency] the first few times to be able to talk to somebody, I’m for it. Eventually you will see a decrease in the drug use. Not quit but see a decrease and then you can work with people who get into the care and the housing and that there are other options in their life, they don’t have to live like they live.” “So what is the motivation (for clients)? So, really, what becomes the motivation is this external feeling; that’s what motivates people. What would be the internal or external motivation to engage in treatment prior to feeling lousy? Prior to getting sick? It’s developing good relationships with the care providers.”
Meet client priorities first	No suggestions fit in this category.
Readiness for care	<ul style="list-style-type: none"> “I also wonder for a small portion of those people if we just need to accept that HIV is different disease than it was. It’s a chronic illness and they are going to fall in and out of care because it’s tough to stay in care. How many of us have always tried to maintain a health plan for a long period of time to exercise or to diet or to stop smoking. It is tough to maintain that behavior change. They felt good, so maybe what we may be seeing is a trend of going in and out of care... They are simply out of care because they feel good.”
Client health beliefs/health literacy	No suggestions fit in this category.

Table E3. Suggested Provider/Clinic Activities Agencies Use to Engage PLWH/As to Get Them in Care or Keep Them in Care

HRSA Subcategory	Representative Comments
Get out into the community	No suggestions fit in this category.
Be welcoming and accessible	<ul style="list-style-type: none"> “If we can have maybe one point of contact that can help with those major issues (that clients have), not overburdening the social workers because social workers at the ID clinic or at primary care sometimes see a lot of people.” “You have to create the system that welcomes people into care before you say no to them.” Problem of providing care to undocumented individuals “alleviated with the planning council allocating funds to have a clinic where there is a specialist or doctor who can provide care.”
Break down physician resistance	No suggestions fit in this category.
Staffing	No suggestions fit in this category.
Peers and community members	No suggestions fit in this category.

HRSA Subcategory	Representative Comments
Staff training	No suggestions fit in this category.
Measurable outcomes	No suggestions fit in this category.

Table E4. Suggested System Level Activities Agencies Use to Engage PLWH/As to Get Them in Care or Keep Them in Care

HRSA Subcategory	Representative Comments
Collaboration	<ul style="list-style-type: none"> • “Co-locate medical case management at the hospital or clinic setting” • The need to cultivate relationships. “I think that (what) a lot of our discussion comes down to is relationships and it comes down to relationships between the service providers, and between the patients and service providers and so forth. I think when you know somebody you can get a heck of a lot more done than if you’re shooting in the dark...” • “A lot of our clients access providers that aren’t HIV related all the time. So those systems outside of this little network are very challenging so within the HIV providers it is relatively simple. We all know each other pretty well and there may be barriers due to the systematic issues or hospital based issues or policy issues but it’s the other people we interact with that needs balancing.”
Multi-level collaboration	No suggestions fit in this category.
Data sharing	No suggestions fit in this category.
Community and provider education	No suggestions fit in this category.

Table E5. Suggested Solutions that do not Fit the HRSA Framework

Subcategory	Representative Comments
Financial Restructuring	<ul style="list-style-type: none"> • “Expand the new First Care dollars program that some hospitals have signed contracts to provide.” • “Create a ‘second back door’, a community based clinic in which clients don’t have to go through CICP.” • “Have a fee-for-service model where the money follows the client and so they can go to whoever they want to. The money would follow the patient, so they show this card and they have a Ryan White insurance card and it would cover certain things.” • “Denver Health reallocated a pot of money to pay for specific services (specialty treatment). There should be a number of small pots, a number of small purses, if you will, instead of just one big purse and that those purses then would be very focused on the niche that they fill...” • “Transportation. Fund bus passes with money other than Ryan White dollars. It’s not necessarily Ryan White that has to go to buying bus passes...Why not get a system to buy bus passes. Why not say there is a lottery system or we are going to take the people with the very lowest income till we meet this amount of money that we can allocate.”
Future planning	<ul style="list-style-type: none"> • “We should now be thinking about what happens in 2 and 3 years from now to ensure that we don’t create a much bigger burden of unmet need by people that are in care now but it becomes difficult to keep them in care so they move out.”

Provider Participant Agency Background

Table E6. Ryan White Funding Category for Provider Participants

Service Category	N	%	Service Category	N	%
Mental Health Counseling	5	38.5	Housing	3	23.1
Substance Abuse Treatment	5	38.5	Nutrition	2	15.4
Case Management	4	30.8	Health Insurance	1	7.7
Dental Care	4	30.8	Home Delivered Meals	1	7.7
Medical Care	3	23.1	Home Health Nurse	0	0.0
Medicines	3	23.1	Home Health Care Aide	0	0.0
Transportation	3	23.1	Child Care	0	0.0

Table E7. Provider Participant Agency Background Information

	N	%
Primary position in agency (%)		
Director/Administration	7	53.8
Case Manager	3	23.1
Other	3	23.1
Direct contact with PLWH/As		
No direct contact	2	15.4
Less than once a month	0	0.0
More than once a month, but less than once a week	1	7.7
Weekly	2	15.4
Daily	6	46.2

Table E8. Years Employed by Agency Serving PLWH/As

	Mean	Range
Years working at agency serving PLWH/As	9.0	.5 – 27.0

References

¹Health Resources and Services Administration, HIV/AIDS Bureau [HRSA/HAB] (2006). Outreach: Engaging people in HIV care. Summary of a HRSA/HAB 2005 consultation on linking PLWH into care. Retrieved January 29, 2008 from <ftp://ftp.hrsa.gov/hab/HIVoutreach.pdf>.