

# **Track D: Access, Linkage & Retention in Care**

## ABSTRACT 99

## Disparities in HIV-treatment Responses between Haitians, African Americans and Hispanics Living in the U.S.

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**OBJECTIVE:** Haitians living in United States (Haitians) constitute a fast growing immigrant population in the US. No outpatient studies to date have evaluated the response to highly active antiretroviral therapy (HAART) among Haitians. This study was designed to investigate the response to treatment with HAART between these three groups.

**METHODS:** A retrospective cohort study was conducted on adult HIV infected patient charts from Jackson Memorial Hospital Special Immunology Clinic and the Prevention and Treatment Center (PET Center). All charts reviewed were for patients who had initiated HAART between January 1, 2000 and May 1, 2008. Data extraction was conducted using standardized data collection forms. The inclusion criteria for the study were: patients on HAART for 96 weeks, who were naïve to therapy when presenting to the clinic, with an ethnicity of African American, Haitian or Hispanic. The outcome variables were CD4 Lymphocyte counts, HIV viral load, opportunistic infections, and other comorbidities. Data was analyzed using SPSS 17.0.

**RESULTS:** We initially reviewed 891 charts. Of the charts reviewed 205 met all criteria and were analyzed. The sample included 96 Hispanics, 60 AA and 49 Haitians patients. The study population was predominately male. A higher percentage of the Hispanics (62.4%) were men who have sex with men (MSM) in comparison to the AA (16.7%) and Haitians (8.3%) patients. There was no significant difference among insurance status. African Americans had a higher rate of Hepatitis C co-infection compared to other two groups, while there was no significant difference with Hepatitis B co-infection. The number of patients achieving successful virologic suppression at 96 weeks was, 58.5% (24) of Haitian patients, 74.1% (40) of AA patients, and 82.8% (77) of Hispanic patients ( $p = 0.011$ ). Median CD4 lymphocyte counts at baseline were lowest among

Haitians, 158 cells/mm<sup>3</sup>, and higher in AA patients, 176 cells/mm<sup>3</sup>, and Hispanics, 199 cells/mm<sup>3</sup>, however, this was not statistically significant. Throughout the 96-week treatment period Haitian patients remained with lower CD4 T-cell counts than the AA or Hispanics, with no significant difference. We observed a higher rate of Kaposi's Sarcoma and Mycobacterium Tuberculosis in the Haitian patient group.

**CONCLUSIONS:** This study suggests that Haitians in the US may not be doing as well on treatment because of difficulty with adherence and we can speculate that this may occur due to language barriers, inability to navigate this complex health care system, emigration status, acculturation, fear of deportation, poverty or physicians own biases.

## ABSTRACT 100

## Keeping Clients in Care: Retention in Care - a Model that Works!



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**OBJECTIVE:** Many PLWHA (Persons living with HIV/AIDS) who know their status but are not in care are dealing with serious substance abuse issues or mental health problems. They are "underground" and will not come into care until they are ready. "Readiness" is individual to the person. Only trusted persons can locate and access these individuals to discuss coming into HIV care.

**METHODS:**

- Electronic Medical Record
- Street outreach
- Referral - substance abuse/mental health services
- Homes visits
- Phone calls
- Letter notices

**RESULTS:**

28 Home visits, 816 phone calls and 589 letters contacts  
Health system navigation support for 91 individuals.

Three Learning Objectives:

1. Understanding the stages of behavioral change to determine a persons 'readiness' to return to care.
2. Acknowledging 'Engagement' as a fundamental technique to getting a person to care and staying in care.
3. Employing cultural competence to assure successful and effective outreach.

**CONCLUSIONS:** In 27 months, 91 persons returned to care. 59/65% remained in care, making two or more medical appointments.

**LESSONS LEARNED:**

Culturally competent staff with similar life experience, strong empathy for clients and knowledge of the local community are most effective.

**ABSTRACT 101**

**Linking Newly Diagnosed HIV Patients to Care – If You Build It, Will They Come? The Harris County Hospital District’s Service Linkage Program**



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**OBJECTIVE:** Provide a linkage to care program targeting newly diagnosed and out-of-care HIV+ patients who are identified through routine screening in hospital emergency centers of a busy, urban health care system.

**METHODS:** Within a recent 21-month period, 78,319 patients were screened for HIV in our two hospital emergency centers. 1,519 were found to be positive, of which 493 were new diagnoses. Service Linkage Workers received test results of all positives directly from the lab and attempted to deliver them to patients before they left the EC. Approximately 10% of positively diagnosed patients left the EC before being contacted by a SLW. These were referred to City of Houston Disease Intervention Specialists for follow-up. For the remainder, SLWs provided post-test

counseling, referral to primary care and other services, and extended contact to ensure that clinic appointments were kept and patients’ immediate needs were addressed prior to being assigned a case manager.

**RESULTS:** Approximately twice as many known positives as newly diagnosed cases were identified. A large portion of these previous diagnoses were out of care. More than 40% of newly diagnosed patients, as well as a substantial number of the known positives, were successfully linked or re-connected to care within HCHD HIV/AIDS programs. Service Linkage Workers relieved EC staff of the responsibility for informing patients of an HIV diagnosis. Working relationships with the City of Houston DIS staff were expanded and strengthened, as was coordination between the hospital-based Infectious Diseases physicians and HCHD’s HIV clinic.

**CONCLUSIONS:** Developing an effective service linkage program requires sensitivity to expectations of many components of a health care system and attention to a wide range of training needs. Delivering positive HIV test results in a busy emergency center requires different approaches from those historically used in post-test counseling. Linking data between systems of testing and care delivery to evaluate entry into care will require extensive coordination at both the federal and local level. Successfully linking newly diagnosed patients to care can be a very time-intensive endeavor.

**ABSTRACT 102**

**From Testing to Primary Care – Impact of the HIV Testing Expansion Initiative (HTEI) of a Large Public Hospital System on Linking and Retaining Patients in HIV Primary Care**



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**OBJECTIVE:** Following recommendations encouraging routine HIV screening, concerns arose about the impact of aggressive expansion of screening on other aspects of HIV

care given finite resources. Here we evaluate the impact of a screening program within a large public hospital system on linkage to HIV primary care and retention in care.

**METHODS:** With 14% of AIDS-related deaths, New York City (NYC) remains the epicenter of the HIV/AIDS epidemic in the U.S. In 2006, the NYC Health and Hospitals Corporation (HHC) established the HTEI within the 11 acute care hospitals and 6 community clinics of NYC's public hospital system which provides care for 1.3 million individuals annually. HTEI provided facilities: planning assistance, limited financial support, and a uniform M&E system. HIV testing targets were established and some financial incentives were provided based on target achievement. To track linkage and retention in care data on variances between HIV primary care appointments, scheduled and kept, and viral load and CD4 tests provided, were documented. Targets for these services were not established. Growth in the number of patients tested and the proportion of HIV patients retained in care from the pre-HTEI average through FY2006-2009 are assessed along with linkage to care data from FY2007-2009.

**RESULTS:** Annual HIV testing grew from ~50,000 (pre-HTEI) to 92,123 in FY06, and in FY09 187,732 individuals were tested – a 104% increase between FY06-09. Retention in care grew from 77% in 2005 to 89% in 2009. HHC data from FY07-09 demonstrate that over 60% of HIV positive patients were linked to care within the month of diagnosis. These findings are supported by specific NYC Department of Health data for 2007-08 indicating that over 90% of HHC-diagnosed patients were linked to care within 90 days of diagnosis.

**CONCLUSIONS:** Linkage and retention in care efforts can be strengthened alongside initiatives to aggressively expand HIV screening, and should be included at the initiation of programs expanding HIV screening.

## ABSTRACT 103

### Take the Test and Risk Arrest: How State Criminal Laws Impede HIV Testing and Disclosure



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**OBJECTIVE:** Most states have laws that criminalize conduct based on HIV status, and many of those that do not have used general criminal laws to impose penalties on people with HIV typically for conduct that is legal for those not tested for HIV and those who are HIV negative. Because liability can only be imposed if the person knows his or her status, such laws may serve as a disincentive to learning one's HIV status. This project assesses the evidence for or against such an impact.

**METHODS:** \*A comprehensive literature search of electronic databases of social science and legal articles was conducted. In addition, several persons who have analyzed and/or studied this issue were consulted, to learn of additional articles and works in progress. \*A comprehensive search of electronic databases of state statutes related to HIV, STIs, HIV disclosure and general criminal law; reported and unreported criminal case decisions; news reports and related databases was completed and analyzed for all U.S. states/territories.

**RESULTS:** We have established that: 1) While most individuals with or at risk of HIV appear to believe that disclosure of HIV status to partners is an ethical imperative, a significant number of gay men fear becoming the victims of inappropriate prosecutions; 2) There has been an increase in prosecutions in the U.S. for HIV exposure and failure to prove prior notification of HIV status to a partner; 3) There is an increasing perception among members of HIV-affected communities that highly-publicized criminal prosecutions of people with HIV generally undermine public health goals.

**CONCLUSIONS:** There is increasing evidence that criminal HIV disclosure and exposure laws and prosecutions may work against the efforts of public health officials to

reduce stigmatizing attitudes about and among people living with HIV and may be increasing the perception of legal vulnerability among gay men that may affect willingness to test. More research is needed to assess the actual impact of criminal HIV disclosure and exposure laws on the testing behavior of at-risk populations.

#### ABSTRACT 104

### **Project ACCEPT: A Behavioral Intervention to Improve Engagement in Care for Youth Newly Diagnosed with HIV**

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**OBJECTIVE:** Engagement in medical care is crucial for HIV-positive youth in order to improve medical, psychological, and public health outcomes. Adolescents and young adults newly diagnosed with HIV are often confronted with complex difficulties as they try to integrate traditional adolescent development with the burden of living with a stigmatized illness. These difficulties create barriers for adequately engaging in care. This presentation presents pilot data from Project ACCEPT (ATN 068), a behavioral intervention aimed at addressing a range of issues that impact engagement in care for youth newly diagnosed with HIV.

**METHODS:** In ATN 068, we completed intervention development, produced an intervention manual, trained interventionists and peer facilitators, implemented the 12 session manualized intervention at 4 ATN sites, assessed feasibility and acceptability, and calculated initial effect sizes. A total of 50 participants (28 male, 22 female; mean age = 19.65) diagnosed with HIV for an average of 8.36 months (range 1-16) were enrolled into the study. The majority of participants were African American (78%). Ninety-six percent of females identified as straight and 97% of males identified as gay/bisexual.

**RESULTS:** Session attendance was calculated as an indicator of feasibility. Eighty-four percent of participants attended 6 or more group sessions, 100% attended the first 2 individual sessions, and 86% completed the final individual session--there was a 4% attrition rate over the entire study. Client satisfaction questionnaires indicated high levels of satisfaction with the intervention. Regarding engagement in care, the number of missed doctor's appointments decreased at post-intervention and three-month follow-up, with effect sizes of  $d=.30$  and  $.15$ , respectively. Participants had an average of 2.42 ( $SD=1.99$ ) medical visits during the 12-week intervention period. The number of participants on medication increased by 42% from baseline ( $n=8$ ) to post-intervention ( $n=12$ ), and increased even further from baseline to the three-month follow-up (67% increase,  $n=20$ ). Further, participants expressed increasing levels of comfort with asking their doctor questions ("very comfortable" asking questions = 76%, 85%, and 87% at baseline, post-intervention, and follow-up). In post-intervention focus groups, staff discussed marked improvements in youth's perceptions regarding the relationship of health care to positive health outcomes, while youth expressed improvements in motivation to consult with their health care providers on health-related issues.

**CONCLUSIONS:** While a controlled trial is still needed, results from this study demonstrate that Project ACCEPT is feasible to implement in clinical settings and acceptable to youth newly diagnosed with HIV.

#### ABSTRACT 105

### **Differences in Client Care Status Indicators as Measured through Housing Services Provider Reporting and through Routine HIV/AIDS Surveillance Reporting**

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**OBJECTIVE:** The federally funded Housing Opportunities for Persons with AIDS (HOPWA) program addresses the housing needs of low-income HIV-infected persons.



Contracted New York City (NYC) HOPWA providers submit client data (e.g., housing status/type, services, and care events) monthly via a web-based system called eCOMPAS, newly implemented in 2008. One of NYC HOPWA's main goals is to connect and maintain clients in HIV primary care. The evaluation of program progress on goals requires that providers report complete, up-to-date care data. In addition to administering NYC HOPWA, the NYC Department of Health and Mental Hygiene (NYC DOHMH) houses NYC data from the surveillance system (HIV/AIDS Reporting System, or HARS), which contains laboratory and physician data on reportable events including tests and diagnoses. This project's objective was to evaluate the completeness of HOPWA provider reporting of clients' care events, by comparing documentation of care in eCOMPAS with documentation in the HARS database.

**METHODS:** HOPWA data for clients enrolled continuously from January-December 2008 were matched with HARS, using identifiers collected in both data systems. HARS-derived care status at baseline (July-December 2007) and in two six-month periods after enrollment (January-June and July-December 2008) was compared to eCOMPAS-derived care status during the same periods. In the eCOMPAS analysis, evidence of primary care was defined as any viral load or CD4 test or primary care visit documented by HOPWA service providers (typically through client self-report) in the six-month period of interest. In the HARS analysis, evidence of primary care was defined as any viral load or CD4 test reported (by a laboratory or physician) in the six-month period of interest; actual primary care visits are not reportable events in HARS.

**RESULTS:** HARS analyses demonstrated that 91.1% of HOPWA clients were in care at baseline and 88.0% had care during both halves of 2008. Reporting in eCOMPAS suggested that only 59.0% of HOPWA clients were in care at baseline and 59.4% received care during both halves of 2008.

**CONCLUSIONS:** Programmatic evaluation of clinical indicators derived from non-medical provider report may not accurately represent the impact of such programs on health and healthcare-related outcomes. The merged analysis of program data with HIV surveillance data allows verification and/or supplementation of provider reports and more confident inference about program efficacy. Partly in response to these HOPWA findings, the NYC DOHMH is

rapidly building capacity to conduct routine HARS matches and merged analyses of all clients in DOHMH-funded HIV service programs.

## ABSTRACT 106

### Reducing Redundancies in HIV Care Services in Virginia's Southwest Health Region



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**OBJECTIVE:** The Central Virginia Health District and other districts in Virginia's Southwest Region receive multiple streams of funding to provide HIV care, treatment, case-finding, and services to assist with linking clients to care. Health department Disease Intervention Specialists are the primary entry point for newly diagnosed HIV-positive individuals. The Virginia Department of Health (VDH) and community partners developed a collaboration at both the state and local level for the purposes of facilitating better communication amongst providers while establishing a safety net to assist with client engagement and retention into care.

**METHODS:** VDH HIV Care Services and Field Services staff collaborated to conduct an analysis of potential client-provider contacts for newly diagnosed clients entering the HIV care system. A provider forum was held with all identified agencies in attendance. The forum included educating regional stakeholders involved in the HIV care community and providing a comprehensive overview of the care system in the region. As a result, several barriers to seamless referrals between both private and public agencies and funding sources were identified. A regional Advisory Committee was formed with representation from different funding sources as well as areas of expertise. In tandem with VDH staff, the Advisory Committee developed a resource tool to assist with communicating more effectively between providers, close the referral loop, and assist with better coordination of services.

**RESULTS:** As a result of agency and area-wide collaboration, providers now have a better understanding of roles and responsibilities as they relate to the HIV care system. The newly developed regional Advisory Committee has taken a lead role in addressing care coordination issues in the area. Also, a “Coordination of Services Agreement” form was created as a universal tool to assist with referrals and to ensure adequate assessment of clients’ needs and necessary follow-up.

**CONCLUSIONS:** Obtaining input and buy-in from stakeholders is critical to maximize communication and improve coordination of HIV services. Each agency has been empowered to assume ownership over their role in the referral process and coordination of care. These partnerships will eventually lead to earlier engagement into care, better facilitation of services, and ultimately long-term retention in care.

#### ABSTRACT 107

### Report on the Poor Quality of HIV Testing for Pregnant Women in U.S. Prisons



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**OBJECTIVE:** The Rebecca Project for Human Rights and the National Women’s Law Center collaborated to collect, analyze, and present a comprehensive state-by-state report on existing policies and practices specific to prenatal care, shackling, and alternative to incarceration sentencing policies for pregnant and parenting women. One component of the prenatal care policies examined in the report was whether states offer HIV testing as a component of prenatal care.

**METHODS:** This information is derived from an American Civil Liberties Union report, State Standards for Pregnancy-Related Health Care in Prison, which compares state policies to nationally recognized standards on health care for imprisoned pregnant women issued by the National Commission on Correctional Health Care

and the American Public Health Association. The 2008 report is available at [www.aclu.org/reproductiverights/gen/pregnancycareinprison.html](http://www.aclu.org/reproductiverights/gen/pregnancycareinprison.html). ACLU’s data is used with the organization’s permission and ACLU staff assisted in some of this report.

**RESULTS:** Three (5.9%) states (e.g., California, Pennsylvania and Texas) indicated that they provided HIV testing options for pregnant women held in correctional facilities. The remaining 48 states either indicated that no specific policy existed requiring that pregnant women be offered HIV testing (n=20, 39.2%) or no information on HIV testing policies for pregnant women were found (n=28, 54.9%).

**CONCLUSIONS:** Pregnant and incarcerated women have higher rates of physical/sexual abuse, drug addiction and histories of survival/commercial sex work compared to the general population. These factors place incarcerated women at increased risk for a variety of adverse health related outcomes, most notably HIV/AIDS. Early HIV screening and therapeutic intervention is imperative for both the mother and the child. Recommendations include repealing the “inmate exemption” to the Social Security Act and mandating all state and federal facilities provide HIV/AIDS counseling and optional testing.

#### ABSTRACT 108

### The Effect of Early Counseling, Education and Linkage in Care for Individuals Newly Diagnosed with HIV/AIDS; Optimizing Engagement and Retention via the Compass Services Project

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**OBJECTIVE:** The dual purpose of the Compass Services project is to 1) link and retain people living with HIV/AIDS in medical care and 2) optimize wellness (longevity and quality of life).

**METHODS:** Compass Services utilizes an independently licensed social worker to provide counseling and education to people newly diagnosed with HIV/AIDS. The program serves both individuals testing positive elsewhere in the community and referred to MetroHealth for HIV care and individuals testing positive for HIV at one of MetroHealth's outpatient clinics or inpatient units. Newly diagnosed counseling and education sessions are typically 60-90 minutes in length and include the following elements: 1) offering hope and reassurance that one can live a long, good-quality life despite having HIV, 2) developing coping strategies and emotional supports; including referral to support groups and peer mentoring / adherence support, 3) providing basic information about HIV transmission and disease progression, 4) linkage to resources that help the individual manage their HIV 5) providing assistance with navigating the system of medical care, including ongoing contact with the person to increase the likelihood that they will continue to engage in medical care for HIV.

**RESULTS:** Statistics: Since Compass Services began in June 2008 through August 30, 2010, 180 people newly diagnosed with HIV received newly diagnosed counseling and education. Outcomes: A retrospective analysis compared retention rates for all patients newly diagnosed with HIV seen in the MetroHealth ID Clinic in 2007 versus those seen in ID Clinic since Compass Services began (June 2008). Regular medical care is considered the hallmark of living well with HIV/AIDS, so patients were compared at 1 year and 2 years post-diagnosis to determine if they remained in medical care. The analysis revealed the following: Of patients newly diagnosed with HIV in 2007, 72% were still in-care at 1 year, and 66% at 2 years. Of patients newly diagnosed with HIV in 2008 – present, when Compass Services provided newly diagnosed counseling and education, 86% were still in-care at 1 year, and limited 2-year data shows that holding steady at 86%.

**CONCLUSIONS:** Results suggest that providing newly diagnosed counseling, education and service linkage for patients soon after or as soon as they are diagnosed can significantly increase their chances of being retained in medical care and therefore optimizing wellness - living a healthier, longer life with HIV.

## ABSTRACT 109

### Breaking Down the Barriers to Care

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**OBJECTIVE:** Maintenance in care (MIC) program at Harlem United (HU) was an outreach-based intervention program designed to reduce HIV-related morbidity by assisting people living with HIV/AIDS (PLWHA) who have sporadic care or are out of care to access and engage in HIV medical services and specialty care. The program has three objectives: - To connect or reconnect all clients to HIV primary care provider (PCP) within 60 days of enrollment- To connect hard to engage clients to supportive services within 90 days of enrollment- To maintain clients' engagement with an HIV PCP and/or medical specialty care.

**METHODS:** To accomplish program objectives, MIC adopted an intervention model that is client-centered and medically driven. The intervention encompasses a number of strategies including:- Medical driven case finding - Door-to-door client outreach- Effective telephone contact- Brief assessment of need- Goal driven service plan, demonstrating need for enrollment - Quarterly re-assessment and service plan update- Accompaniment and other strategies such as client escort service for getting patients to their scheduled appointments- Information and education- Referral for services which are necessary for engagement in primary care, and follow-up on referrals- Establishing/maintaining communication with Primary Care Provider on engagement- Cultivating linkage agreements with diverse community partners such as Single Room Occupancy (SRO) housing entities and community centers.

**RESULTS:** The intervention model adopted by MIC was successful in re-engaging and connecting 843 clients within one year.

**CONCLUSIONS:** The high re-engagement and connection to care rate demonstrated evidence of the MIC program efficacy in reducing barriers to healthcare for hard to engage clients. We also learned that an important aspect of the program that promoted the success of the intervention was



the emphasis set in meeting clients where they are in regards to healthcare.

## ABSTRACT 110

### Linking Faith Based Organizations to Existing Care and Treatment Centers



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**OBJECTIVE:** Through collaboration with the faith community, state and local agencies, the JACQUES Initiative (JI) implemented Project SHALEM. Faith-based venues serve as “A Safe Place” for testing and linkage to care in addition to providing volunteers to perform HIV testing at locations in the community. This word “Shalem”, derived from the “shalom” or “salaam”, was chosen for its common expression across faiths and can be interpreted as “peace”, “completeness”, or “safety”.

**METHODS:** Project SHALEM is based on a “hub-satellite” testing and linkage to care model. Faith institutions serve as satellite testing/linkage to care centers where volunteers engage in testing. Those who test positive in these faith settings are referred to JI for linkage to HIV care (at JI or other local HIV service facilities) and needed wrap-around services (housing, drug rehabilitation). JI provides technical assistance and capacity building for volunteers from the faith community. Volunteers serve as HIV testers and support personnel to guide clients through the testing/linkage process, including spiritual/psychosocial support and community mobilization to inform the public of offered services. The project works in close partnership with Maryland’s Infectious Disease and Environmental Health Administration and the Baltimore City Health Department, who provide support for training volunteers as well as disease surveillance and intervention to maximize contact with new and previous positives and linkage to care.

**RESULTS:** Total Tested Y1 (May-December ‘09): 1335 Y2 (January-July ‘10): 1339 Total positives (new): Y1: 41(6) Y2: 51(6) In Y2 35/45 previous positives were either re-engaged in care or verified to be actively engaged in care Total new

positives linked to care (rate): Y1: 4 (.67) Y2: 4 (.67) (data pending for remaining 2 new positives) Rate of previous positives not in care re-engaged: Y1: .18 Y2: .67 Venues for linkage to care have included JI and 5 other local HIV service providers.

**CONCLUSIONS:** 1. Necessary components of the model include: Faith-based community Academic institution/technical expert State and local policy/regulatory agencies 2. (Re)Linkage to care is difficult and requires intensive psychosocial support, communication and collaboration with faith volunteers and local policy/regulatory agencies for surveillance and disease intervention. 3. A strong system of local HIV and wraparound service providers is crucial. To maximize (re)linkage to care, it is important to link clients to the service provider that will work best for them – may be a venue where previously engaged or that meets insurance/geographical needs. 4. Mobilizing the faith based community for HIV testing/linkage has been an effective strategy to identify those newly diagnosed and out of care.

## ABSTRACT 111

### Developing a Medical Case Management Guideline: Tools for Retention

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**OBJECTIVE:** The District of Columbia experienced considerable high burden of HIV/AIDS as more than 3 percent of the city’s adults and adolescents are infected. Medical case management (MCM) is a key component of the continuum of care to ensure entry, linkages and retention in care. HAHSTA set out to develop a minimum standard to ensure consistency in service and for the provision of quality medical case management services that focus on: -Achievement of good health outcomes -Importance of viral load suppression -Treatment adherence at every stage of the Medical case management process and -Engagement in a primary medical home. -Coordination of linkages to services.

**METHODS:** Workgroups comprised of HAHSTA staff and the community partners were convened to develop the

guidelines. The work group reviewed other states MCM models and published best practices. Multiple tools were developed. These include a comprehensive and mini client assessment tool; a four-level Acuity Scale; a supervisor's worksheet; a "SMART" MCM Service plan guide and several program and client monitoring tools. Tools were phased in over a 12 month period. A trial utilization and feedback period allowed for broad community input, enhancement of the final product and informed collaborative development of trainings for over 200 medical case managers.

**RESULTS:** Medical case managers now track CD4 counts and viral loads and ensure that clients are engaged in medical care. Medical case managers without clinical backgrounds are empowered to forge strong relationships with the primary medical team to ensure positive clinical outcome for clients. Preliminary first quarter report of nine providers implementing the tool showed consistency of care across all medical case management services. Assessment using the acuity scale categorized 42% of clients as intensive, 14% moderate, 32% basic and 12% self management level. The preliminary results also showed 47% of clients have CD4 count greater than 350; 41% virally suppressed while 80% receive treatment adherence counseling per visit. Medical case managers ensure that clients are maintained in primary care and adherent to medication through tracking their laboratory values.

**CONCLUSIONS:** The guideline has provided a basis for evaluating the effectiveness of medical case management services. Phased release of the document over a 12 month period reduced apprehension especially among providers in non-clinical settings. Community involvement from the onset created a sense of ownership facilitating implementation. Training medical case managers was vital to effective dissemination of the information. Several connections were made among service providers that enhanced linkage networks.

## ABSTRACT 112

### Housing Subsidy as an Effective Structural HIV Prevention and Health Care Intervention



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**OBJECTIVE:** Studies have shown that stable housing is correlated with better HIV prevention and health outcomes, but few rigorous evaluations have been completed to assess the ground-level effectiveness of housing programs administered by community based organizations (CBO). We describe the comprehensive evaluation that will assess the effectiveness of the San Francisco AIDS Foundation's (SFAF) rental subsidy program for HIV-related health outcomes and report preliminary results.

**METHODS:** SFAF has provided rental subsidies to low-income, HIV-positive individuals for more than 15 years. In addition, subsidy recipients work with case managers and financial benefits counselors to access health care and social services.

Data are being compiled from a variety of sources including:

- Comprehensive, annual psychosocial- and behavioral-risk assessments completed by subsidy recipients;
- Client progress notes from confidential case management files; and
- Annual, anonymous client satisfaction surveys.

These data will be aggregated into an electronic database to track client progress over time. Multivariate analyses will test the independent relationship of rental subsidies with multiple HIV-related outcomes, including viral load and CD4 count.

**RESULTS:** The program has 390 participants. Over two thirds have stayed in the program more than 10 years; 64.2% fall between ages 45 and 64; 86.2% are male; nearly half (47.4%) are Caucasian, with sizable Latino (19.6%) and African American (16.4%) subpopulations; 71.6% self-identify as gay/homosexual; and 67% have co-existing

psychiatric diagnoses, challenges with ongoing drug use, or complex syndemic conditions.

Almost three quarters (74.5%) of program participants report having a normal CD4 count (>250) and 70.5% report having an undetectable viral load. The vast majority (96.8%) report visiting their HIV provider within the last six months; (96.4%) feels that the rental subsidy improves their overall quality of life; and 86.2% think rental subsidies help them adhere to their medication regimen.

**CONCLUSIONS:** These preliminary, mostly self-reported results suggest that SFAF's rental subsidy program leads to improved health outcomes and quality of life among participants. We currently are engaging in the design and implementation of a comprehensive program evaluation, which will build on these preliminary data and test specifically whether program participation increases access to and utilization of HIV health services and improves HIV health outcomes, including lowering viral load and increasing CD4 T-cell counts. We will report on our progress at the Summit. Our goal is to contribute to the evidence-base for CBO-generated structural interventions for HIV prevention and care.

#### ABSTRACT 113

### Barriers to Accessing HIV Testing, Care, and Treatment in the United States



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**OBJECTIVE:** Despite widespread availability of HIV services, many patients present well-beyond the clinical period recommended by guidelines. The purpose of this hypothesis-generating survey was to assess US patient and health care providers (HCPs) perceived barriers to HIV testing, care, and treatment to better understand areas for intervention.

**METHODS:** The survey assessed barriers to receiving HIV services for three patient groups: 1) diagnosed, under care (DUC); 2) diagnosed, not under care (DNUC); and 3) At-

risk (AR). Interviews were conducted with HIV patients and HCPs to identify commonly perceived barriers. A study-specific questionnaire was then developed to measure those barriers. In this quantitative phase, subjects underwent interviews by phone, on-line, or in person. Participants were recruited from AIDS service organizations, physician offices, advertising, and de-identified patient databases. Multiple barriers were tested and sized for each patient group through a discrete choice Latin-Square method. Barriers were further grouped in a post-hoc fashion as Structural or Emotional.

**RESULTS:** 234 patients (104 DUC, 54 DNUC, 76 AR) and 299 HCPs (90 MDs, 40 NPs, 33 PAs, 136 AHCPs) participated. For patients DUC, HCPs perceived more circumstantial barriers than patients (finances, transportation, family care: 58% versus 37%, drug/ethanol abuse: 49% versus 21%) whereas emotional barriers were stronger for patients (fear of side effects: 82% versus 74%, fear of people knowing: 58% versus 47%, stigma: 55% versus 44%, fearing death: 41% versus 29%, being seen at clinic: 39% versus 29%). Findings were similar for patients diagnosed not under care. Among the AR, HCPs more frequently cited denial, drug/ethanol abuse, and fear of being seen at clinic than patients, who more frequently cited fear of disclosure, basic needs, facing reality, and fearing side-effects.

**CONCLUSIONS:** HCPs generally underestimate the impact of emotional rather than structural barriers on a patient's willingness to undergo HIV testing, care, and treatment.

#### ABSTRACT 114

### Estimation of the Size and Treatment Status of the HIV Population in the United States

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**OBJECTIVE:** In 2006, the CDC estimated 1,106,400 persons in the U.S. were living with HIV with 21% undiagnosed. No reliable data are available describing the proportion of known HIV+ persons who are under medical care or who have initiated antiretroviral therapy.

**METHODS:** Multiple sources were used to estimate the size and treatment status of the US population of HIV+ individuals, through the end of 2008, who were diagnosed and under physician care, whether treated or not, or diagnosed but not under physician care. The total HIV+ population and number of undiagnosed individuals were derived from temporally-adjusted CDC prevalence estimates. The number of antiretroviral-treated HIV patients was derived from national prescription data and combined with data from an ongoing national survey to estimate the total number of patients under HIV-treating physician care, categorizing them as: a) currently on antiretroviral treatment; b) between treatment; or c) antiretroviral -naïve. The number of those not under physician care was then calculated.

**RESULTS:** After adjustment, an estimated 1,135,000 individuals were HIV+ as of the end of 2008. National prescription data from all distribution channels reflect an estimated 493,000 individuals receiving antiretroviral treatment. Survey data from 4007 patients in physician practices indicate that approximately 83% of HIV patients were currently receiving antiretrovirals, 3% were between treatments, and 14% were antiretroviral naïve. Overall estimates of HIV patients under physician care were 594,000, leaving 314,000 individuals diagnosed but not under care in contrast to an estimated 227,000 undiagnosed individuals.

**CONCLUSIONS:** These data suggest that the number of patients who are diagnosed with HIV infection but not under physician care in the U.S. may exceed the number of HIV+ individuals who have not been diagnosed. As efforts to expand HIV screening are implemented, effective linkage of those individuals into care will be essential to improving patient outcomes.

## ABSTRACT 115

### Sustainability of a Statewide System to Identify and Link HIV-positive Pregnant Women to Care in Illinois



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**OBJECTIVE:** To prevent perinatal HIV transmission by identifying and linking pregnant, known or newly diagnosed, HIV-positive women not currently in care to medical care and social services through a statewide Hotline and sustainable safety net of collaborative services.

**METHODS:** The State of Illinois has developed an integrated system of rapid, real-time identification and linkage for pregnant HIV-positive women that facilitates identification of critical cases of HIV in pregnancy, and provides medical consultation and social service support through a statewide 24/7 Perinatal HIV Hotline (Hotline). All Illinois birthing hospitals offer rapid testing to HIV-undocumented women presenting to labor and delivery units and are supported by the Perinatal Rapid Testing Implementation Initiative in Illinois (PRTII). Positive rapid tests are mandated by Illinois law to be reported to the Hotline to facilitate medical consultation, linkage to care and referral to enhanced case management services of the Pediatric AIDS Chicago Prevention Initiative (PACPI). Known or newly diagnosed HIV-positive pregnant women are also voluntarily reported to the Hotline for linkage assistance. The Hotline activates on-call case managers to link patients to medical care and provide intensive services, including benefits assistance and wrap around services to facilitate patients staying in care. The Hotline tracks retention in care and infant HIV status outcomes.

**RESULTS:** The sustainability of Illinois' safety net for pregnant HIV-positive women is demonstrated by a subset of 29 high-risk women repeatedly identified and referred from January 2004-August 2010. Of the 842 Hotline calls, 70 repeatedly identified 29 women with 47 pregnancies



(41 live births, 4 losses, 2 presently undelivered). Women were referred multiple times in one pregnancy or across different pregnancies due to repeated identification via rapid testing, prenatal testing and need for case management. All pregnancies were linked to prenatal care when identified prior to delivery. For 29 of 41 births (71%), maternal AZT was administered at delivery; 3 women delivered at home. All 41 infants received AZT at birth (100%) and 16 (39%) received nevirapine due to elevated risk of transmission. Two cases of HIV transmission occurred; neither mother was identified prior to delivery. The remaining infants are confirmed negative or have negative testing to date.

**CONCLUSIONS:** The integration of a statewide program of rapid HIV testing at delivery, a Hotline and intensive case management has identified hard-to-reach HIV-positive pregnant women and helped ensure optimal treatment. Active collaboration between all programs of the safety net has produced healthy outcomes for women and infants in Illinois.

## ABSTRACT 116

### Linkages to Care: Getting Those Released From Jail Connected to Care



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**OBJECTIVE:** To get all HIV-infected inmates connected to case management and into primary care upon release from New York City jails.

**METHODS:** The New York City Department of Health and Mental Hygiene's Transitional Health Care Coordination (THCC) team engages nearly all HIV+ inmates who remain jailed on Rikers Island for at least 48 hours. The THCC team conducts a needs assessment, arranges for discharge medications and transfer of medical information, makes medical appointments, and links the client with a community-based partner who provides case management. Once released, clients are offered transportation and escort to and from their first medical appointment. Clients who do not follow up with their community partner and miss

their medical appointment are then referred back to THCC's home visit team which attempts to locate and, if they are still in the NYC community, contact the client, offering a home visit and escort to a new appointment with a provider. Linkages to care are tracked for an additional 3 to 6 months post-release.

**RESULTS:** Nearly 80% of clients who received a discharge plan were connected to care post-release. Along with primary medical care, clients were connected to substance abuse treatment (52%), case management (53%), housing (29%), and court advocacy (18%). Approximately 65% of clients accept the offer of accompaniment and transportation to their first medical appointment. The home visit team is generally able to locate about 90% of clients referred, finding that approximately one third of those referred have been reincarcerated.

**CONCLUSIONS:** By attempting to engage all known positives, the THCC team now provides discharge planning to nearly 80% of all HIV+ inmates who are not quickly released, an improvement from 55% three years ago. We found that the majority of inmates released to the community with a discharge plan and linkage to a community case manager get connected to care and services. Access to primary care, as well as housing, substance abuse treatment, and other social service benefits, is often more efficiently provided through a medical case-management model. Collaborations are key to help foster relationships between the community and jail-based health service providers, closing the gap between correctional and community health care systems and facilitating continuity of care and retention in treatment.



## ABSTRACT 117

## Predictors of Late Linkage to Medical Care after a New HIV Diagnosis: A Statewide Population Based Study

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**OBJECTIVE:** Routine opt-out HIV testing at all health care facilities is recommended by the US Centers for Disease Control and Prevention (CDC). Public health benefits of expanded HIV screening will be adequately realized only if an early diagnosis is followed by prompt linkage to care. The objective of this study was to characterize rates and factors associated with failure to enter into medical care within 3 months of HIV diagnosis and to assess the predictors of time to enter care over a follow-up period of up to 48 months after HIV diagnosis.

**METHODS:** Retrospective cohort study of South Carolina (SC) residents =13 years of age, who were newly diagnosed with HIV infection from January 2004 through December 2008. All licensed laboratories in SC have been mandated since 2004 to electronically report all viral loads (VL) and CD4 count/percent to SC HIV/AIDS reporting system (eHARS). We used the date of first VL or CD4 count/percent reported to eHARS after a 30-day washout period from the date of HIV diagnosis as a proxy for linkage to care. Cox proportional hazards analyses were used to assess time to linkage with care over a follow-up period of 12 to 48 months after diagnosis.

**RESULTS:** Mean age ( $\pm$  standard deviation: SD) of the study sample (N= 3,823) was 37 $\pm$ 12 years and the majority were men (69%), Black (72%) and urban residents (71%). In our sample, 1,768 (46%) entered care within 3 months; 1,115 (29%) in 4-12 months after diagnosis; and 940 (25%) failed to initiate care within 12 months of diagnosis. Compared to hospitals, entry into care was earlier in those diagnosed at state mental health/correction facilities (Hazards ratio [HR] 1.16; 95% confidence interval [95% CI] 1.02-1.34); and delayed in those diagnosed at county health departments

(HR 0.87; 95% CI 0.80-0.96) and at 'other testing sites' such as blood banks (HR 0.79; 95% CI 0.70-0.89). Entry into care was significantly delayed in men (HR 0.82; 95% CI 0.75-0.89); in blacks (HR 0.91; 95% CI 0.83-0.98) and 'others' (HR 0.80; 95% CI 0.68-0.95) compared to whites; and in MSM (HR 0.89; 95% CI 0.80-0.98 and those with unspecified mode of exposure (HR 0.62; 95% CI 0.56-0.68).

**CONCLUSIONS:** Delayed entry to HIV care is a challenge to controlling HIV transmission in SC. Better integration of testing and care facilities and mitigation of sociodemographic disparities would improve the rate of timely linkage to medical care among newly HIV-diagnosed persons.

## ABSTRACT 118

## Predictors of Retention in HIV Care and Correlates of Survival: A Statewide Study

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**OBJECTIVE:** Retention in HIV medical care ensures adequate therapeutic and preventive intervention. Current literature is mostly on urban clinic-based data, which may fail to account for patients who continually/simultaneously access different providers. We evaluated predictors of retention in care and examined the association of early retention after linkage with clinical outcomes and survival in a statewide population.

**METHODS:** Retrospective cohort study of South Carolina (SC) residents =13 years old who were diagnosed with HIV-infection in 2004-2007 and were linked with HIV care after diagnosis. In SC, since January 2004, all viral load (VL) and CD4 counts/percent are mandatory reported to HIV/AIDS Reporting System (eHARS). Retention was defined as report of at least one CD4 count/percent and/or VL in each six-month period over two years after linkage to care. Retention was categorized as 'optimal' (= 75% visits); 'sub-optimal' (<75% visits) and 'dropout' (no visit over two

years). Logistic regression and Cox proportional analyses were used to examine retention.

**RESULTS:** Mean age of the cohort (N= 2,247) was 37±12 years and a majority were men (66%), black (72%) and urban residents (71%). In our cohort, 68% had optimal retention, 22% had sub-optimal retention, and 10% were 'dropout'. Sub-optimal retention was more likely among men (Adjusted odds ratio [aOR] 1.41; 95% confidence interval [CI] 1.06-1.87); blacks (aOR 1.37; 95% CI 1.04-1.79); urban residents (aOR 1.41; 95% CI 1.02-1.97) and in counties of residence with higher poverty markers (aOR 1.03; 95% CI 1.01-1.06). 'Dropout' was more likely in men (aOR 1.83; 95% CI 1.22-2.74); blacks (aOR 2.10; 95% CI 1.36-3.24) and other race/ethnicity (aOR 2.21; 95% CI 1.03-4.77); and in those diagnosed at county health departments (aOR 1.70; 95% CI 1.09-2.65) or other/unknown testing sites (aOR 1.94; 95% CI 1.16-3.24) as compared to hospitals. Older age and concurrent AIDS were associated with higher rates of retention. Mean decrease in baseline log<sub>10</sub> VL (3.92 vs. 1.53; p <0.001) and increase in CD4 count (169.70 vs. 15.82; P <0.0001) over two years was greater in optimal retention compared to sub-optimal retention. In survival analysis, increased risk of mortality was associated with sub-optimal retention (Adjusted hazard ratio [aHR] 1.81; 95% CI 1.11-2.97) and 'dropout' (aHR 3.01; 95% CI 1.35-6.67); with higher VL (aHR 1.11; 95% CI 1.01-1.22); and poorer county (aHR 1.04; 95% CI 1.02-1.07).

**CONCLUSIONS:** Rate of poor retention was relatively lower than reported in clinic-based data. Increasing rate of retention in early HIV care could substantially improve survival outcomes.

## ABSTRACT 119

### Enhancing Linkages to HIV Care for Racial and Ethnic Minorities in Virginia

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**OBJECTIVE:** In 2009, an estimated 21,000 Virginians were known to be living with HIV/AIDS. For every five

Virginians living with HIV/AIDS, approximately three are African American. As a result of these staggering statistics, two community-based organizations and two health districts have been funded to provide a wide range of programs and services targeting racial and ethnic minorities, each based on an assessment of service delivery needs in their local communities. Their unique efforts have resulted in an increase in care, support services and enrollment in the AIDS Drug Assistance Program.

**METHODS:** Contractors have established collaborative relationships with Ryan White Part A, B, C, and D providers, ADAP Coordinators within local health departments, HIV counseling and testing providers, and medical facilities. Educational and outreach programs have emphasized early detection, linkage to care, and treatment education. MAI contractors have developed an immediate and personal bridge from HIV testing to care through agreements that allow for sharing of client-level data to link individuals to care. HIV case-finders assist clients in accessing care immediately following receipt of HIV-positive test results, allowing clients to be successfully linked to medical and/or comprehensive support services. Health systems navigators assist in guiding the client through the health care and support services system.

**RESULTS:** From January 1, 2009 through December 31, 2009, 3,161 individuals identified as racial/ethnic minorities received medical care and/or support services, representing approximately 62.46% of the total number of clients receiving medical care and/or support services (5,061). A total of 3,807 persons were enrolled in ADAP during this same time period, including 2,759 identified as racial/ethnic minorities. Thus, clients enrolled as a result of MAI activities accounted for 91.8% of new ADAP enrollment and 36.9% of the racial/ethnic minority population new enrollment. This represents an increase of 31.5% from the previous year.

**CONCLUSIONS:** Contractors have been successful in providing culturally appropriate education and outreach case-finding services, and in working with HIV-positive clients to lead them through the service delivery system. This helps to ensure that clients receive ADAP services and are assisted as they transition to case management for access to ongoing medical care and supportive services. While Minority AIDS Initiative (MAI) funds specifically target minority populations, consumers in these communities also receive preventative care and treatment services from programs receiving funds through a variety of sources. Based on current health outcomes data, it is clear that services

provided via MAI funds compliment programs provided through other Ryan White funding.

#### ABSTRACT 120

### **Linkage of Preliminary Reactive Diagnosed Clients to Care and Treatment Services: An Intensive Approach to Initiating and Ensuring Linkage to Care for Preliminary Reactive Diagnosed Clients in the High Risk Heterosexual Population in Wards 7/8 of DC**

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**OBJECTIVE:** Throughout 2008 and 2009 Community Education Group (CEG) counseling, testing, and referral (CTR) staff, referral and linkage staff, and management staff identified a problem with linking clients diagnosed preliminary reactive through rapid HIV testing to partner care and treatment providers for HIV care and treatment services using the traditional method of offering preliminary reactive diagnosed clients referrals to care and treatment services. Our overall linkage to care rate for individuals diagnosed preliminary reactive through rapid HIV testing was under 5%.

**METHODS:** In October 2009 CEG staff developed and implemented an intensive linkage strategy in order to ensure that clients being diagnosed as preliminary reactive through rapid HIV testing were being linked to HIV care and treatment providers to receive care and treatment services, through the use of incentives and strong connection and follow-up methods.

**RESULTS:** As a result of this aggressive strategy and existing relationships with care and treatment providers CEG has been able to link or confirm that 54 of 59 preliminary reactive diagnosed clients to date have been linked to or are receiving care and treatment services. These numbers indicate a dramatic increase in our ability to link clients to or confirm that clients are receiving care and treatment services

than we were capable of before using this more intensive linkage to care and treatment strategy.

**CONCLUSIONS:** Using a more intensive strategy for linking clients to care and treatment services including staff escort, transportation, staff support during visits, and incentives has shown to be far more effective than referring clients to care and treatment providers and other methods of linkage to care and treatment services. The benefit in a more intensive linkage to care and treatment strategy is shown in the number of preliminary reactive diagnosed clients that CEG has been able to link to or confirm that they are receiving care and treatment services. In light of the importance of ensuring that preliminary reactive diagnosed clients are receiving care and treatment services, CEG feels that the extra effort and resources needed to implement this strategy are well worth the end result of more HIV positive individuals receiving care and treatment services and ultimately decreasing their viral load and increasing their quality of life while living with HIV.

#### ABSTRACT 121

### **Capacity Building Efforts and Strategies for HIV Testing, Referral and Linkage to Care**



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**OBJECTIVE:** a. Participants will gain an understanding of the resources available to them to assist in training medical care providers with routine HIV testing in medical care settings; b. Participants will be able to describe and implement new models of outreach that assist with entry and retention of individuals with HIV in care; c. Participants will be able to utilize, and request as necessary, technical assistance and training resources that are available to HIV service providers and organizations.

**METHODS:** This presentation will provide an overview of models and resources from the AIDS Education and Training Center (AETC), and Special Projects of National Significance (SPNS) Programs, tested technical assistance

interventions and resources, and pilot efforts that address HIV testing, referral, and linkage to care for underserved populations. On-site training and consultation with medical providers and methods of targeted outreach will be described. Selflearning modules/workbooks and regional TA training resources will be described.

**RESULTS:** AETC HIV testing training in health care settings resulted in 48,800 providers being trained at 527 new sites over a 1 ½ year period. Improvements were noted the percentage of clinics offering routine testing (51?81%), linkage to care policies in effect (41?75%), clinic policies on routine testing (59?88%), and median number of patients receiving testing (53?65%). A pilot project in community health centers (CHCs) yielded routine testing of 28% of the patient population in 6 CHCs with 21 clinical sites with a confirmed diagnosis rate of 0.16%. 10 SPNS demonstration outreach projects sampled 1,076 clients to identify structural, financial, personal and cultural barriers to care with participants with 9 or more outreach contacts in the first three months being twice as likely to be retained in medical care. 42 methodologies have been described and are offered to connect individuals with HIV to care, as appropriate for a variety of service settings and populations of focus. The effective involvement of “consumers” through varied methods is also to be fully described.

**CONCLUSIONS:** A variety of effective training and technical assistance interventions have been shown to be helpful to organizations in identifying HIV positive unaware individuals and providing linkage and increased access to care.

## ABSTRACT 122

### **From Prison/Jail to the Community: Project START, a Best Practice and Effective Linkages Model**



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**OBJECTIVE:** The purpose of Project START is to reduce HIV/STI/hepatitis risk behaviors (both sexual and drug related) while integrating the competing life needs and challenges of people being released from prison/jail into

their prevention, treatment and care plans. The original research studying the effectiveness of Project START targeted young men leaving prison; the intervention was later pilot tested targeting people with HIV transitioning from prisons and jails. During the translation from research to practice, Project START was expanded to be implemented with populations regardless of gender, age, HIV status or type of correctional setting. Recent efforts have included HIV testing as a component of the prevention activities.

**METHODS:** Project START is a risk reduction and community linkages program for individuals transitioning from a correctional setting back into the community; its approach is based in Harm Reduction. The original effectiveness research included a comparison group that attended a single individual HIV-STD-Hepatitis risk reduction counseling session before release from prison; the study arm (Project START), received both the single session, plus an additional individual session before release focused on broader reintegration goals and four follow-up post release sessions in the community focused on review of the goals and linkages to community resources. Original study sites were based in California, Mississippi, Rhode Island and Wisconsin. Current efforts are underway to adapt the intervention for women, people with HIV and people with drug and mental health problems.

**RESULTS:** The original research demonstrated that men who participated in the multi-session Project START intervention that included both HIV/STI/hepatitis risk reduction and competing life needs, were less likely to report sexual risk behaviors at six months after they were released from prison compared to those in the single prerelease intervention session. In a separate pilot study of Project START targeting people with HIV, over 70% of participants attended their first medical appointment after being released from prison or jail. Project START has recently been translated from a multi-site, 10 year research study to a community based program and is currently being disseminated both domestically and globally.

**CONCLUSIONS:** Project START is an effective model that links people before their release from prison and jail to the community. It has been shown to decrease sexual risk behavior as well as increase retention in care and treatment post release.