

Expanding access, improving retention in HIV care

The SPECTRuM Project Implementation Manual

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH
BUREAU OF INFECTIOUS DISEASE AND LABORATORY SCIENCES
OFFICE OF HIV/AIDS



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Participating Sites

- **Boston Medical Center**
- **Brockton Neighborhood Health Center**
- **Greater New Bedford Community Health Center**
- **Holyoke Health Center**
- **Morton Hospital**
- **UMass Memorial Medical Center**

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This manual can be found in its entirety on the web at <http://www.mass.gov/dph/aids>
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CONTENTS

Introduction	6
Strategy 1: The Peer-Nurse Enhancement to Medical Case Management	9
Working with the HIV care team and community to create buy-in	12
Developing, preparing, and integrating the peer-nurse team	13
Training the peer-nurse team	19
Peer-nurse team services	23
Case examples	30
RESOURCES Strategy 1: The Peer-Nurse Enhancement to Medical Case Management	33
SPECTRuM initiative intervention protocol #1	33
Working with the HIV care team and community to create buy-in	34
Presentation to clinical team and stakeholders	34
Developing, preparing, and integrating the peer-nurse team	40
SPECTRuM project pilot agency assessment	40
SPECTRuM project questions: Initial agency meeting.....	45
Sample peer job descriptions.....	46
Sample nurse job descriptions	50
Training the Peer-Nurse Team	55
Training for peers.....	55
Training for nurses.....	56
Nursing technical assistance site assessment tool.....	57
SPECTRuM RN orientation/Training needs assessment.....	59
Presentation: SPECTRuM nurse role and RN/peer dynamic.....	60
Presentations from nurse HIV overview training	65
Supplemental materials on linkage and retention in care.....	67
Joint training for the peer-nurse team	69
SPECTRuM nurse technical assistance monthly site visit guide.....	69
SPECTRuM nurse technical assistance case study presentation guide	71

TABLE OF CONTENTS

Case studies	72
Case discussions and technical assistance	73
Presentation: Client self-advocacy	74
Presentation: Motivational interviewing.....	76
Motivational interviewing tips	83
Supervision resources	85
SPECTRuM Supervision Workshop	85
Presentation: SuperVision in support of the SPECTRuM project	86
SPECTRuM clinical supervision framework.....	90
Peer-nurse team services	91
SPECTRuM outreach protocol	91
Acuity assessment resources.....	92
MDPH and BPHC HIV/AIDS medical case management acuity tool	92
CAGE-AID assessment tool	99
GAD-7 assessment tool	100
PHQ-9 assessment tool	100
BMC communication and contact authorization form	101
BMC enrollment email notification to staff	103
BMC peer phone call scripts	104
BMC letters to clients	105
GNBCHC letter to re-establish contact with clients	108
HHC reminder cards	109
UMMC crisis management policy	110
UMMC protocol for home visit.....	114
UMMC client consent for home visit.....	116
HHC guidelines for outreach and home visits	117
BMC request for home visit	118
Transition resources	119
SPECTRuM transition tip sheet.....	119
Sample transition letter to client.....	123
BMC transition email to staff	124

TABLE OF CONTENTS

Strategy 2: Enhancing Surveillance Systems to Strengthen Retention in Care	126
Role of the state health department	129
Role of health care providers	133
RESOURCES Strategy 2: Enhancing Surveillance Systems to Strengthen Retention in Care	138
SPECTRuM initiative intervention protocol #2	138
SPECTRuM surveillance site communication form	139
HHC detectable viral load tracker terms and definitions.....	140
HHC detectable viral load tracking sheet.....	141
UMMC client discharge/Drop out form	142
BMC process for updating the line list report and example of tracking spreadsheet	143
Sample community health center line list report.....	144



Introduction

Purpose of this manual

There are more than 20,000 people known to be living with HIV/AIDS (PLWH) in Massachusetts.¹ Current therapies have improved health outcomes and the quality of life for PLWH; however, for some, accessing and maintaining continuous care and treatment can be challenging, particularly for individuals experiencing comorbidities and competing life needs. Massachusetts has a 64% rate of viral suppression overall, and between 84% and 87% of PLWH who are engaged and retained in care are virally suppressed respectively, yet approximately 10% of PLWH experience persistent challenges to accomplish viral suppression.²

In 2011, the Massachusetts Department of Public Health (MDPH), Office of HIV/AIDS utilized funding from the Health Resources and Services Administration, Special Projects of National Significance (HRSA/SPNS) to design and implement the “Systems Linkages and Access to Care for Populations at High Risk of HIV Infection” project, referred to in this manual as the “Strategic Peer-Enhanced Care, Treatment and Retention Model” (SPECTRuM) project. The goal of SPECTRuM was to expand access to, and improve retention in, HIV care and treatment for out-of-care PLWH using a two-pronged approach:

- **Strategy 1:** Employ peer-nurse teams to provide intensive services as an enhancement to routine HIV/AIDS medical case management (MCM) interdisciplinary care teams operating within the existing HIV health care service delivery system.
- **Strategy 2:** Implement a mechanism for MDPH HIV/STD Surveillance to communicate with health care providers regarding clients who may be out-of-care or who have not reached viral suppression.

This manual describes the processes and lessons learned from the SPECTRuM project. It provides information and resources for organizations to enhance current service delivery models intended to engage and retain PLWH in care and treatment. The manual presents examples that can be used in a variety of settings, from large, urban-based hospital centers to small, community-based facilities. It is suitable for organizations, both within and outside of Massachusetts, that work with diverse populations including newly diagnosed individuals, hard-to-reach clients with multiple comorbidities, persons from immigrant communities, individuals recently released from correctional facilities, persons with lower health literacy, and those with limited experience navigating the health care system.

¹Massachusetts Department of Public Health (MDPH) HIV/STD Surveillance (2015). <http://www.mass.gov/eohhs/docs/dph/aids/2015-profiles/epidemic-glance.pdf>

²Massachusetts Department of Public Health (MDPH) HIV/STD Surveillance (2015). “Stages of Care Among People Living with HIV/AIDS in Massachusetts,” (2014).

Intended audience

The intended audience for this manual is medical and social service providers serving PLWH. This includes staff who work in AIDS service organizations and other community-based organizations, community health centers, and hospitals who aim to improve the quality and delivery of care and treatment for their patients and clients. Specifically, the manual is intended to assist the following types of staff:

- Program supervisors or practice managers who want to enhance systems for timely linkage and ongoing retention in HIV care;
- Case managers, peers, and other non-clinical support staff who work directly with PLWH and who want to provide intensive services to clients who struggle with retention in care and treatment;
- Physicians, nurse practitioners and other clinical staff who want to be able to identify and retain those clients who may be at high risk for falling out of care or struggling with treatment; and
- Program leaders and directors who want to improve health outcomes and quality-of-life indicators for PLWH.

Background

The SPECTRuM project tested, implemented, and evaluated a set of system- and service-level interventions aimed at 1) maximizing timely linkage to care and treatment for individuals newly diagnosed with HIV, and 2) re-engaging and supporting retention in care for HIV+ individuals who had fallen out of care, who were at risk of dropping out of care, and/or did not accomplish sustained viral suppression.

Objectives were aligned with the goals of the National HIV/AIDS Strategy³ and the Massachusetts State HIV/AIDS Plan⁴ and included the following:

- Increase the proportion of newly diagnosed individuals linked into HIV care and treatment within 30 days of diagnosis;
- Improve retention in HIV primary care, defined as having at least two HIV medical-care visits (or labs) in 12 months at least 3 months apart;
- Increase the rate of viral suppression;
- Increase the rate of referral and receipt of substance use treatment services within 60 days;
- Increase the rate of referral and receipt of mental health services within 60 days;
- Increase the rate of referral for housing services and receipt of those services within 60 days.

During the first phase of the project, three pilot sites implemented both Strategy 1 and Strategy 2: Boston Medical Center (BMC); UMass Memorial Medical Center, HIV Clinic (UMMC); and Holyoke Health Center (HHC). During the first expansion phase, three additional agencies were invited to participate. One of these sites, Greater New Bedford Community Health Center (GNBCHC), implemented both Strategy 1 and Strategy 2. Two sites, Brockton Neighborhood Health Center (BNHC) and Morton Hospital (MH), implemented only Strategy 2.

Sites participating in the SPECTRuM project

- **Boston Medical Center (BMC)**
- **Brockton Neighborhood Health Center (BNHC)**
- **Greater New Bedford Community Health Center (GNBCHC)**
- **Holyoke Health Center (HHC)**
- **Morton Hospital**
- **UMass Memorial Medical Center (UMMC)**

³The National AIDS Strategy 2020. Available at: <http://aids.gov/federal-resources/national-hiv-aids-strategy/overview/>

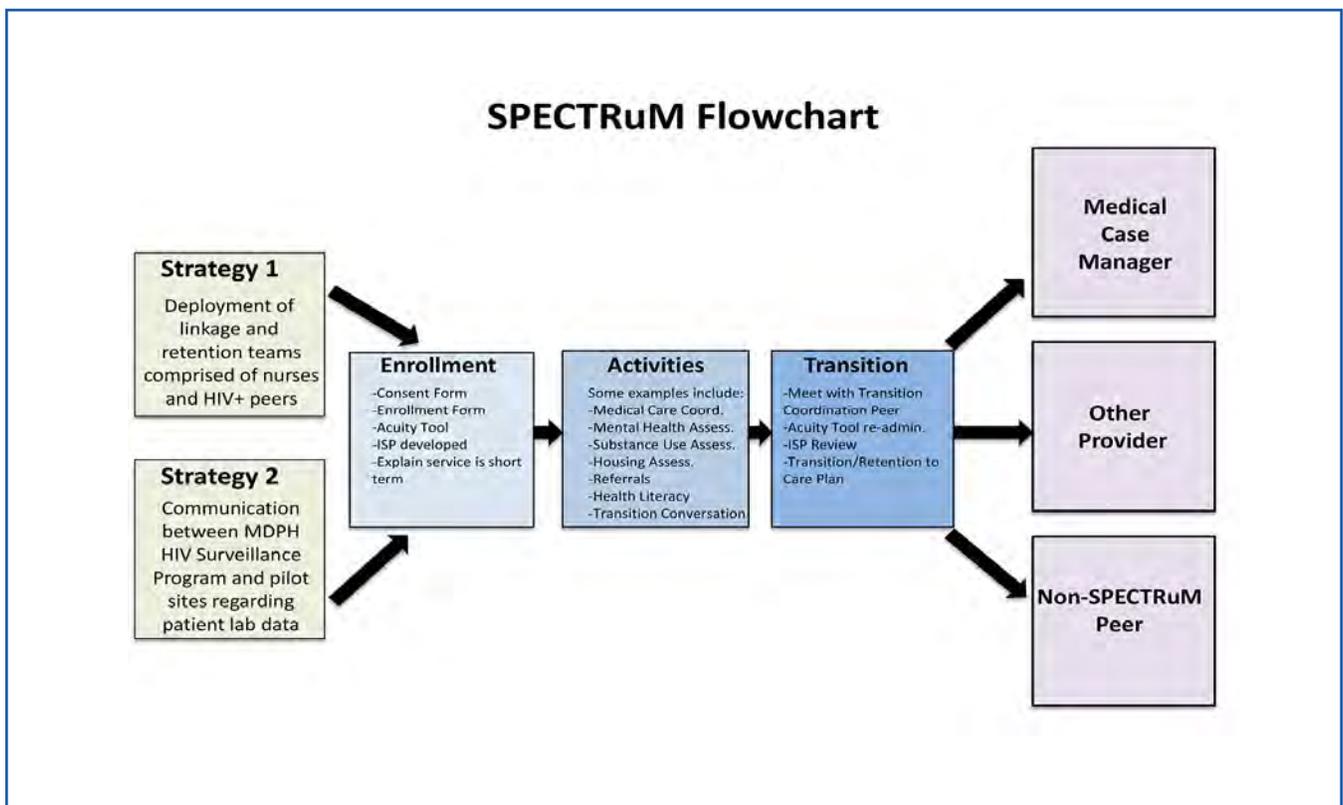
⁴Massachusetts State HIV/AIDS Plan, 2013. <http://www.mass.gov/eohhs/docs/dph/aids/mass-hiv-aids-plan.pdf>

INTRODUCTION

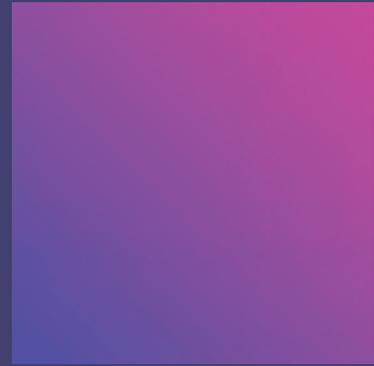
During a second expansion phase, MDPH worked with two community health centers to initiate a modified Strategy 1 intervention (a team consisting of a peer and licensed social worker, rather than a nurse) and an identical Strategy 2 surveillance data communication intervention to identify clients either lost to care or experiencing challenges with retention in care and treatment. These health centers, Boston Healthcare for the Homeless Program and East Boston Neighborhood Health Center, were not designated as official SPECTRuM sites but were added in an effort to promote wider-scale implementation outside of the SPECTRuM project. MDPH leveraged existing CDC-funded HIV prevention and screening contracts to integrate the new HRSA-funded specialized linkage and retention program, which complemented Ryan White Part A-funded Medical Case Management services. The expansion project was notable for using three intersecting funding mechanisms as a foundation for activities emphasizing the integration of HIV prevention and care.

MDPH selected all six SPECTRuM sites based on diverse client population demographics, regional HIV prevalence, and the suitability of agency's HIV service delivery systems to integrate project components. MDPH ensured the inclusion of large hospital settings and community health centers, and aimed to site demonstration sites in all regions of the Commonwealth.

The flow chart below demonstrates how the SPECTRuM strategies intersected to work toward accomplishing project objectives:



Flow chart provided by Greater New Bedford Community Health Center.



EXPANDING ACCESS, IMPROVING RETENTION IN HIV CARE: THE SPECTRuM PROJECT IMPLEMENTATION MANUAL

Strategy 1: The Peer-Nurse Enhancement to Medical Case Management

Overview

SPECTRuM Strategy 1 sites hired peer-nurse teams to provide short-term services to caseloads of approximately 20 clients with acute service needs. MDPH allowed each site some flexibility in how it integrated the peer-nurse team into its existing HIV service system in order to meet the needs of that site's client population and service delivery models.

MDPH worked with sites to refine proposed eligibility criteria, with a goal of focusing service provision on clients with the highest levels of need who were most likely to benefit from the intervention. The final criteria included the following:

- Newly diagnosed (within one year of diagnosis);
- New to HIV care at the facility who meet one of the following criteria:
 - Have been released from jail/prison within the past 12 months;
 - Have immigrated to U.S. within the past 5 years;
 - Scored moderate-to-high level of need on the SPECTRuM Acuity Tool (see Resources, pp. 92-98) in HIV care, housing, mental health, or substance use; and/or
 - Missed intake appointment or first HIV medical visit after intake.

- Out-of-Care:
 - Missed two or more consecutive appointments;
 - No CD4 or viral load laboratory results reported in 6 months or more; and/or
 - Has not achieved viral suppression.

Sites had the flexibility to identify additional characteristics to assess suitability for the intervention. This helped sites determine which clients to prioritize based on those most likely to benefit from the services.

Sites enrolled clients for a minimum of six months and a maximum of twelve months. The peer-nurse teams worked with clients to develop service plans that outlined goals, action steps, and timelines with a focus on linkage to and/or retention in care and a goal of helping clients achieve a level of stability that would enable them to transition to routine HIV medical case management (MCM) or self-management.

The teams provided intensive services in person—in health care settings, client homes, and/or other venues—and by communicating via telephone calls, texts, and/or e-mail. During the first few months of service provision, the peer and/or nurse were expected to meet with, or otherwise contact clients at least every other week; however some staff saw clients more

STRATEGY 1: The Peer-Nurse Enhancement to Medical Case Management: Overview

frequently, including daily. In general, meetings with clients occurred based on client need and site-specific implementation practices.

The SPECTRuM service delivery on the next page illustrates the flow of SPECTRuM service provision.

SPECTRuM peer-nurse sites

Boston Medical Center (BMC), Department of Infectious Disease: BMC is New England's largest safety net hospital, located in the heart of Boston. BMC's Center for Infectious Disease serves approximately 1,500 HIV+ individuals annually. The clinic provides HIV/AIDS medical case management; peer support; integrated HIV/HCV/STI prevention, screening, and treatment; and linkage to care for individuals diagnosed with HIV in other hospital departments. Staff provide mental health and substance use treatment and also coordinate outside referrals for these services.

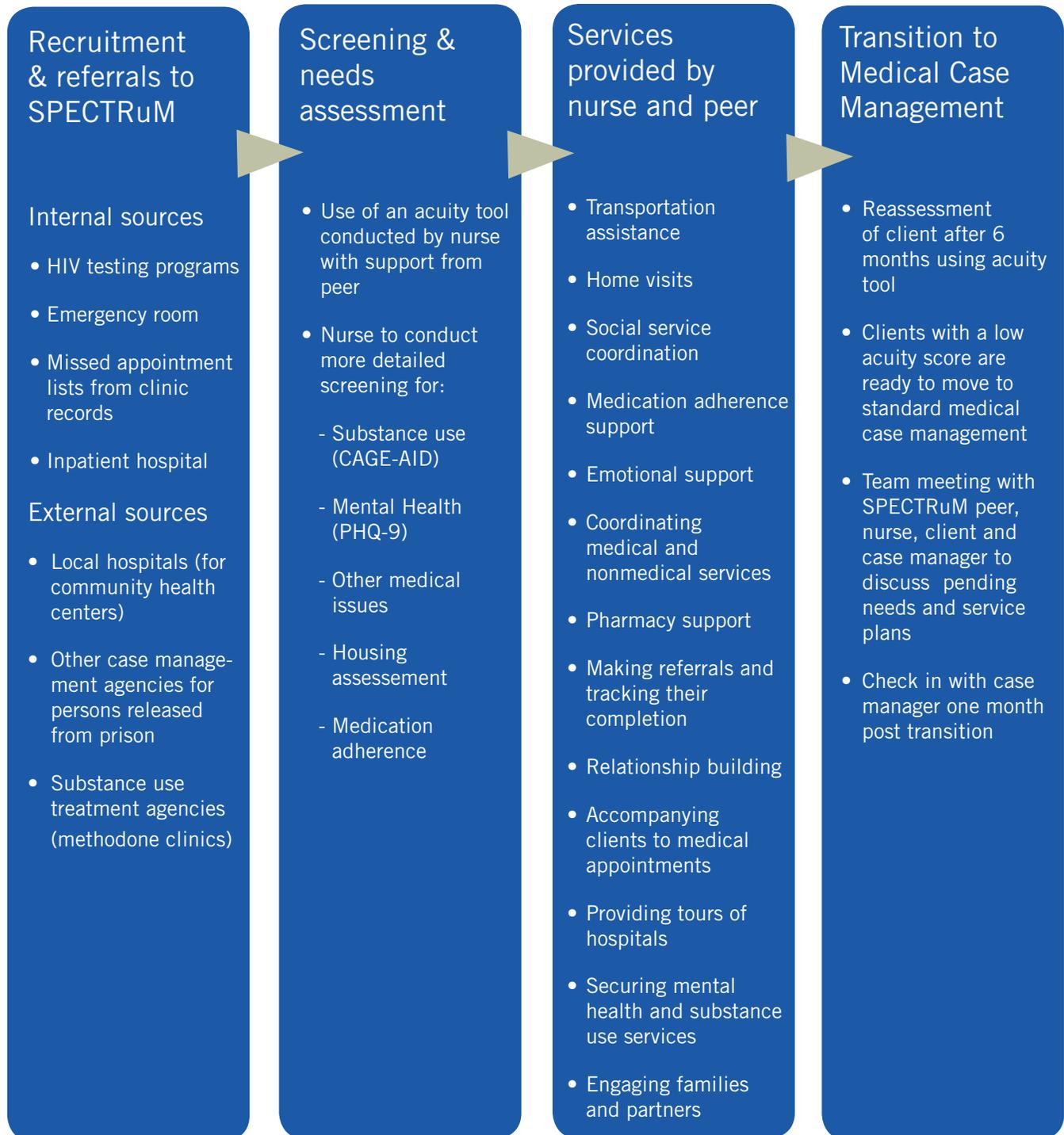
Greater New Bedford Community Health Center (GNBCHC): GNBCHC is a community health center that provides comprehensive HIV care and social services to more than 350 clients annually in New Bedford and surrounding communities in southeastern Massachusetts. The health center provides HIV/AIDS medical case management; peer support; integrated HIV/HCV/STI prevention, screening, and treatment; and referrals for substance use treatment, mental health support, and other services as needed.

Holyoke Health Center (HHC): HHC is a federally qualified health center in western Massachusetts that provides comprehensive HIV services including primary care and medical case management to over 200 individuals annually. The health center provides integrated HIV/HCV/STI prevention, screening and treatment; mental health; and substance use treatment services.

UMass Memorial Medical Center, HIV Clinic (UMMC): A large hospital in central Massachusetts, UMMC serves mainly individuals who live in the city of Worcester and in surrounding communities. The HIV clinic serves approximately 800 clients annually and offers HIV/AIDS medical case management, mental health, and substance use treatment and also coordinates referrals to agencies throughout Worcester.

STRATEGY 1: The Peer-Nurse Enhancement to Medical Case Management: Service Delivery Model

SPECTRuM service delivery model





STRATEGY 1: The Peer-Nurse Enhancement to Medical Case Management

Working with the HIV care team and community to create buy-in

Developing buy-in from the existing HIV care team, infectious disease clinic staff, and senior staff is essential to establishing a foundation for effectively integrating and implementing peer-nurse services. Articulating intervention goals, clarifying staff roles and responsibilities, and explaining how the services will support other HIV team staff in their work with high-need clients promotes acceptance of the new model. In Massachusetts, sites emphasized the ability of the peer and nurse to provide services outside of the clinic, an activity that typically was not feasible for members of the HIV teams. Sites described how peers would be able to provide clients with “real world” examples of how to successfully manage living with HIV and could spend significant periods of time educating clients about issues such as HIV treatment.

System-wide buy-in to the need and purpose of the SPECTRuM program by the entire Center for Infectious Diseases team, including the medical director, physicians, clinic program director, data manager, nurses, case managers, peers, and other hospital staff was key to the success of the program.

- BMC program staff

It is essential to have a strong champion among the medical provider staff.

- UMMC program staff

Medical providers who acted as “champions” of the SPECTRuM model enhanced its credibility and helped facilitate referrals into services. As an example, at GNBCHC, two infectious disease physicians educated other clinic staff about the purpose and importance of SPECTRuM, and when the services became operational, they referred clients for potential enrollment and consulted with the SPECTRuM team on client cases.

Some SPECTRuM sites organized stakeholder focus groups with other agencies and consumers as a method to gain buy-in to the new service model. By discussing barriers and challenges faced by clients in accessing care, these organizations were able to help clarify key roles of peer and nurse relative to local population needs. These groups also helped define the profile of clients who might receive the most benefit from SPECTRuM services. Sites also used their Consumer Advisory Boards as a forum for informing HIV+ individuals about the program and discussing complex and common barriers to care. For additional resources related to integrating the peer-nurse team, see Resources, pp. 34 - 45, including sample assessment forms to help guide the team integration process.



STRATEGY 1: The Peer-Nurse Enhancement to Medical Case Management

Developing, preparing, and integrating the peer-nurse team

Introducing a new program can be challenging but presents opportunities to improve the quality of service response. Steps recommended by the SPECTRuM sites to develop and integrate a peer-nurse team model and to promote effective communication within a new interdisciplinary team include the following:

1. Develop job descriptions with clearly defined roles and responsibilities.
2. Provide a comprehensive orientation about SPECTRuM for all employees who interface with the peer and nurse; include case examples or other scenarios to illustrate how the peer and/or nurse work independently and as part of a team.
3. Maintain weekly supervision of the SPECTRuM team; include linkages and other collaborations as a standing agenda item.
4. Hold regular meetings inclusive of SPECTRuM and other clinic staff to discuss client cases, share concerns, and coordinate planning. Create mechanisms for staff to communicate systemic and individual issues related to staff roles and responsibilities, and consider including a standing agenda item to maintain communication regarding 1) what is working well relative to the collaboration with the peer-nurse team, and 2) areas in need of improvement.
5. Find opportunities to highlight examples when the SPECTRuM team supported the mission of the clinic, while regularly acknowledging successes of the entire staff.

The sections below describe several of these recommendations in more detail and address additional strategies and tools used by SPECTRuM sites in incorporating the peer-nurse service model into their interdisciplinary HIV care teams. For specifics regarding caseloads, frequency of contact, key service elements, and steps to identify readiness for transition, see the SPECTRuM Initiative Intervention Protocol available at <http://www.mass.gov/dph/aids> ⁵

Defining the roles and responsibilities of the peer and nurse

Clearly identifying the roles of the peer and nurse help define how the peer and nurse will work together and how the team will interact and collaborate with the rest of the HIV care team. In Massachusetts, managers included other staff in this process to ensure that the job descriptions would articulate roles without duplicating staff responsibilities and accurately describe how team members would work together. Sites that offered HIV peer support services prior to SPECTRuM had to determine how the SPECTRuM peer services would complement these services without duplication. The

⁵MDPH Bureau of Infectious Disease HIV/STD Surveillance and Office of HIV/AIDS. Strategic Peer Enhanced Care and Treatment Retention Model (SPECTRuM) Initiative, Intervention Protocol #1. September 2014.

STRATEGY 1: The Peer-Nurse Enhancement to Medical Case Management: Developing, Preparing and Integrating the Peer-Nurse Team

It was important to review the role of the SPECTRuM peer and nurse model and how they would interact with the rest of the [HIV care] team.

- BMC program staff

sites providing HIV peer services for the first time had to engage in a comprehensive orientation to goals and functions of peer services in general, while clarifying the responsibilities of the SPECTRuM peer as a member of the larger HIV care team. The Resource Section, pp. 46-54, contains sample peer and nurse job descriptions.

The core responsibilities for the SPECTRuM peer and nurse are listed below. Although the peer and nurse

shared many responsibilities, their unique perspectives and complementary skill sets contributed to the provision of an integrated set of services for clients.

Recruiting and hiring the peer-nurse team

Human resources (HR) departments need to conduct hiring processes in accordance with their HR rules, while allowing the job descriptions for the peer and nurse to incorporate enough flexibility to accommodate unique duties and responsibilities. At BMC, program management found that meeting with HR to discuss the qualities they were seeking in applicants, and later carefully reviewing respondents' resumes for those qualities, helped them identify strong candidates.

Suggestions for questions to discuss with Human Resources as job descriptions are being developed include the following:

Nurse responsibilities

- Clinical assessments
- Psychosocial assessments
- Sexual risk assessment and risk reduction planning
- Side effects management
- Medical advocacy on behalf of clients
- Education of clients about:
 - Opportunistic infections/comorbidities
 - Medication adherence, resistance, and resistance testing
 - Treatment issues/side effects management
 - Drug and food interactions
 - Interpretation of lab values
- Outreach
- Medical service navigation

In working with clients, the nurse draws on **clinical knowledge and experience**.

Peer responsibilities

- Emotional support
- Mentoring
- Basic needs assessment
- Check-in phone calls or texts
- Appointment reminders
- Attend appointments with clients
- Advocacy on behalf of clients
- Education of clients about:
 - Overcoming fear/acceptance of HIV status
 - Disclosure
 - Sexual health
 - Preparing for medical appointments
 - Side effects management
 - Community resources
 - Medication adherence support
- Outreach
- Social service navigation

In working with clients, the peer draws on **personal or community knowledge and experience**.

STRATEGY 1: The Peer-Nurse Enhancement to Medical Case Management: Developing, Preparing and Integrating the Peer-Nurse Team

- How well do the proposed peer and nurse job descriptions align with current hiring practices?
- Will the peer and nurse positions be considered union positions? If yes, what is the impact of the union designation on roles and responsibilities?
- What will the screening process for candidates involve?
- How will supervision be structured for each position?
- What are considerations for peers who may be receiving Social Security or other public or private disability benefits?

To develop job descriptions, agency staff identified key qualifications and skills important to address client needs and work successfully with their HIV care teams. Qualifications recommended by sites include the following:

“Adaptability was a very important qualification at HHC. We had never worked with peers before the SPECTRuM program and neither had our clients. The clients are not used to new people on the team, and it took a while for clients to adapt to new people and the new program. We needed someone who could go with the flow as we all tried new things and made changes as we went along.

– HCC program staff

“The SPECTRuM peer or nurse should be, if at all possible, an actual case manager, as case management services are required to service the client. In addition, many of the documents are required forms and applications that must be submitted to external agencies by a case manager, so a hybrid role is beneficial.

- BMC program staff

- **Case Management Experience**—Agencies incorporating case management activities (insurance/medication access, housing, etc.) into an intensive team model will want to recruit individuals with experience providing these services.
- **Adaptability**—For high-need clients that have not found standard/routine service provision effective in the past, staff will need to develop creative, new client-centered approaches, such as home/community-based visits, accompanied medical appointments, and meetings that take place outside of typical office hours.
- **Cultural competence**—To build effective and trusting relationships, staff must engage with clients in a responsive manner that acknowledges personal backgrounds and contexts including, but not limited to, age, gender, race/ethnicity, sexual orientation, religion, history of incarceration, and immigration and socioeconomic status.
- **Substance use background**—The capacity to identify client needs, make appropriate referrals, operate within a harm reduction framework, and understand the connections between substance use and care engagement is essential. Agencies may also

STRATEGY 1: The Peer-Nurse Enhancement to Medical Case Management: Developing, Preparing and Integrating the Peer-Nurse Team

benefit from hiring staff that can assess for medical complications related to substance use (e.g., seizures, abscesses, sepsis, etc.).

- **Language capacity**—A bilingual peer and/or nurse can be helpful for agencies serving clients for whom language barriers exacerbate obstacles to health care. If bilingual staff are not available, ensure access to interpreters or an interpretation call line.
- **Personal readiness** (peer)—It is important for the peer to be comfortable with his or her own HIV status. He or she must be able to share personal experiences in living with HIV in a professional manner. One of the critical tasks of the peer is to provide strategies for navigating the service system based on his or her own experience. Sharing tips about how to understand laboratory values, and how to find resources in the community are important peer functions.

A common concern for applicants interested in the peer positions involved the potential impact of employment on their Social Security benefits, and sites recognized the importance of addressing this concern prior to hiring individuals. Information regarding issues of disability benefits when hiring peers can be accessed on pp. 51-55 of the *Building Blocks to Peer Program Success* toolkit at <http://cahpp.org/resources/HIV-peer-program-dev>

“The SPECTRuM nurse, accompanied by the peer (or other staff person) should be able to perform home visits in the community and obtain labs for clients who require additional monitoring.

- BMC program staff

“At UMass, prior to the SPECTRuM project, nurses didn’t really go out into the field. Because of this, there were challenges and issues to be worked through, including what resources from the hospital, such as charts or vaccines, could be brought to a patient’s home. If there had been an agency orientation about how to do that, including working with information and technology personnel and addressing issues of confidentiality, this would have been helpful.

- UMMC program staff

STRATEGY 1: The Peer-Nurse Enhancement to Medical Case Management: Developing, Preparing and Integrating the Peer-Nurse Team

The group hiring process at BMC

At Boston Medical Center, the peer was involved in the nurse's hiring process and participated on the interview team which also included the data manager, medical director, SPECTRuM program manager, case manager, and program manager. This allowed the peer to have a voice in hiring their team partner. Similarly, when the peer position became vacant, the SPECTRuM nurse participated in the hiring process. Because the SPECTRuM model is inherently team-based, it is important to assess the compatibility of team members, in addition to considering skills and experience.

Establishing a hiring team and developing interview questions

Including current HIV team members as part of the hiring process helps ensure that agency staff most likely to interact with the peer and nurse have some input into assessing the qualifications of applicants. SPECTRuM sites invited program supervisors, medical case managers, physicians, nurses (for peer interviews), peers (for nurse interviews), and others to participate on their interview teams. Although including team members in this process involved an up-front investment of time, it helped sites find the most qualified individuals for the positions.

SPECTRuM sites added to their agencies' standard list of interview questions to incorporate content addressing the unique role of the peer-nurse team. To develop relevant interview questions, site staff utilized resources from other peer programs, such as those found at <http://cahpp.org/wp-content/uploads/2016/04/5Resources-Recruitment-and-hiring.pdf> (part of a toolkit for developing HIV peer programs at <http://cahpp.org/resources/HIV-peer-program-dev>).

The questions below are recommended by the sites as options for agencies considering similar service models.

- Provide a scenario and ask how the candidate would address a specific need with a client or work with another team member to address a service need.
- *Nurse-specific:* Ask about experience in managing HIV and other comorbidities such as substance use, mental health issues, and hepatitis C.
- *Peer-specific:* Ask about readiness to talk about HIV: "Part of the role of being a peer is to assist others living with HIV to manage the illness. How comfortable are you discussing your experience living with HIV with other clients? Can you give an example of how you have shared information about HIV with others?"

Securing appropriate space and resources

It is important to ensure that the nurse and peer have adequate office and service provision space and access to office equipment that will enable them to fulfill their responsibilities. SPECTRuM sites carefully considered the space and equipment requirements of their peer-nurse teams. Finding appropriate space for the team prior to implementing the program prevented potential confusion and conflict among staff members with competing needs. In ideal situations, the peer and nurse were colocated near the HIV medical care team to promote optimal communication. Access to private space to meet with clients was essential.

Providing the peers and nurses with their own computers enabled them to document services and client communications. This helped them track their own service provision while enhancing service coordination with other HIV staff. Having access to the Electronic Medical Record (EMR) was essential so they could monitor their clients' care engagement, assist with service referrals, and monitor laboratory values and prescription refills.

STRATEGY 1: The Peer-Nurse Enhancement to Medical Case Management: Developing, Preparing and Integrating the Peer-Nurse Team

We found it helpful to have the SPECTRuM team operate in an office separate from the general case management and peer services staff but near the HIV team. Having a separate office allows us to see patients and create a space that is specifically designed for patient comfort (including a coffee machine) and education (filled with educational material and posters). It also allows us to maintain a tracking system using a wall chart and de-identified information indicating when patients were last contacted, their acuity, the external services they need, their upcoming appointments, their upcoming appointments in other clinics, whether they have an Individual Service Plan, and their last viral load and date.

- UMMC program staff

The peer-nurse teams required a dedicated telephone number so clients could reach them directly. SPECTRuM staff found that mobile, internet-enabled phones helped them connect and engage with clients. Many clients preferred contacting the team by means of texting, and staff found it useful to have the ability to show clients educational information available on the internet.



STRATEGY 1: The Peer-Nurse Enhancement to Medical Case Management

Training the peer-nurse team

Intensive training and technical assistance must be provided to the peer and nurse prior to, and throughout, service provision. In Massachusetts, training and technical assistance providers developed and implemented capacity-building activities that were specifically designed for the peer and nurse roles. These activities included a range of group-level and agency-level initiatives, some of which were offered to the peers and nurses together and some of which were offered to each group separately. See Resources, pp. 55-90 for additional training information.

Nurse training

SPECTRuM nurses participated in an eight-session curriculum which generally took place monthly for three to four hours per session. A minimum of 24 hours, and maximum of 40 hours, of training is recommended. Training topics included the following:

- Medical training: conducting screening and assessments
- HIV-specific topics
 - o HIV infection and disease progression/HIV viral life cycle
 - o Opportunistic infections
 - o HIV medications, including adverse reactions, side effects, and drug interactions
 - o HIV medication adherence and strategies to address adherence challenges (including side effect management)

- o Understanding HIV viral load and CD4 labs (including goals of HIV treatment)
- o Health literacy

- Recommended certifications/trainings
- Recommended reference/resource materials
- Recommended membership

See Resources p. 59 for details on recommended trainings, resource materials and membership.

STRATEGY 1: The Peer-Nurse Enhancement to Medical Case Management: Training the Peer-Nurse Team

Peer training

A minimum 40 hours of initial training is recommended for peers. Initial capacity-building activities for the SPECTRuM peers involved one-on-one technical assistance activities. After peers provided feedback highlighting the value of group training, the training and technical assistance providers implemented group-level activities for the peers.

Core components of the peer training included the following topics:

- HIV knowledge
 - HIV 101, including transmission and the HIV viral life cycle
 - HIV treatment overview
 - Managing side effects and understanding resistance
 - Understanding lab values
- Communication skills
 - Motivational interviewing skills, including the stages of change
 - Strategies for supporting client's interaction and communication with providers
- “How to tell your story:” How to share personal experiences with clients in appropriate and helpful ways
- Addressing stigma and managing disclosure
- Navigating the service system
- Harm reduction
- Supporting a client with service referrals
- Sexual health
- Case management 101 (e.g., how to complete a client service plan, how to complete an application for the HIV Drug Assistance Program, etc.)

Training for the peer-nurse teams

Trainings that were offered to the peers and nurses together addressed the following topics::

- Acuity tool: Training on how to administer the tool and how to track client progress using the tool
- Documentation: Writing progress notes, administering Individual Service Plans (ISPs), and completing client assessments
- Motivational interviewing techniques
- Strategies on how to work as a team
 - Methods for sharing information in team meetings, in group supervision, and through the EMR (e.g., flagging doctors regarding a client's care status)
 - Strategies for providing support to the client as a team while differentiating roles, e.g., nurse to discuss medication management, and peer to discuss disclosure
- Working with HIV medical case managers and other clinic staff
 - Case review: Strategizing to support clients
 - Role clarification
 - Getting to know others in the agency and their roles/responsibilities
- HIPAA training (basics of how to be HIPAA compliant)
- Trauma informed care (basic overview of what it means to work with clients who may have a history of trauma)
- Mental health and substance use assessment
 - Strategies and tools to assess clients and provide referrals to appropriate services

See Resources, pp. 59-84 for joint training materials, including a presentation on client self-advocacy.

STRATEGY 1: The Peer-Nurse Enhancement to Medical Case Management: Training the Peer-Nurse Team

Training for agency staff members

As referenced above, involving key agency direct care staff and administrators in planning related to the peer-nurse service model helps establish clarity of roles and responsibilities and lays a foundation for effective care and service coordination. SPECTRuM sites that solicited input from staff of other departments (e.g., mental health, women's health, nutrition, primary care) about how the peer-nurse team could support their work and potentially improve the quality of their care also helped orient these departments to the functions of the team.

Sites found that it was important to provide detailed information about the team and to offer mechanisms for communicating with the peer and nurse. Methods included introducing and describing the team at agency-wide meetings, and distributing information about the team in agency newsletters. See Resources pp. 34 - 39 for a presentation used to introduce the peer-nurse team to agency staff.

Developing systems for continuing education, training, and technical assistance

In addition to addressing the initial training needs of the peer and nurse, SPECTRuM sites offered continuing education provided by medical staff, harm-reduction specialists, other internal and external staff, and the regional AETC, the New England AIDS Education and Training Center (<http://www.neaetc.org>). The sites prioritized topics related to the needs of populations they served, including individuals who are out-of-care, newly diagnosed, on the younger or older ends of the age spectrum, managing substance use disorders and/or mental health issues, and others. These activities helped build the capacity of the peer-nurse team while strengthening relationships between the sites and partners within a broader network providing care to clients.

Ongoing technical assistance included monthly calls for sites to share client updates and discuss issues related to the service system. A facilitator encouraged the sites to provide guidance and support to each another by sharing successful methods and brainstorming new ideas. This practice method of sharing information and best practices created a *learning community* that was a core tenet of this SPNS project. When specific topic areas became a common theme, the facilitator would provide a didactic workshop, a learning

“It is important to have staff who are familiar with mental health and/or substance use issues. If they do not have that expertise personally, a strong clinical supervisor is essential. SPECTRuM staff needs to understand that it is impossible to ‘undo’ or ‘fix’ decades’ worth of dysfunction in the short timeframe of this particular intervention. Although they can help a client accomplish particular improvements in his or her health promotion goals, specialists in mental health or substance use will likely be the only people that can address some of these long-standing challenges.

-UMMC program staff

STRATEGY 1: The Peer-Nurse Enhancement to Medical Case Management: Training the Peer-Nurse Team

opportunity that was woven into the existing calls. This workshop model, together with the monthly technical assistance calls, provided opportunities for the peer-nurse team to continue to develop skills and improve their capacity in treating clients with complex medical and psychosocial issues.

Supervision

Both administrative and clinical supervision must be available to the peer and nurse on a regular basis.⁶ Ideally, the nurse and peer report to the same administrative supervisor. SPECTRuM sites learned that it was important for clinic staff to view the peer and the nurse as equal partners, and having a third party supervise both provided a mechanism to support this goal. Peers and nurses participated in administrative supervision on a weekly basis and accessed additional support by telephone as necessary when working in the field. Licensed clinical social workers and psychologists provided clinical supervision on a monthly basis. Routine supervision was provided at an individual staff level. Periodically, joint supervision took place to help support the development and ongoing maintenance of a healthy working relationship. See pp. 85 -90 for additional supervision resources.

Training and technical assistance providers trained supervisors in motivational interviewing techniques in order to support team members in working collaboratively and performing at optimal levels. See Resources, pp. 76 - 84 for a presentation outlining motivational interviewing principles and suggestions for implementation.

Supervision at BMC

At Boston Medical Center (BMC), ongoing supervision of the peer and nurse took place after the weekly SPECTRuM meeting with the principal investigator as well as individually as needed. Initially, the peer reported to the peer program manager, and the research nurse reported to the principal investigator. The principal investigator identified early in the process that the peer and nurse who would be working as a team should both report directly to him. Having both report to one supervisor helped manage the flow of the operations while helping all to remain on the same page from the supervisory perspective. During these supervision meetings, topics included the SPECTRuM process from recruitment, enrollment, and ongoing management of clients to the transition of clients out of SPECTRuM. In addition, programmatic issues such as completion of IRB requirements, revisions, and updates as well as client progress and/or problems were discussed.

The BMC SPECTRuM team met together monthly for clinical supervision with a counselor from Behavioral Health. This proved to be effective in some cases, but it was determined that the team also needed to meet individually with the counselor as individual issues came up that were better addressed one-on-one with the counselor.

⁶Administrative supervision focuses on accomplishing the goals of an organization and includes activities such as clarifying roles and responsibilities and promoting effective communication among staff. Clinical supervision functions as a psychological support mechanism for individuals to have an opportunity to discuss how their work with clients affects them.



STRATEGY 1: The Peer-Nurse Enhancement to Medical Case Management

Peer-nurse team services

SPECTRuM peers and nurses worked intensively with small caseloads of clients. They devoted significant time to helping clients build self-efficacy, had the freedom to do more field work than other HIV team members, and were able to perform home visits, which enabled them to identify medical and psychosocial issues that needed follow-up. This section describes lessons learned by SPECTRuM teams while delivering the peer-nurse service model. The purpose is to provide organizations with strategies on how to deliver the intervention. For additional detail, see the “SPECTRuM Initiative Intervention Protocol #1” in Resources, p. 33.

Leveraging partnerships to facilitate recruitment

Agencies can recruit clients from within their organizations and from other agencies in the community. Internal referral sources may include HIV testing programs, emergency department staff, physicians, case managers, nurses, mental health providers, data managers, program managers, and outreach teams. SPECTRuM sites reviewed missed appointment lists and medical records to find names of clients who had not been seen in the clinic or who did not have viral load laboratory results documented during the previous six months.

SPECTRuM sites also reached out to community partners to identify and recruit eligible clients. These partnerships not only yielded referrals, particularly of newly diagnosed individuals, but also strengthened connections with local resources available to meet client needs. (See sidebars this page and next for more information about these partnerships.)

BMC: Using internal records to identify clients

When conducting outreach to potential SPECTRuM clients, BMC reviewed lists of clients who have been persistently out of care and conducted chart reviews to assess for eligibility. If a chart indicated that BMC staff had previously communicated with a client who did not appear to be engaged in care, the peer-nurse team attempted to contact the client again. If contact was made, the peer and nurse assessed the challenges to care retention and discussed how peer-nurse services could be helpful. The peer and nurse then requested a meeting to discuss services in detail and, ideally, to offer enrollment into services.

UMMC and HHC: External partnerships improve coordination of client care

In addition to strengthening internal hospital connections to solicit referrals, UMass Memorial Medical Center worked with a local AIDS service organization which agreed to refer newly diagnosed clients to SPECTRuM. At Holyoke Health Center, the SPECTRuM team established new mechanisms to communicate with external mental health and substance use providers. Due to these partnerships, the peer-nurse team was able to share information, such as upcoming appointments, with these providers, when permitted by clients.

STRATEGY 1: The Peer-Nurse Enhancement to Medical Case Management: Peer-Nurse Team Services

BMC: Leveraging partnerships to recruit clients

As a large hospital with many existing internal partners, Boston Medical Center's HIV clinic had preexisting working relationships with medical case management, the emergency department, the HIV testing department, and physicians, nurses, and social workers within the Center for Infectious Diseases (CID), all of whom referred clients to SPECTRuM.

Doctors, nurses, and other staff flagged clients who were out of care or experiencing adherence problems via the Electronic Medical Record and in person. Face-to-face discussions between the SPECTRuM and Medical Case Management teams helped facilitate communication and awareness about SPECTRuM and helped facilitate the flow of referrals. SPECTRuM team members attended hospital staff meetings to talk about the program and its potential benefits to clients and to strengthen relationships across programs and departments.

Referral sites included programs serving ex-offenders, HIV counseling and testing providers, mental health clinicians, and local housing providers.

GNBCHC: Connecting with clients being discharged from hospital

At Greater New Bedford Community Health Center, the SPECTRuM team connected with hospitalized clients before they are discharged to ease the transition to SPECTRuM services. This helped staff create a foundation for building trust with new clients.

BMC: Partnership smooths the way to reintegration

Boston Medical Center strengthened its partnership with an organization that helps reintegrate recently incarcerated individuals into the community in order to facilitate linkage to care for these individuals. BMC established a method to accommodate timely scheduling of medical appointments for reintegrating clients.

Acuity screening and needs assessment

Using an acuity scale and needs assessment form can help agencies determine client eligibility, assess the suitability of eligible clients for services, collect information regarding client needs to inform an Individual Service Plan (ISP), and evaluate readiness for transition into other services. SPECTRuM sites piloted an acuity tool and needs assessment form that helped them identify needs and barriers related to medication adherence, housing, engagement and retention in health care services, health literacy, transportation, financial resources, and legal assistance. See Resources, pp. 92 - 100 for an example of the acuity assessment tools used by the peer-nurse teams.

UMMC: Using the acuity tool to share information with the care team

UMass Memorial Medical Center staff used the SPECTRuM acuity tool with a client who was recently diagnosed and new to the clinic. After the client was diagnosed, he missed four scheduled appointments within a five-month period.

The SPECTRuM nurse reached out to the client through home visits and used the acuity tool to help identify needs and barriers to care. Utilizing the CAGE-AID substance use screening tool (See Resources, p.99), the nurse identified substance use as a barrier. During the visit, the client voiced a desire to decrease his substance use. Together, the client and nurse called and set up an appointment with a local Suboxone clinic. The following week, the nurse made another home visit and scheduled an appointment with the HIV clinic with the client present. Together, the client and nurse set up transportation for the upcoming appointment.

The most helpful tool for the nurse in identifying needed services for this client was the mental health assessment. The client scored high on both

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STRATEGY 1: The Peer-Nurse Enhancement to Medical Case Management: Peer-Nurse Team Services

the GAD-7 and PHQ-9 mental health screening tools (See Resources, p. 100), demonstrated disorganized thinking, and struggled with remembering tasks. The assessment prompted the nurse to assist the client to access needed services and build his skills for self-advocacy. UMMC found that the acuity tool provided an organized, concise, and objective method for sharing information with other health care team members and enabled the full team to have a clearer understanding of the SPECTRuM intervention.

BMC: A single point of intake

Boston Medical Center found that assigning one person to complete intakes ensured consistency in assessing and triaging new clients, and that having a nurse in this role allowed for a more thorough assessment of clinical service needs. Clients who were determined to be eligible during intake were introduced to the peer-nurse team for additional screening. The team then conducted a detailed needs assessment which included the GAD-7 and PHQ-9 mental health screening tools and the CAGE-AID substance use screening tool. SPECTRuM clients who demonstrated a need for mental health services were “fast tracked” so they could be seen by a mental health provider

Building relationships with new clients

Whether a client is newly diagnosed, new to the clinic, or reengaging in care, relationship building is an essential component of service provision. SPECTRuM sites found that positive initial contacts helped the peer-nurse team build trust and orient clients to available services. For Resources related to reaching out to and communicating with clients, see Resources, pp. 101 - 109.

SPECTRuM staff indicated that frequent contacts early in the enrollment process improved client engagement in HIV care. Agencies utilized a variety of

successful engagement strategies. For example, BMC developed scripts for staff to use when reaching out to clients who were new to care or potentially out of care. (See Resources p. 104 for an example of these scripts.) UMMC’s team offered to meet new clients in the hospital lobby to introduce themselves and show clients how to find the clinic. This helped to build rapport from the beginning of the professional relationship and enabled clients to raise questions or concerns prior to his/her appointment. Additional strategies are identified in the sidebar below.

GNBCHC: Helping a client manage a new diagnosis

PJ was a 33-year-old, Spanish-speaking male who was hospitalized after reporting that he had a fever, was unable to tolerate food, and was experiencing abdominal discomfort, weakness, and a headache. He was diagnosed with viral meningitis, tested for HIV, and discharged with a follow-up appointment scheduled at Greater New Bedford Community Health Center.

When PJ presented at the health center, he was unaware of his HIV diagnosis. When the Infectious Disease physician explained to him in Spanish that he had HIV, he immediately expressed suicidal thoughts. A clinical social worker was brought into the room to conduct a mental health assessment, and the physician explained to PJ that he could live a healthy life with medication and medical care. PJ appeared to grow calmer and was introduced to the SPECTRuM peer who spent time with PJ, communicating with him in Spanish. The peer arranged for PJ to return home and contacted PJ the following morning to check in. Although PJ stated that he was feeling sad and depressed, he expressed no suicidal ideation.

PJ returned to the clinic the following day for an intake and met with the physician and the SPECTRuM team. At this visit, PJ appeared more comfortable expressing his thoughts and feelings. The SPECTRuM peer and nurse frequently called PJ after this visit to check in on his new

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STRATEGY 1: The Peer-Nurse Enhancement to Medical Case Management: Peer-Nurse Team Services

medication regimen, but he did not respond. Eventually the peer and nurse visited PJ at his home, engaged in a discussion about medication side effects, adherence, and disclosure, and provided emotional support. The SPECTRuM team worked with PJ on the process of engaging him in care, and PJ became more hopeful. PJ remains in care today and has an undetectable viral load.

UMMC: Building a relationship with a newly diagnosed client leads to return to care

At UMass Memorial Medical Center, the SPECTRuM nurse spent a great deal of time building a relationship with one 47-year-old client in order to support her reengagement in care. The client had a recent diagnosis with an extremely low CD4 count. Presenting barriers to care included disclosure issues, stigma, lack of trust of the medical system, mental health issues, and addiction. The team tried to engage with this client for over a year with some success, however, when the original program peer left, the client disengaged from the clinic.

The nurse developed a relationship with the client's daughter, who was the only other person who knew her status, and communicated with the client through her daughter on a weekly basis. The nurse met with the client's daughter to coordinate efforts to support the patient. Two weeks later, the nurse brought the client to see her primary care physician, where her CD4 and viral load were drawn. While the client experienced a range of health and psychosocial challenges over the subsequent months, the ability to deploy home-based, family-centered care coordination was critical to her sustained engagement and retention in care.

Managing missed appointments

Due to the complex lives and needs of clients, missed appointments are not uncommon. Having a deliberate and thoughtful approach to handle missed appointments in a nonpunitive manner, while improving clients capacity to adhere to care plans is key. SPECTRuM peer-nurse teams were proactive and thoughtful about following up on clients who did not attend their medical appointments. As described in the BMC case study below, contacting clients who miss appointments and spending time with them before and after their appointments can help clients feel empowered to take greater control of their care. As a result of this strategy, BMC experienced an increase in client-initiated contacts and rescheduled appointments.

BMC: Addressing missed appointments

At Boston Medical Center, when an appointment is missed, the client is called the same day to determine the reason for the missed appointment. If the client is running late, the peer or nurse will flag the medical doctor to see if they are able to wait for the client to arrive, even if the arrival time would fall outside of clinic hours.

The SPECTRuM nurse also offers to meet with the client before or after the medical appointment to prepare, create a list of questions or concerns, debrief, and/or explain labs, medications, or anything the client did not understand. Spending time to reinforce medical information helps clients feel in control of their health care and empowered in the decision-making surrounding their care. If the client is not able to be contacted the same day as the missed appointment, BMC calls the client the following day and on subsequent days until the client is reached and the appointment is rescheduled. It is helpful that at BMC, both the peer and the nurse have the capability to reschedule appointments for these clients.

STRATEGY 1: The Peer-Nurse Enhancement to Medical Case Management: Peer-Nurse Team Services

GNBCHC: Disclosure and engagement in care

At Greater New Bedford Community Health Center, the peer-nurse team worked with a male client who routinely cancelled or did not show up for medical appointments. The client had not disclosed his HIV status to his partner and avoided taking HIV medications for fear that his partner would discover his status. When the client attended an appointment with his primary care doctor for another condition, he was introduced to the SPECTRuM peer. The peer spoke candidly with the client and shared his own experience with HIV and disclosure. Over time, the client came to trust the peer and nurse and eventually brought his partner in for a session where he was able to disclose his status. At the peer-nurse team's suggestion the partner was tested for HIV (and tested negative). The client has since started HIV medications, has an undetectable viral load, and is actively engaged in his health care.

Providing services in the field

The ability of the peer and nurse to provide services outside of the clinic setting allows for flexibility and creativity in designing and implementing services that are tailored to individual client needs. The peer-nurse teams took frequent advantage of opportunities to engage with clients in other areas of their hospitals or health centers, in client homes, and in other locations in the community that they were likely to frequent.

Sites experienced many benefits to conducting home visits. Conducting brief environmental assessments of clients' living space allowed them to scan for potential health, safety, and quality-of-life concerns (e.g., mold, peeling paint, food quality/safety, temperature regulation, accessibility issues). In addition to having relevance for medical providers, these types of issues presented opportunities for client education and advocacy.

As an example, when the UMMC team visited a client receiving care at the medical center, the client described a rash potentially needing medical attention. The nurse took a picture of the rash and sent it to the client's HIV physician. The nurse and doctor discussed a treatment plan with the client by telephone, which helped him address a medical need without having to make a trip to the clinic.

At BMC, the peer and nurse jointly conducted home visits after a client missed scheduled medical and/or SPECTRuM team appointments and was unable to be contacted. The team followed a home visit policy and procedure to protect their safety. It is important for agencies to have a home visit and/or safety policy for staff who provide services outside of the clinic or agency. For examples of home visit policies used by the SPECTRuM sites, see Resources, pp. 114 - 118.

Communicating via team meetings and case conferences

Team meetings and case conferences help site staff work collaboratively to provide services to shared clients. SPECTRuM sites used these venues to discuss clients with complex life issues and to brainstorm strategies.

“Regular, positive meetings between the...HIV [care team] and SPECTRuM staff are very important. It is vital that an ‘us against them’ mentality never be allowed to develop.

- UMMC program staff

STRATEGY 1: The Peer-Nurse Enhancement to Medical Case Management: Peer-Nurse Team Services

BMC: Case conferences as a means to increase buy-in to the program

Buy-in is essential for optimal effectiveness and utilization. At Boston Medical Center, the clinic's medical director participated in weekly SPECTRuM meetings where client case conferences took place. The SPECTRuM peer participated in meetings with physicians to provide information about the program and to solicit referrals.

“Having weekly SPECTRuM meetings that include the principal investigator, program manager for case management and peer services, the data manager who prepares the line lists, and the clinical medical director really helped the project stay on track.

- BMC program staff

Assessing for transition out of peer-nurse services

Implementing successful transition presents significant challenges for many staff and clients. As a short-term, transitional service model, the peer-nurse team provided intensive services for six to twelve months before transitioning clients to routine Medical Case Management (MCM) services or self-management. The team used the acuity tool to assess client readiness to transition. Clients whose acuity level prompted a continuation of additional SPECTRuM services were reassessed on a regular basis for up to six additional months.

Sites developed the following recommendations for facilitating a smooth transition out of peer-nurse services:

- Discuss the transitional nature of the service at the beginning of service provision so it becomes a goal for the client.
- Work with clients to identify their own criteria for readiness to transition (e.g., attendance at medical appointments, less contact with SPECTRuM staff, etc.)

BMC: Creating an alumni group

At Boston Medical Center, a SPECTRuM alumni group was created for active and former SPECTRuM clients to come together to provide support, learn from each other's experiences, and stay in touch with transitioned clients. The group has also served to provide feedback to the peer-nurse team on service strategies. One client reported she connected with the SPECTRuM staff when the peer-nurse team called her on a Sunday to check-in and follow up on GI symptoms. Another client reported he connected with the team when a home visit was conducted in the evening to accommodate his work schedule. This prompted the SPECTRuM team to try unconventional outreach methods for future clients.

GNBCHC: Local partnerships strengthen transition support

Greater New Bedford Community Health Center worked with Steppingstone, a housing and support services provider, to streamline referral for clients transitioning out of SPECTRuM into Steppingstone. GNBCHC also helped transition clients to a local sober living house affiliated with a visiting nurse. Health center staff and the visiting nurse coordinated service provision to promote continuity in services, such as HIV medication adherence support, that SPECTRuM staff and clients had identified as critical for ongoing engagement in HIV care.

STRATEGY 1: The Peer-Nurse Enhancement to Medical Case Management: Peer-Nurse Team Services

- Discuss client readiness to transition at weekly staff meetings/case conferences.
- Incorporate references to transition in the client's Individual Service Plan (ISP) and on an ongoing basis, including at the point when the client is ready to transition.
- Introduce clients to the medical case managers and other providers who will be involved in serving the client after transition, and encourage open communication with these staff.
- Send a written communication to clients and a separate communication to physicians, nurses, case managers, peers, and other staff working with the client to ensure all are aware of the transition. (See Resources pp. 123 - 124 for examples.)
- Establish mechanisms for the peer and nurse to communicate with medical case managers and other staff to follow up on the status of clients who have transitioned. Maintain open communication in case a client may need to be referred back to intensive services.
- Ensure that both clients and staff understand and follow protocols regarding transition and communication post-transition.

See Resources, pp. 119 - 124 for transition tools used by the SPECTRuM sites.



STRATEGY 1: The Peer-Nurse Enhancement to Medical Case Management

Case examples

BMC: helping a client with multiple needs to gain control of his health and his life

BMC worked with a 36-year-old male who was newly diagnosed with HIV in the hospital's emergency department. The client had high acuity levels at enrollment in SPECTRuM. He was homeless, dealing with substance use and mental health issues, and experiencing other health-related challenges. He had difficulty maintaining his supply of medications, challenges with budgeting, and had been banned from all area shelters.

During the first two months of enrollment, the peer worked with the client daily. The peer and nurse provided the client with HIV education, and the nurse worked with him on behavior modification techniques. The nurse also helped the client keep track of the numerous medications he was prescribed by various providers and assessed for interactions.

During the third and fourth months of enrollment, the peer helped the client address his housing needs by participating in visits and calls with community partners. The nurse worked with the client, his doctors, and his pharmacy to help increase the client's understanding of the relationship between nutrition and the side effects of his medications.

During the fifth and sixth months of enrollment, the client attended mental health counseling, sometimes accompanied by the peer. He and the peer worked together to secure stable housing, and he worked with the nurse to manage side effects from the treatment of Kaposi Sarcoma and other health issues.

The peer and nurse discussed transition with the client three months after enrollment, whenever his individualized service plan was updated, and whenever progress was discussed with him. For the SPECTRuM team, indicators that the client was ready for transition included his taking on more responsibility, less frequent calls, attending medical appointments, and personal and environmental stability. For the client, indicators of his readiness for transition included not calling the peer daily, fewer calls to the police department, fewer visits to the emergency department, fewer pages to the doctors, and effective management of his medications.

The client moved into a new apartment and told the SPECTRuM peer that he felt stable, safe, and less anxious about his living situation and life in general. He felt he could take care of himself medically. Because he now had a stable and safe home, he no longer had to worry about living on the street with his many medications. He could leave his medications, belongings, and service dogs at home, and start to live independently. The nurse, peer, and the client met with the pharmacist to establish a plan for his medications. At reassessment, the client's acuity level was much lower, and he transitioned out of SPECTRuM after ten months.

STRATEGY 1: The Peer-Nurse Enhancement to Medical Case Management: Case Examples

GNBCHC: A consistent relationship that supports client resilience

The peer-nurse team at Greater New Bedford Community Health Center worked with a female client with a history of abusive relationships and extreme partner violence. She suffered from cognitive impairment as well as mental health issues which impacted her relationship with her family. She had been in psychiatric facilities on more than one occasion, rarely followed her health care plan for more than several months, and was inconsistent with taking her HIV medication. The peer-nurse team worked consistently with her over many months to secure the appropriate psychiatric help, including consultation with internal and external specialists. The team advocated on the client's behalf to ensure that appropriate wrap-around services were in place for her.

Eventually the client was properly diagnosed and is currently receiving the care and treatment that she needs. The peer-nurse team has also supported the client in building a relationship with her family as a means of support.

As a result of the peer-nurse team's diligence and hard work with the client, she is now attending her medical appointments and has an undetectable viral load. The team is currently working with the client to prepare her for her transition out of SPECTRuM.

UMMC: Helping a client learn to manage his HIV care

UMMC had a 23-year-old client who was newly diagnosed with HIV and referred to UMMC by a residential employment services provider. At the time of his enrollment in SPECTRuM, the client had a high acuity level, and safety was a primary concern for him. At his first clinic visit, he met with the SPECTRuM peer and nurse for an hour. They escorted him to the

lab and waited with him until his transportation arrived. During this first clinic visit, they also educated him on the basics of HIV.

During the first and second months of enrollment, the peer and nurse spoke with the client weekly and met with him every two weeks. They worked with the client to help him understand the importance of nutrition and its impact on medication side effects. The peer and nurse continued to meet with the client every two weeks during the third and fourth months of enrollment and met in the clinic for his medical appointment once a month.

During months five and six, the nurse and peer called the client every other week, provided appointment reminders, and ensured he had transportation to and from his clinic appointments. They met with the client prior to his appointments and helped coordinate the delivery of his medications with his residential program. During months six through nine, the peer and nurse called the client once a month.

From the beginning of his enrollment, transition was discussed at every encounter. The peer was usually the one to initiate these discussions. As communication with the client decreased over time, he demonstrated an improved capacity to navigate his health care. The SPECTRuM team and the client determined that indicators for his readiness for transition would include a decrease in client-initiated encounters, a consistently undetectable viral load, and stability in other social factors. Transition was initiated four months prior to the actual transition, beginning with discussions of how SPECTRuM service provision was coming to an end. The client eventually transitioned to routine HIV peer support at the clinic, where a nurse also checks in with him via the peer on a monthly basis.

STRATEGY 1: The Peer-Nurse Enhancement to Medical Case Management: Case Examples

GNBCHC: Flexibility in transition time frame helps keep at-risk client in care

Greater New Bedford Community Health Center enrolled a female client who was at risk of falling out of care, whose acuity levels were starting to increase, and who was experiencing multiple co-occurring conditions and complicated life issues. During her enrollment in SPECTRuM, the client accessed counseling, attended medical appointments, and took her medications. The peer and nurse asked the client about her goals and strategized on how they could help her reach them. Initially the peer and/or nurse contacted the client every week and made referrals with a nutritionist and other providers.

When the client neared the six-month mark of enrollment, her HIV laboratory results had improved; however the acuity of need in other areas continued to rise. The client reached out to the SPECTRuM nurse when she got very depressed and stopped taking her psychotropic medications and informed the nurse that she wasn't doing well. The SPECTRuM team decided to extend services for the client rather than initiate transition.

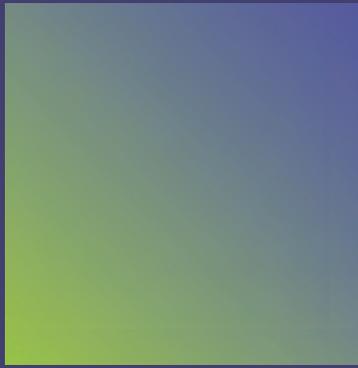
GNBCHC: Trusting relationship helps overcome barriers and improves self-care

The peer-nurse team at Greater New Bedford Community Health Center worked with a male client who did not speak English and who experienced barriers related to literacy. The client's challenges with communication impacted his ability to develop relationships. He was diagnosed with HIV after seeking help when feeling ill, and stated that he was unaware of his infection and how he became infected. He was referred to the peer-nurse team who quickly engaged with him in an attempt to address his isolation. The peer worked closely with the client to build trust so that the client would feel connected to GNBCHC and begin to understand his health care options.

The client needed a great deal of education, not only because he was newly diagnosed, but also because language and cultural barriers increased his isolation. The team was able to help build the client's comfort and confidence and worked with him on using creative ways to navigate the health care system that took into account the client's literacy challenges. With the help of the peer-nurse team, he continues to become more independent and better able to advocate for himself. The client continues to progress with confidence; he has transitioned out of SPECTRuM, manages his own health care, has sustained HIV viral suppression, and has returned to work.

BMC: Complementary peer and nurse expertise helps a client access necessary treatment

Boston Medical Center learned the value of the SPECTRuM peer role with respect to clients with health concerns who were more comfortable turning to a peer than a medical provider. BMC's peer built trusting relationships with clients and shared similar life experiences to support client engagement in care. In one example a client called the peer to report that he didn't feel well. The peer used his knowledge of the client to ask relevant questions about symptoms, use of drugs or medications not prescribed by the doctor, and other details. The peer shared relevant information with the nurse who then contacted the client to ask more detailed questions about the intensity and duration of specific symptoms. The nurse provided the client's doctor with a synopsis of the situation which provided her with more detailed information and a richer context than she might have received in a direct conversation with the client to determine the most appropriate course of action for the client.



RESOURCES STRATEGY 1

Strategic Peer-Enhanced Care and Treatment Retention Model (SPECTRuM) Initiative

Intervention Protocol Strategy #1¹

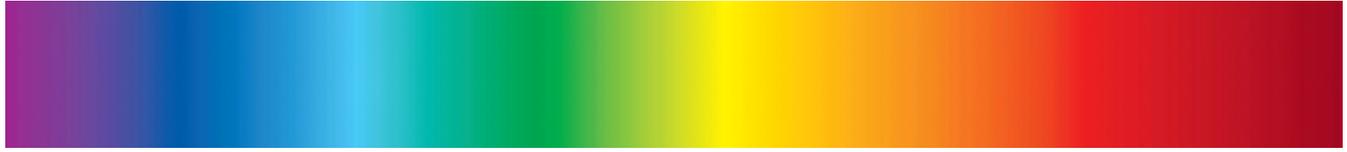
Staff from the Massachusetts Department of Public Health, Bureau of Infectious Disease and Laboratory Sciences, Office of HIV/AIDS met regularly to provide guidance to the organizations conducting the interventions. They set down guidance and processes for the intervention in this document which was periodically revised based on consensus upon review of proposals for improvements from the sites.

The protocol outlines the goals of the program, team member responsibilities, and operational procedures.

The Intervention Protocol is available, together with this SPECTRuM Project Implementation Manual, on the Massachusetts Department of Public Safety website at <http://www.mass.gov/dph/aids>

¹MDPH Bureau of Infectious Disease HIV/AIDS and STD Surveillance Program and Office of HIV/AIDS. Strategic Peer Enhanced Care and Treatment Retention Model (SPECTRuM) Initiative, Intervention Protocol #1. September 2014.

RESOURCES STRATEGY 1: Working with the HIV care team to create buy-in



Presentation to clinical team and stakeholders

The below presentation was used to introduce the SPECTRuM project to the clinical team at UMass Memorial Medical Center. It can be adapted to introduce a similar project within other organizations.

SPECTRuM
Strategic Peer-Enhanced Care and
Treatment Retention Model

Presentation to UMass
Laura Fizek, JRI Health
Sophie Lewis, MDPH Office of HIV/AIDS
February 1, 2013

1

Background
How did we get here?

- MDPH BID applied for HRSA SPNS Award “Systems Linkage and Access to Care for Populations at High Risk of HIV Infection” Initiative
- Received four-year award—range \$950K - \$1M range per fiscal year
- Emphasis is on systems-level changes using data-driven approaches, information technology, and innovative organizational practice

3

Introductions

- Name and Role
- One lesson learned from working with other disciplines.

2

National HRSA SPNS Initiative

- Goal: Improve access to and retention in high quality, competent HIV care and services for hard-to-reach populations of HIV+ persons
- Objectives
 1. Develop innovative and sustainable linkage interventions in seven states
 2. Evaluate effectiveness of linkage interventions and disseminate findings for replication

4

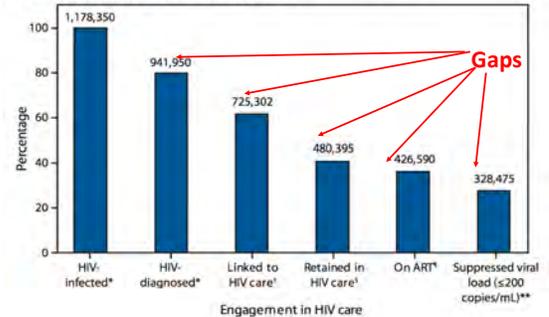
Presentation to clinical team and stakeholders (cont.)

Special Projects of National Significance (SPNS) Program

- Advances knowledge, skills of organizations delivering health and support services to underserved populations diagnosed with HIV
- Develop, test innovative models of care
- Quickly respond to emerging needs of people living with HIV/AIDS
- Promote replication of successful models by others

5

FIGURE 3. Number and percentage of HIV-infected persons engaged in selected stages of the continuum of HIV care — United States



MMWR / December 2, 2011 / Vol. 60 / No. 47 1621

8

Program Partners

- MDPH staff
 - Office of HIV/AIDS
 - Bureau of Infectious Disease
 - HIV/AIDS Surveillance Program
- Boston University, Health and Disability Working Group
- Justice Resource Institute
- Health Innovations
- Consumers
 - Consumer consultant
 - Agency clients
 - Agency CABs and Statewide CAB
- Pilot agencies
 - Boston Medical Center
 - Holyoke Health Center
 - UMass

6

How can we advance linkage and care engagement?

- Routine HIV testing
- Effective agency and program collaboration
 - CTR and care/services
 - Clinic- and community-based
- Comprehensive service assessments
 - Proactive supports
 - Population and client-specific strategies



9

Rationale Why focus on Linkage?

- National concerns from CDC and HRSA
- 20% of PLWHA do not know their status
- 60% of PLWHA are in care
- 40% stay engaged in care
- Just over one-third of PLWHA on HAART
- Just over one-fourth of PLWHA have an undetectable viral load
- This means that up to 75% of PLWHA nationally may be unaware of their status, out of care, and/or have detectable HIV viral loads

7

SPECTRuM Strategies

1. Deployment of linkage and retention teams comprised of nurses and HIV+ peers
2. Communication between MDPH HIV Surveillance Program and pilot sites regarding patient laboratory data

10

Presentation to clinical team and stakeholders (cont.)

Pilot Program Agencies

- Boston Medical Center
- Holyoke Health Center
- University of Massachusetts, Memorial Medical Center

11

Agency-Level:

- New/expanded agency practices:
 - Coordinated linkage to care from CTR
 - Establish standardized acuity screening process to identify issues that may predispose disengagement, with referral to/activation of enhanced linkage supports when indicated
 - Improved use of data to monitor care engagement and adjust service models
 - Increased focus on intensive, time-limited services
 - Expansion of clinic-based staff deployment to community settings
- New staffing models:
 - Role of nurse as retention specialist
 - Peer support as fully integrated service

14

Implementation of Strategies

- Multiple levels of change:
 - Systems Level
 - Agency Level
 - Care Level
 - Statewide

12

Care-Level:

- Development of peer/nurse teams
- Component of interdisciplinary HIV Medical Case Management team
- Partnership with medical provider
- Flexible and responsive service model:
 - Tailor services to individual needs
 - Make service adjustments based on data
 - Conduct clinic-based, community-based, and home visits

15

Systems-Level:

- Novel use of HIV/AIDS surveillance data (Electronic Lab Reporting)
 - Regular reports from MDPH HIV Surveillance Program to health care providers at pilot sites:
 - Patients without a CD4 or VL submitted to Surveillance within 30 days of initial diagnosis,
 - Patients with a gap of 120 days in receipt of CD4 or VL
 - Patients with a detectable VL
- Identify delays in linkage from HIV CTR/dx
- Highlight gaps in HIV care
- Evaluate impact on patient engagement and quality of care

13

Intended Client Populations

- The nurse-peer team will provide intensive support focused on linkage and retention for:
 - Individuals newly diagnosed with HIV
 - Individuals re-engaging in HIV care
 - Individuals who are sporadic users of HIV care
 - Individuals who are out of care
- Priority populations include:
 - Individuals with moderate or high acuity levels
 - Individuals who are recent immigrants or refugees
 - Individuals who were recently released from jail
- Enrollment requires signed consent

16

Presentation to clinical team and stakeholders (cont.)

What Makes SPECTRuM Different?

- SPECTRuM is:
 - Short term
 - Time limited
 - Intensive
- SPECTRuM staff:
 - Includes team of nurse and peer
 - Have small case loads (about 20)
 - Have frequent (a minimum of bi-weekly) interaction with clients

17

Peer/Nurse Roles continued

- Peer and nurse should coordinate with internal case management to determine who is providing other components of case management like utility assistance, rental assistance, social security applications and visits, etc.
- Peer and nurse should coordinate with other providers the client is working with (e.g., external case managers, medical specialists, etc.)

20

Peer/Nurse Roles

- All intakes and initial assessments administered by SPECTRuM team
- Initial activities (may be pre-intake and pre-assessment) may include interaction with clients prior to first medical appt, meetings with clients off-site, phone calls, etc.
- Clients who meet inclusion criteria based on brief assessment are offered SPECTRuM
 - Other clients referred to medical case management or “self management”

18

Transitioning Out

- In general, SPECTRuM clients who no longer meet the inclusion criteria at their six month reassessment are transitioned to medical case management
- Peer and nurse should coordinate transition from SPECTRuM to case management
- Clients transitioning from SPECTRuM will be stable and fully engaged in care
- Win Win for clients and clinic staff!

21

Peer/Nurse Roles continued

- Peer and nurse are expected to address SPECTRuM clients' case management needs related to retention in treatment and care
 - e.g., HDAP applications, transportation to appointments, health literacy discussions, preparation for medical visits, accompaniment to medical visits, adherence support, etc.
- Peer and nurse may provide some initial case management services for all new clients even if the client is not being referred to SPECTRuM, however this should just be during the transition process to MCM

19

Local Evaluation

- Client Outcomes
 - Viral suppression
 - Increased CD4
 - ART prescription
 - Appointment frequency
- Systems Level Changes
 - Organizational behavior change
 - Impact of ELR
 - % of clients engaged/retained over time

22

Presentation to clinical team and stakeholders (cont.)

Project Requirements

- Years 1-2
 - Develop and pilot test innovative linkage interventions and Collaborative Model
 - Host 3 collaborative meetings/learning sessions
 - Develop state-level evaluation plan
- Years 3-4
 - Implement successful linkage on a wider scale
 - Implement state-level evaluation plan
 - Participate in cross-state evaluation with ETAC
 - Disseminate project findings and lessons learned
 - Develop a systems linkages strategy manual

23

Pilot Site Requirements continued

- Development of strategy one interventions using PDSA model, including utilization and submission of PDSA worksheets
 - Identify area to test
 - Develop plan, including data to be used
 - Evaluate test
 - Repeat if necessary
 - Implement

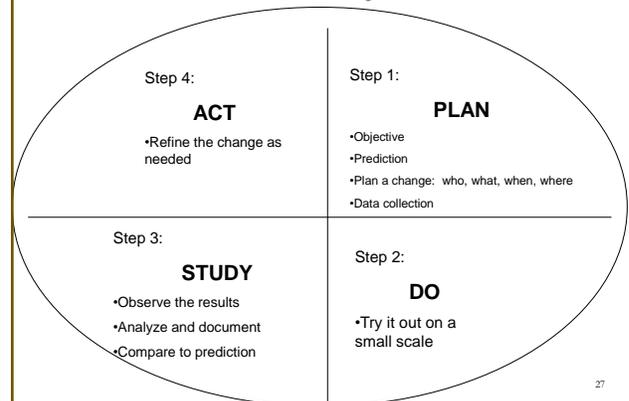
26

Collaborative Learning Model Components and Activities

- Planning Group
- Project Implementation Team
- SPECTRuM Initiative Network (including pilot sites and other interested parties like BPHC)
- Faculty/Content experts
- Learning sessions
- Plan, Do, Study, Act (PDSA)

24

PDSA Cycle



27

Pilot Site Requirements

- Monthly calls with Office of HIV/AIDS
- Bi-monthly calls with organizational TA provider
- Weekly individual TA with peer
- Monthly individual TA with nurse
- Attendance at other trainings as recommended
- Group TA as needed (approximately 5 times/year)
- Attendance and participation in two-day SPNS meetings twice a year in Boston (including development of presentations and materials)
- Engagement of stakeholders

25

Reporting Requirements

- Outreach Log
 - Used to track work done with clients pre-consent and enrollment in SPECTRuM
- Enrollment Form
- Peer/Nurse Daily Encounter Form
- Quarterly Reporting Form
 - These will also be submitted for two years after the client has transitioned out of SPECTRuM to evaluate on-going engagement in care
- Review and respond to ELR line-lists
- SPECTRuM work plan

28

Presentation to clinical team and stakeholders (cont.)

Here's what the UMass Team
can do...

- Refer clients
- Coordinate services
- Engage in educating others on SPECTRuM and retaining HIV+ folks in care
- Support each other when seeking guidance or resources
- Work together to ensure that clients are being assigned and transferred to appropriate staff person
- Contribute ideas

29

Questions?

Thank You

30

RESOURCES STRATEGY 1: Developing, preparing, and integrating the peer-nurse team



SPECTRuM project pilot agency assessment

Agency name: _____

Contact person(s): _____

Address: _____

Phone: _____

- Who are the members of your care team?
 - ID Doc
 - Primary care doc
 - Nurse or Nurse Practitioner
 - Medical Case Manager
 - Social Worker
 - Peer
 - Nutritionist
 - Other: _____
- How would you describe the strengths of your current service model in terms of linkage to and engagement in care?
- In general, what gaps are you hoping to fill with this new nurse/peer linkage team?

Point(s) of Entry/Linkages

- Describe the process of internal referral to your program. From what departments are clients referred? Who is the point of contact?
- Describe the process of external referral to your program. From what community programs are clients referred? Who is the point of contact?
- What are the challenges at point of entry to the program (system, agency, client) that negatively impact successful linkage to care?
- What currently works well with the system, agency, for the client?

SPECTRuM project pilot agency assessment (cont.)

- How are you planning to change/improve/augment your points of entry/linkage system with the nurse/peer model?
- What challenges do you anticipate in this area when implementing the nurse/peer model?

Initial Intake/Assessment

- Describe your intake process including: Who is responsible for conducting intake? What type of providers are part of the intake and initial assessment process? How quickly is client seen for ID appointment, case management appointment, mental health appointment, psych appointment, other?
- In what ways are you assessing client/client criteria for anticipating the likelihood that a client/client will fall out of care? Is there a set of criteria determining client acuity or level of need in order to prioritize clients?
- How do you assess client for mental health concerns? At what stage along care continuum does this occur? How often? Who conducts assessment? What happens to client if a concern is identified?
- What are the challenges related to mental health (system, agency, client) that negatively impact successful retention in care?
- How do you assess client for substance abuse concerns? At what stage along care continuum does this occur? How often? Who conducts assessment? What happens to client if a concern is identified? How is this client retained in HIV care when he/she enters detox?
- What are the challenges related to substance use (system, agency, client) that negatively impact successful retention in care?
- What currently works well with the system, agency, for the client?
- What are the challenges at intake/initial assessment (system, agency, client) that negatively impact successful linkage to care?
- How would you change/improve/augment your assessment/intake process based on the nurse/peer model?
- What challenges do you anticipate in this area in implementing the nurse/peer model?

Ongoing service provision and engagement in care:

- How often are clients seen for routine lab work/follow-up?
 - Every 3 months
 - Every 4 months
 - Every 6 months?
- How do you assure clients understand their lab values? (check all that apply)
 - Doctor explains lab values in laymen's terms
 - Client debriefs with Medical Case Manager after medical appointment
 - Client is given a copy of lab report
 - Client receives fact sheet or other printed materials explaining lab values
 - Other: _____

SPECTRuM project pilot agency assessment (cont.)

- How quickly do clients find out about lab results?
 - As soon as the report is received from the lab
 - Within 30 days
 - At next visit
 - Other: _____
- What happens when a client is having trouble with meds? (check all that apply)
 - Client receives a referral to adherence nurse/counselor
 - Client is given literature on adherence strategies
 - Client receives education on:
 - Side effects management
 - Medications at work in the HIV life cycle
 - Dosing schedules and food restrictions
 - Reminder strategies
 - When to call in for refills/automatic refills
 - Other: _____
- Describe the process for follow-up visits. Are appointments client-driven (client responsible for scheduling/rescheduling) or provider driven (provider proactive in monitoring appointment adherence)?
 - How are appointments scheduled? (check all that apply)
 - Client given a written date for next appointment at each visit
 - Via mail Phone Both
 - Client calls in to make appointment
 - Other: _____
 - How are clients reminded of upcoming appointments?
 - Client receives a phone call the day before the appointment
 - Client gets a letter in the mail
 - Other: _____
- Approximately what percentage of clients miss appointments? What do you think is the main reason that they miss appointments?

SPECTRuM project pilot agency assessment (cont.)

- What happens when a client misses an appointment? (check all that apply)
 - Someone in the team schedules the next available appointment and calls to inform client
 - Someone in the team calls to determine cause of missed appointment
 - The client receives a letter with new appointment
 - Other: _____
 - How does your agency define “follow-up/lost to care”?
 - What methods are employed to find clients lost to follow up?
 - Someone in the team goes out to try to locate the client
 - Letter or email is sent to the client
 - Someone in the team reaches out to the client’s emergency contact
 - Other: _____
 - In your program, at what stage along continuum of care are clients lost to follow-up? Newly diagnosed/initial assessment, transition to follow up visits/more regular care or much later on after a period of engagement in care? Please explain.
 - Describe communication methods between client and provider. How does client communicate with provider team? How does provider team communicate with clients? Is communication client driven or provider driven? What are the challenges related to client/provider communication (system, agency, client) that negatively impact successful retention in care?
 - Does the program utilize a Motivational Interviewing approach to health care delivery? If so, how would you describe that approach?
 - What currently works well with the system, agency, for the client?
 - What are the challenges at follow-up (system, agency, client) that negatively impact successful retention in care?
 - How would you change/improve/augment follow-up/lost to care strategies when implementing the nurse/peer model?
 - In what ways would you ensure flexible scheduling and outreach activities in this new model?
 - What is the process and criteria for terminating or disenrolling clients from the program?
 - What are the challenges related to client termination or disenrollment (system, agency, client) that negatively impact successful retention in care?
- General:**
- What do you have in place to create the ideal integration of the nurse/peer team?
 - How have you engaged decision-makers and key stakeholders in discussions regarding this nurse/peer model?

SPECTRuM project pilot agency assessment (cont.)

- What kinds of strategies has the program implemented in the past to address linkage and retention in care issues? Which were successful and which were not? Please explain.
- What do you anticipate might be some challenges in introducing the nurse/peer model to your organization, clients/clients and care team?
- What do you still need for technical assistance and training?

SPECTRuM project questions: Initial agency meeting

- Walk us through your current service system, focusing on care and retention
- How do you currently identify those at risk for not getting into care and those who have fallen out of care?
- What do you offer those newly diagnosed?
- What is your feedback loop to CTR for the newly diagnosed?
- What is your understanding of the SPNS/SPECTRuM Project?
- What are your ideas about how the nurse/peer model would look like/work?
- What do you anticipate might be some of the successes in implementing this model?
- What do you anticipate might be some of the challenges in implementing this model?
- How does your system plan on supporting this model?
- What other supports might you need?
- What do you hope to get out of this project?
- What ideas do you have about learning from other agencies who may be doing similar work?

Sample peer job descriptions

This peer job description was used by UMass Memorial Medical Center:



Employee's signature _____ Date _____

UMass Memorial Health Care, Inc.

UMass Memorial Medical Center

POSITION DESCRIPTION

Job Title: Peer Advocate, Sr.

Title #:

Department: HIV, Division of Infectious Diseases

Grade: ADM7

Employee Expectation: Supports the organization's mission, vision and values by incorporating "Our Commitments", UMass Memorial's Service Standards, into the daily work to address the unique needs and expectations of patients, families and employees. "Our Commitments" are: Personal Accountability, Appearance, Caring for Patients and Families, Confidentiality, Commitment to Co-workers, Communication and Physical Environment.

Quality improvement initiatives are activities focused on changing systems to meet our customer's needs and expectations and developing the full potential of the resources used in the process. To continue to develop a quality conscious environment at all levels, each employee plays an essential role in understanding and raising the quality of care and services across the organization.

Each employee is able to describe and contribute to the ways the work area/department is improving processes for patients, families and other staff. Additionally, takes initiative to learn more about the department/discipline, actively participates in improvement and/or problem-solving efforts with the goal of achieving excellence.

Employees are also expected to support and participate in UMass Memorial's Diversity Initiative by addressing those elements essential to building, preserving and fostering diversity in the workplace, and delivering quality health care to a diverse patient population.

I. Position Summary:

Reporting to the HIV Program Manager, the Peer Advocate provides education, support and advocacy for individuals with HIV/AIDS in Central MA, in clinic or other designated settings, as appropriate. This position is part of a Special Project of National Significance (SPNS) for Massachusetts, as well as other parts of the country.

Sample peer job descriptions (cont.)

II. Major Responsibilities:

Provide education, emotional support and practical support to newly diagnosed HIV/AIDS patients and/or difficult to retain patients to advocate the patients continue their medical care. Understands what patients are struggling with (such as food, housing, transportation, social support) and provides resource information that can assist the patients.

As part of the SPNS initiative, assists in the design and assessment of unique interventions to maintain HIV patients in medical care.

Model and teach self-advocacy skills, advocating for patients as needed and assisting them with obtaining benefits and entitlements.

Counsel and instruct patients regarding specific harm/risk reduction, sexual health promotion, and positive prevention techniques, and provide appropriate written materials and/or supplies.

Offer information/referral/follow-up to available community resources and accompany patients to groups/appointments, providing escort when requested.

Assess client needs every 3-6 months, as needed, and work with the Care Coordination Team to complete individual service plans for patients.

Engage patients, as appropriate, in HIV Disease Self-Management activities and strategies.

Identify core needs, in partnership with the patient, related to physical health, mental health, and psychosocial stability.

Complete all required documentation in a timely manner.

Attend regular assigned SPNS and Care Coordination Team meetings and trainings.

Refer to and work with other UMMHC program components.

Co-facilitate HIV educational groups with HIV Program Social Worker.

Comply with established departmental policies, procedures, and objectives.

Attend variety of meetings, conferences, seminars as required or directed.

Demonstrate use of Quality Improvement in daily operations.

Comply with all health and safety regulations and requirements.

Respect diverse views and approaches, and contributes in maintaining an environment of professionalism, tolerance, civility and acceptance toward all employees, patients and visitors.

Perform other similar and related duties as required or directed.

All responsibilities are essential job functions.

RESOURCES STRATEGY 1: Developing, Preparing, and Integrating the Peer-Nurse Team

Sample peer job descriptions (cont.)

III. Position Qualifications:

Extensive first-hand knowledge of HIV/AIDS and experience with HIV care and treatment and commitment to working with others to improve HIV care. High school diploma or equivalent years of related experience in Human Service field preferred. Must have familiarity with the HIV service community and have “street smarts.”

Must have demonstrated ability to interact with people from diverse backgrounds and communities and knowledge of the Worcester area and local provider community.

This position requires traveling to Fitchburg, Southbridge and other locations as needed. Must have a valid driver’s license, insurance and vehicle.

This individual must have good written, listening, verbal and interpersonal communication skills.

Must have the ability to embrace and communicate a positive, self-affirming, empowering attitude toward the lives of people living with HIV/AIDS.

Ability to manage stress and self-advocate.

Unless certification, licensure or registration is required, an equivalent combination of education and experience which provides proficiency in the areas of responsibility listed in this description may be substituted for the above requirements.

Department-specific competencies, including age-specific competencies and their measurements, will be developed and maintained in the individual departments. The competencies will be maintained and attached to the departmental job description. Responsible managers will review competencies with position incumbents.

IV. Physical Demands and Environmental Conditions

Work is considered sedentary. Position requires work indoors in a patient care area and/or normal office environment. This position travels to homes throughout Central MA.

The Organization reserves the right to modify position duties at any time.

Department Manager	Date
Human Resources	Date

Sample peer job descriptions (cont.)

This job description was used when recruiting peers at Holyoke Health Center.



Holyoke Health Center job description: Peer outreach worker

Serving as an active member of a multidisciplinary team and working collaboratively with a primary care and case management team, this position is responsible for providing a comprehensive range of services to help clients navigate HIV treatment and services including client outreach, intake and referral services.

Qualifications include:

- First-hand understanding of issues related to living with HIV or AIDS
- Expert knowledge of available HIV services in the Holyoke and surrounding communities, knowledge of treatments and substance abuse issues required
- Completion of a Peer Outreach Worker Training Program within one year of hire date required; training and/or certification in HIV treatment, Peer Education/Advocacy preferred
- At least one year in recovery if addiction has been an issue
- Excellent oral and written communication skills
- Ability to work independently and as part of a multidisciplinary team
- Comfortable working with a diverse population (i.e., ethnicity, sexual orientation, socioeconomic status, etc.)
- Willingness to accept direction from supervisor
- Ability to use good judgment regarding confidentiality issues
- Demonstrated ability to be a strong advocate for the HIV population
- Ability to maintain required work schedule, arrive to work on time and be accountable for how time is used
- Demonstrated ability to work well with people at all levels, both within and outside the organization.

Those living with HIV are strongly encouraged to apply. This position requires bilingual (English/Spanish) language capability

Sample nurse job descriptions

This nurse job description was developed by Health Innovations for the SPECTRuM project:



Agency

Job Description

JOB TITLE: Nurse - SPECTRuM Program

DEPARTMENT:

LOCATION:

TYPE OF ASSIGNMENT: Full-time/Part-time

ANNUAL SALARY:

BENEFIT ELIGIBLE POSITION:

EDUCATIONAL REQUIREMENTS:

1. Bachelor of Science in Nursing (BSN) from an accredited university.

LICENSE(S) OR CERTIFICATION(S) REQUIRED:

1. Licensure as a Registered Nurse (RN) by the Massachusetts Board of Nurse Examiners.
2. MDPH OHA Certifications: Fundamentals of HIV/AIDS, Behavioral Risk Assessment, HIV CTR, HIV Rapid Testing.

EXPERIENCE REQUIREMENTS:

1. 3-5 years work experience as an RN in a clinical or hospital setting is required.
2. Prior experience in public health, community health center, family planning or communicable/infectious disease is preferred.
3. Experience with HIV, STI, Viral Hepatitis, substance abuse, mental health issues strongly desired.
4. Familiarity with Harm Reduction theories strongly desired.

COMPUTER PROFICIENCY:

1. Experienced with Microsoft Office Suite.
2. Excellent data entry skills.
3. Experience with EHR/EMR.

SPECIAL SKILLS AND/OR ABILITIES:

1. Ability to speak Spanish is desirable, but not required.
2. Capable of exercising autonomy and independent judgment in planning and implementation of daily activities.
3. Ability to be self-directed.
4. Proficiency in patient education and clinical risk assessment.

Sample Nurse Job Descriptions (cont.)

5. Strong organizational and communication (written and verbal) skills required.
6. Valid Driver's License and dependable means of transportation.
7. Cultural and socioeconomic sensitivity in dealing with patients and staff of diverse backgrounds.
8. Ability to be flexible and work days, nights and weekends as required.

TRAVEL REQUIRED:

1. Ability to travel to meetings and trainings.
2. Ability to travel to provide health navigation/medical escorting for patients as required.
3. Ability to make patient home visits as required.
4. Ability to travel to community-based organizations to disseminate program information and to coordinate patient care.

BACKGROUND CHECK:

1. CORI Required

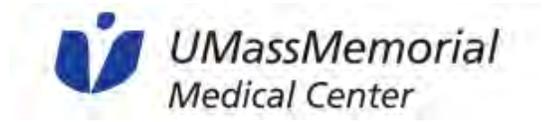
PHYSICAL REQUIREMENTS:

1. The ability to lift and transfer materials up to 25 lbs. is required.

GENERAL STATEMENT OF DUTIES: The SPECTRuM Program RN is responsible for providing safe, therapeutic care to persons living with HIV infection in a holistic and systematic way utilizing a nurse/peer team model. Responsibilities will include coordinating the care of HIV-positive clients who have been identified as at risk for falling out of care or who have already been lost to follow-up; participating in monitoring and facilitating the achievement of optimal clinical outcomes; negotiating, procuring and coordinating appropriate services and resources needed by the clients; developing partnerships with multidisciplinary providers (internally and externally) and community based programs to ensure unified, cohesive care; and at key points, intervening to address and resolve barriers to timely and efficient care delivery. This SPECTRUM Program RN plays a critical role in program development and quality improvement (QI) initiatives utilizing the PDSA cycle model. This position is also responsible for treatment adherence counseling; coordinating educational opportunities for clients; and will deliver intensive, comprehensive and coordinated direct client care.

Sample Nurse Job Descriptions (cont.)

This nurse job description was used by UMass Memorial Medical Center:



Employee's signature _____ Date _____

UMass Memorial Health Care, Inc.

UMass Memorial Medical Center

POSITION DESCRIPTION

Job Title: Coordinator, HIV Retention Nurse

Title #:

Department: Division of Infectious Diseases

Grade: NSG 12

Employee Expectation: Supports the organization's mission, vision and values by incorporating "Our Commitments", UMass Memorial's Service Standards, into the daily work to address the unique needs and expectations of patients, families and employees. "Our Commitments" are: Personal Accountability, Appearance, Caring for Patients and Families, Confidentiality, Commitment to Co-workers, Communication and Physical Environment.

Quality improvement initiatives are activities focused on changing systems to meet our customer's needs and expectations and developing the full potential of the resources used in the process. To continue to develop a quality conscious environment at all levels, each employee plays an essential role in understanding and raising the quality of care and services across the organization.

Each employee is able to describe and contribute to the ways the work area/department is improving processes for patients, families and other staff. Additionally, takes initiative to learn more about the department/discipline, actively participates in improvement and/or problem-solving efforts with the goal of achieving excellence.

Employees are also expected to support and participate in UMass Memorial's Diversity Initiative by addressing those elements essential to building, preserving and fostering diversity in the workplace, and delivering quality health care to a diverse patient population.

I. Position Summary:

Under the direction of the Clinical Chief and Principal Investigator for the Mass DPH Medical Case Management and SPECTRuM Program grant, provides retention and engagement to care activities to appropriate patients enrolled in the UMMHC HIV Program. Develops unique, patient-centered strategies, individual service plans, and coordinates follow-up care as required. Assists in data collection that will inform both project and individual patient goals. Provides support and advocacy for patients with HIV/AIDS in clinic, home, community or other designated settings.

Sample Nurse Job Descriptions (cont.)

II. Major Responsibilities:

Provide medical case management and innovative retention techniques for patients with HIV infection. This includes but is not limited to: reviewing of charts for medical needs such as vaccinations, ensuring patient information is collected and documented, assisting newly diagnosed patients with the transition from the testing environment into medical care, and ensuring that applications for additional patient services such as transportation and supplemental insurance are completed and monitored. Monitors patient medications, lab results, and ensures that appropriate follow-up appointments are scheduled.

Works in close partnership with the HIV Peer Advocate and maintains strong linkages with collaborative agencies.

Educates patients about HIV disease, positive prevention techniques and appropriate medical follow-up. Assists with developing and monitoring adherence to treatment plan.

Educates patients about medications and side effects management. Assesses medication side effects and communicate back to the medical provider, as necessary.

Assesses patient's vital signs and reports back to medical provider, as needed.

Helps HIV patients identify and overcome or minimize barriers to care and medication adherence.

Maintains records of patient contacts and appointments in accordance with SPECTRuM Project expectations.

Communicates patient issues on a regular basis with other team members, staff at UMMC and referral agencies.

Engages patients, as appropriate, in HIV Disease Self-Management activities and strategies.

In partnership with the patient, identifies individualized goals and objectives related to physical health, mental health, and psychosocial stability.

Develops outreach activities related to HIV and participates in assigned community meetings.

Participates in SPECTRuM Learning Collaborative meetings and project-specific PDSA cycles and exchanges information with counterparts in other parts of the State.

Maintains current information about HIV through attendance at meetings, interaction with other staff, appropriate trainings, and self-directed learning.

Complies with established departmental policies, procedures and objectives.

Attends variety of meetings, conferences, seminars as required or directed.

Demonstrates use of Quality Improvement in daily operations.

Complies with all health and safety regulations and requirements.

Respects diverse views and approaches, and contributes in maintaining an environment of

RESOURCES STRATEGY 1: Developing, Preparing, and Integrating the Peer-Nurse Team

Sample Nurse Job Descriptions (cont.)

professionalism, tolerance, civility and acceptance toward all employees, patients and visitors.

Performs other similar and related duties as required or directed.

All responsibilities are essential job functions.

III. Position Qualifications:

Requires current registration to practice as a Registered Nurse in the Commonwealth of Massachusetts. Ambulatory experience with HIV-infected patients preferred. Proven work experience in a team environment, as well as a demonstrated ability to function independently. Ability to communicate effectively both verbally and in writing with patients, the public and medical staff. Bilingual in English and Spanish strongly preferred. Knowledge of, or willingness to learn about, HIV/AIDS and commitment to working with others to improve HIV care. Valid Massachusetts driver's license and reliable vehicle required.

Demonstrated ability to interact with people from diverse backgrounds and communities and knowledge of the Worcester area and local provider community.

Unless certification, licensure or registration is required, an equivalent combination of education and experience which provides proficiency in the areas of responsibility listed in this description may be substituted for the above requirements.

Department-specific competencies, including age-specific competencies and their measurements, will be developed and maintained in the individual departments. The competencies will be maintained and attached to the departmental job description. Responsible managers will review competencies with position incumbents.

IV. Physical Demands and Environmental Conditions

Work is considered sedentary. Position requires work indoors in a normal office environment.

The Organization reserves the right to modify position duties at any time.

Department Manager	Date
Human Resources	Date

RESOURCES STRATEGY 1: Training the peer-nurse team

Because of the unique role of both peer and nurse in supporting clients in HIV treatment in the SPECTRuM project, the peer-nurse team received 24-40 hours of intensive initial training, followed by continued one-on-one and group technical assistance. The training for the peer-nurse team is described on pp. 19-22. Below are some of the resources that were used to train peers and nurses as part of the SPECTRuM team.

Training for peers

Staff from Justice Resource Institute with extensive experience training peers worked with the SPECTRuM peers to train them in the core components outlined on p. 20. This training was generally based on materials available in the following peer training toolkits:

PREParing Peers for Success PREP Peer Core Competency Training



<http://cahpp.org/HIV-peer-5-day-training-curriculum/>

This five-day curriculum provides training materials and instructions to train HIV-positive peers to support patients with care and treatment in your community. It covers all of the peer training topics included in the SPECTRuM peer training. Available in English and Spanish.

Building Blocks to Peer Success: A toolkit for training HIV-positive peers to engage PLWHA in care



<http://cahpp.org/resources/HIV-peer-training-toolkit>

This toolkit is targeted to experienced trainers and training organizations who can use it to design, enhance or refine their own training of peers. It also covers all of the core competencies included in the SPECTRuM peer training, plus lessons on continuing education topics and additional ideas for classroom activities. Available in English with core competency components available in Spanish.

Training for Nurses

The nurse training was conducted as an 8-session curriculum which generally took place monthly for 3-4 hours. Much of this training was conducted in partnership with Health Innovations, Inc. (<http://healthinnovationsinc.com/>) and Justice Resource Institute (<http://www.jri.org>).

Session topics were organized as follows:

- Session 1: Site Assessment
- Session 2: Staff Assessment, including training needs; SPECTRuM nurse role and peer-nurse team dynamic
- Session 3: SPECTRuM nurse HIV Overview training (this session was scheduled for 6 hours)
- Session 4: Linkage and retention-in-care issues

The sessions below were conducted as joint trainings with both nurses and peers:

- Sessions 5-8: SPECTRuM program clinical technical assistance and case reviews; joint meeting with SPECTRuM peer and peer technical assistance team. The last two sessions were optional joint meetings with peer and peer technical assistance team.
- Post Session: Transition Planning (See pp. 119 - 124 for resources related to transition)

Nursing technical assistance site assessment tool

A. Linkage/Retention

1. In your program, at what stage along continuum of care are patients lost to follow-up? Newly diagnosed/initial assessment, transition to follow-up visits/more regular care or much later on after a period of engagement in care? Explain.
2. Describe process of internal referral to your program? From what departments are patients referred? Who is point of contact?
3. Describe process of external referral to your program? From what community programs are patients referred? Who is point of contact?
4. What are the challenges at point of entry to the program (system, agency, patient) that negatively impact successful linkage to care?
5. What kinds of strategies has the program implemented in the past to address linkage and retention in care issues? Which were successful and which were not? Explain.



B. Intake/Assessment

1. Describe your intake process including: Who is responsible for conducting intake? What type of providers are part of the intake and initial assessment process? How quickly is patient seen for ID appointment, case management appointment, mental health appointment, psych appointment, other?
2. What are the challenges at intake/initial assessment (system, agency, patient) that negatively impact successful linkage to care?

C. Follow-Up

1. Describe the process for follow-up visits? Are appointments patient driven (patient responsible for scheduling/rescheduling) or provider driven (provider proactive in monitoring appointment adherence)? What happens when patients miss appointments? Explain.
2. What are the challenges at follow up (system, agency, patient) that negatively impact successful retention in care?

D. Mental Health Assessment

1. How do you assess patient for mental health concerns? At what stage along care continuum does this occur? How often? Who conducts assessment? What happens to patient if a concern is identified?

RESOURCES STRATEGY 1: Training the Peer-Nurse Team

Nursing technical assistance site assessment tool (cont.)

2. What are the challenges related to mental health (system, agency, patient) that negatively impact successful retention in care?

E. Substance Use Assessment

1. How do you assess patient for substance abuse concerns? At what stage along care continuum does this occur? How often? Who conducts assessment? What happens to patient if a concern is identified?
2. What are the challenges related to substance use (system, agency, patient) that negatively impact successful retention in care?

F. Patient Acuity

1. Is there an assessment/evaluation of patient acuity or level of need in order to determine which patients are prioritized?

G. Disenrollment

1. What is the process and criteria for disenrolling patients from program?
2. What are the challenges related to patient disenrollment (system, agency, patient) that negatively impact successful retention in care?

H. Communication

1. Describe communication methods between patient and provider. How does patient communicate with provider team? How does provider team communicate with patients? Is communication patient driven or provider driven?
2. What are the challenges related to patient/provider communication (system, agency, patient) that negatively impact successful retention in care?
3. Does the program utilize a Motivational Interviewing approach to health care delivery?

SPECTRuM RN orientation/Training needs assessment

A. Assess staff experience, skills, knowledge with:

1. At-risk populations (Men who have sex with men and other LGBT, injection drug users, incarcerated population, homeless, racial/ethnic minorities, women, recently arrived immigrants, etc.)
2. Infectious diseases (HIV, STDs, Hepatitis C, TB, etc)
3. Mental health issues
4. Substance use issues
5. Case management/coordination
6. Community resources
7. Prevention/education/HIV testing
8. Prevention with Positives
9. PREP
10. Partner Notification
11. HIV Medication Adherence



B. Recommended Certifications/Trainings

1. Statewide training/Certifications: Fundamentals of HIV, HIV Counseling and Testing, HIV Case Management, Prevention for Positives
2. Health Innovations SPECTRuM RN training curriculum (Session 3)
3. Association of Nurses in AIDS Care certification
4. Hepatitis C Support Project/Hepatitis A, B, C training certification

C. Recommended Reference/Resource Materials

1. Association of Nurses in AIDS Care (ANAC) Core Curriculum for HIV/AIDS Nursing
Link <http://www.nursesinaidscare.org/i4a/pages/Index.cfm?pageID=3681>
2. Journal of the Association of Nurses in AIDS Care
Link <http://www.nursesinaidscare.org/i4a/pages/Index.cfm?pageID=3331>
3. *2012 Medical Management of HIV Infection*, John Bartlett, MD
4. HIV/AIDS Treatment Guidelines Link <http://aidsinfo.nih.gov/guidelines>
5. AETC National Resource Center Link <http://www.aidsetc.org/resources>
6. HCV Advocate Link <http://hcvadvocate.org/>

D. Recommended Membership

1. Association of Nurses in AIDS Care (ANAC) national and local chapters
2. New England AIDS Education Training Center (NEAETC) membership
3. International Nurses Society on Addictions national and local chapters

SPECTRuM RN orientation/Training needs assessment (cont.)

E. Shadow Providers

1. Infectious Disease (HIV, STD)
2. HIV Counseling/Testing
3. Hepatologist
4. TB clinic
5. Case Managers
6. Behavioral Health
7. Outpatient substance abuse treatment (Suboxone, Methadone)
8. Pharmacist/Adherence

Presentation: SPECTRuM nurse role and RN/peer team dynamic

<p>SPECTRuM: Nurse Role and RN/Peer Team Dynamic</p>  <p>1</p>	<p>RN Role: Expectations</p> <ul style="list-style-type: none">• Registered RN, Bachelor's prepared• Knowledgeable of infectious disease, co-morbid conditions, psychosocial factors/issues• Experience and comfort with engaging vulnerable populations, community resources & clinic settings/systems• Familiarity with harm reduction approach• Strong organizational & communication skills (verbal, written)• Strong assessment skills• Experienced in Motivational Interviewing• Ability to be self-directed• Team player• Dependable means of transportation• Ability to be flexible with work schedule and adaptable to change• Comfortable with interacting with patients in office, in patient's home, off site in non-traditional settings <p>3</p>
<p>Nurse Role</p> <p>2</p>	<p>RN as Advocate</p> <ul style="list-style-type: none">• Role model advocacy and role play so that clients can learn to do it on their own• Put patient first• Push the envelope• Address homophobia, racism, discrimination & stigma <p>4</p>

Presentation: SPECTRuM nurse role and RN/peer team dynamic (cont.)

RN as Coordinator

- Take the lead
- Monitor care plan/follow up
- Monitor adherence to appointments
- Monitor adherence to care and treatment

5

RN as Educator

- Increase patient knowledge
- Assess patient learning style/health literacy
- Increase self care skills
- Identify patient's health care beliefs
- Move patient toward self sufficiency
- It takes a village....
- Give patient tools to stay engaged in care

8

RN as Problem-Solver

- Identifies challenges in partnership with patient
- Prioritizes needs from patient perspective
- Works with patient, agency and system to decrease barriers
- Solution-focused
- May need to push the envelope
- Strengths-based approach

THERE IS ALWAYS A WAY

6

RN as Interpreter

- Deciphering provider speak
- Systems navigation
- Mapping plan of care with alternate routes
- Reemphasizing/reviewing how personal behaviors can impact on health outcomes – no judgment

9

RN as Partner

- Relationship building extremely important
- Believe!!!
- Patient #1
- Team: RN & Peer
- Internal: everyone with potential for patient contact
- External: everyone with potential for patient contact

7

RN as Investigator

- Know your patient
- Know your agency
- Know your systems
- Know your community

- They need to know YOU!!!
- One nurse = one number

10

Presentation: SPECTRuM nurse role and RN/peer team dynamic (cont.)

RN as Expert Clinician

- Expertise/Quality of care
 - Clinical health assessments specific to HIV and co-morbidities
- Non-judgmental
- Accessible services
- Welcoming environment
- Adapt to patient
- Identifies care team
- Connection

11

Peer Role

14

RN as Facilitator

- Fosters communication
- Holds patient/provider care team accountable
- Continues to offer hope
- Buy in & consensus building

12

What Makes HIV+ Peers Unique?

Peers often gain immediate credibility and trust	Peers are positive role models
Peers focus on empowerment	Peers share personal experiences
Peers give access to someone who has been there	Facilitate communication with medical staff

Peers help medical staff understand the emotional impact of HIV and HIV-related stigma

15

RN as Case Finder

- What might be perceived – like finding a needle in a haystack
- Reality – a little hard to find but doable:
 - need patience
 - creative means to the end
 - obtain good information (assessment skills, trust)
 - the right incentives, motivation
 - the hook = follow through

13

Peer Characteristics

<p><u>Knowledge/Skills</u></p> <ul style="list-style-type: none"> • Peer role and role of other providers • Available services for PLWHA • Client-centered communication • HIV 101/life cycle • Med adherence/how meds work • Resistance, resistance testing • Basic lab values • STIs/sexual health • Disclosure • Stigma 	<p><u>Qualities/Attitudes/Beliefs</u></p> <ul style="list-style-type: none"> • Empathic • Accepting • Non-judgmental • Caring/compassionate • Friendly/approachable • Assertive • Mentor and role model • Positive attitude about HIV • Belief that good health and longevity are possible • Listener
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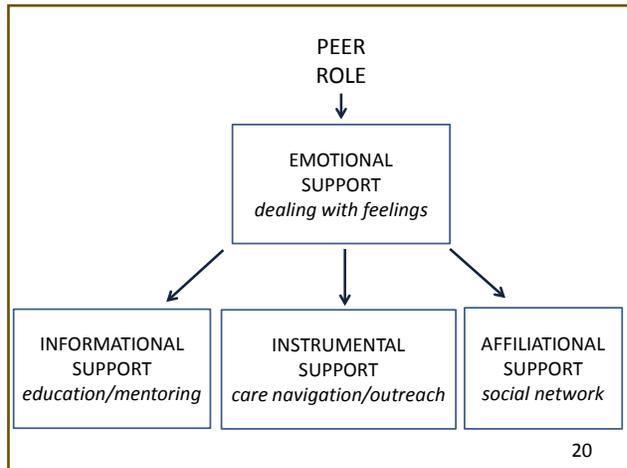
16

Presentation: SPECTRuM nurse role and RN/peer team dynamic (cont.)

Emotional Readiness

- Has accepted HIV status
- Has healed from the initial impact of learning HIV status and the ensuing overwhelming fear
- Has evolved and grown as a person with HIV and feels ready to help others
- Is adherent to care and treatment
- Is able to disclose status

17



Principles of Peer Leadership

People are generally capable of their own growth and change

Each individual is responsible for his/her own growth and change

Everyone has a right to self-determination

18

Emotional Support

- Show empathy, acceptance and positive regard
- Listen attentively; being present and emotionally available
- Provide support around grief, loss and fear (giving a shoulder to cry on)
- Share personal experiences of living with HIV
- Elicit personal stories
- Assist in resolving ambivalence

21

Peers are specially trained not to:

- Tell people what they should, must or need to do
- Give advice
- Cross boundaries
- Violate confidentiality
- Undermine the relationship of other providers with the client/patient
- Diagnose physical or mental health status
- Act on over-identification with clients/patients (transference/counter-transference)

19

Informational Support

- Adherence to regular medical care
- Adherence to HAART
- Side effects management and reminder strategies
- Resistance and resistance testing
- Understanding labs
- The HIV life cycle/how medications work in the HIV life cycle
- Doctor-patient communication

22

Presentation: SPECTRuM nurse role and RN/peer team dynamic (cont.)

Instrumental Support

- Accompany to medical and non-medical appointments
- Facilitate communication with doctor
- Provide advocacy
- Make appointment reminders/follow up with no shows and address barriers to care
- Outreach to persons lost to follow-up
- Help with paperwork/gathering verifications
- Periodic check-in

23

Vision of RN-Peer Working Together

NURSE

- Clinical assessment
- Physical exam
- STI screening
- PPD
- Advocacy
- Education
 - Opportunistic infections/co-morbidities
 - Medication adherence, resistance and resistance testing
 - Treatment issues/side effects management
 - Drug and food interactions
 - Interpreting lab values
- Outreach
- Medical service navigation

PEER

- Emotional support, role modeling, mentoring
- Basic needs assessment
- Check-in calls
- Appointment reminders
- Advocacy
- Education:
 - Internalized stigma/overcoming fear/acceptance of status
 - Disclosure
 - Sexual health
 - Preparing for medical appointments
 - Side effects management
 - Community resources
- Outreach
- Social service navigation

26

Affiliational Support

- Connect clients to:
 - support groups and peer networking
 - community events (e.g. World AIDS Day)
 - conferences
 - training/workshops
 - drop-in programs
 - other social events that connect HIV+ to each other

24

RN-Peer Linkage Model

- Does not replace current HIV standard of care but enhances it
- Separate but integrated into the larger HIV service mix
- Ongoing TA to providers and peers to be provided by SPECTRuM team
- Intervention tailored to each site

27

RN-Peer Working Together

25

Presentations from session 3 SPECTRuM nurse HIV overview training

The 6-8 hour training session for nurses was based on the set of master slides outlined below. Slide sets were omitted or included, either in part or fully, based on the training needs identified in the RN Training Assessment (see page 60) and time allowed for the training session. Where available, links to presentations have been included in the presentation descriptions.

HIV Infection

This presentation compiled by Health Innovations provides a clinical overview of HIV statistics in the U.S., HIV counseling and testing, Pre-and Post-Exposure Prophylaxis, signs of primary and acute chronic HIV infection and AIDS.

Antiretroviral Agents for Nursing Professionals

This presentation by a pharmacist from Brigham & Women's Hospital presents information on the classes of antiretroviral medications, interactions with the HIV viral life cycle, drug resistance, laboratory testing and monitoring, management of HIV infection and considerations in a patient's treatment regimen. Occasional quiz questions are presented to reinforce concepts and ensure understanding.

Adherence Overview

This presentation by Health Innovations discusses treatment adherence including the significance of HIV lab results such as CD4 count and viral load, HAART considerations, predictors of non-adherence, linkage to or retention in care, challenges and barriers to adherence and recommendations to increase the likelihood of adherence. The presentation also includes a component on health literacy and its relationship to adherence from the New York/New Jersey AIDS Education and Training Center. The NY/NJ AETC presentation is available at <http://aidsetc.org/resource/health-literacy-and-hiv-aids-overview>

Opportunistic Infections (OIs): Bacterial Respiratory Disease

This presentation by the AIDS Education and Training Center (AETC) Program discusses the epidemiology of bacterial respiratory infections, including pneumonia, enteric disease, and syphilis, as they relate to people living with HIV. A version of this presentation is available on the AETC National Resource Center website: <http://www.aidsetc.org/resource/bacterial-infections-0> (Click on Bacterial Infections – Comprehensive)

Opportunistic Infections: Mycobacterial Infections

This presentation by the AIDS Education and Training Center (AETC) Program discusses the epidemiology of mycobacterial infections, including mycobacterium tuberculosis and mycobacterium avium, enteric disease, and syphilis, as they relate to people living with HIV.

RESOURCES STRATEGY 1: Training the Peer-Nurse Team

Presentations from Session 3 SPECTRuM Nurse HIV Overview Training (cont.)

Opportunistic Infections: PCP Toxo Pneumocystis Jiroveci Pneumonia, HPV, Hepatitis C, and HBV Hepatitis V

These four presentations developed by the AIDS Education and Training Center (AETC) discuss the epidemiology of these opportunistic infections as they relate to people living with HIV.

Oral Health: the Role of the Primary Care Team

This presentation from the New York/New Jersey AIDS Education and Training Center is designed to assist primary care providers in determining the levels of urgency in referring patients to see a dentist for various types of oral lesions. Attached YouTube videos are supplements demonstrating the need for HIV testing in dental clinics as well as providing a resource for head and neck exams for health care providers. This presentation can be found on the AETC National Resource Center website: <http://aidsetc.org/resource/oral-health-role-primary-care-team>

Depression as a Medical Comorbidity of HIV Infection

This presentation from the New York/New Jersey AIDS Education and Training Center discusses depression among people living with HIV, including common depressive disorders, with an emphasis on major depression. The presentation includes symptoms, screening tools, treatment as a medical comorbidity of HIV, associations between psychiatric/substance use disorders and HAART, and interventions. This presentation can be found on the AETC National Resource Center website:

http://aidsetc.org/sites/default/files/resources_files/nynj_HIV_Infection_and_Depression_6_12_12.ppt

HIV Drug Chart

This quick-reference chart compares available medication options, including dosing and dietary restrictions, for all the classes of HIV medications. Available on the web at

<https://www.poz.com/article/2015-drug-chart-27433-4509>

Comprehensive Guideline Summary: Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents

This presentation was developed using the May 2014 treatment guidelines. It reviews the guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents, developed by a working group of the office of AIDS Research Advisory Council within the Department of Health and Human Services. This presentation can be found on the AETC National Resource Center website:

<http://aidsetc.org/resource/guidelines-use-antiretroviral-agents-adults-and-adolescents-training-slide-sets>

(Click on Comprehensive Guidelines Summary)

Supplemental materials on linkage and retention in care

Below are supplemental materials for Session 4 Linkage and Retention in Care. These resources were culled from the results of an extensive literature review to select articles on linkage and retention in care that would be helpful for the nurses and peers as they planned activities and worked on PDSAs to improve services.

Reflections on Retention: Connecting to Care

by Bruce D. Agins MD, MPH

This PowerPoint presentation is a comprehensive review of retaining HIV patients in care: its importance; research to support health and financial benefits; how to define performance measures; and evidence-based, practical interventions for improving retention rates. This presentation, developed by the Office of Medical Director at the NYS DOH AIDS Institute, is based on a literature review and on several years of data provided by more than fifty HIV programs throughout New York State on their experiences improving patient retention rates. Available on the National Quality Center website at <http://nationalqualitycenter.org/resources/reflections-on-retention-connecting-to-care/>

Retention in HIV Care: A Guide to Patient Centered Strategies 2011

by Marla A. Corwin, LCSW, CAC III; Lucy Bradley-Springer, PhD, RN, ACRN, FAAN

Mountain Plains AIDS Education and Training Center, May 2011

This 26-page booklet provides teaching tools to help patients learn the basics of HIV self-care and retention in care. An updated version of this booklet is available on the University of Utah School of Medicine Website at <http://aidsetc.org/resource/retention-hiv-care-guide-patient-centered-strategies>

HIV Treatment Adherence, Patient Health Literacy, and Health Care Provider–Patient Communication: Results from the 2010 AIDS Treatment for Life International Survey

by Jean B. Nachega, MD, PhD; Chelsea Morroni, MPH, PhD; José M. Zuniga, PhD, MPH; Mauro Schechter, MD; Jürgen Rockstroh, MD, PhD; Suniti Solomon, MD; and Renslow Sherer, MD

Journal of the International Association of Providers of AIDS Care, March/April 2012 vol. 11 no. 2 128-133.

This article describes the results of the AIDS Treatment for Life International Survey, a multicountry cross-sectional study (January–March 2010) including 2035 HIV-infected adults. A 40-minute interview was conducted using a standardized self-report adherence questionnaire. Conclusion: “Optimal ART adherence remains a challenge globally. There is a critical need to improve patient–provider communication about the importance of ART adherence and its benefits for patient’s health.” The abstract of the article is publicly available (full article by subscription) on the JIAPAC website: <http://jia.sagepub.com/content/11/2/128.abstract>

How Should We Measure Retention in HIV Care?

by Thomas P. Giordano, MD, MPH

Medscape. Aug 15, 2012.

There is currently no gold-standard measure of retention in care, and the commonly used measures differ in several characteristics. With the increased attention on retention in care, clinicians, administrators, and policy-makers need to understand the nature of each measure as well as its strengths and limitations. This review describes the commonly used measures of retention, provides an overview of their characteristics and limitations, and highlights various situations in which they might be useful. Available on the Medscape website at <http://www.medscape.com/viewarticle/768913> (login required, free account)

Supplemental materials on linkage and retention in care (cont.)

No Gold Standard for Measuring Patient Retention in HIV Care

by Fran Lowry

Medscape, June 05, 2012.

This article reports on the results from a study of more than 10,000 patients at 6 academic HIV clinics presented at the 7th International Conference on HIV Treatment and Prevention Adherence in Miami Beach, FL.

Available on the Medscape website at <http://www.medscape.com/viewarticle/765092> (login required, free account)

Retention in HIV Care: The Scope of the Problem

by Bruce D. Agins, MD, MPH

Medscape, July 30, 2012.

This article describes the in+care campaign launched by the HIV/AIDS Bureau at the U.S. Health Resources and Services Administration (HRSA) and the National Quality Center (NQC) to galvanize improvement in retention across the United States through the Ryan White CARE Act programs. The in+care campaign offers a package of standardized measures, easy Web-based reporting, tracking of interventions, and no-cost technical support from experienced coaches to facilitate the development of improvement efforts. Available on the Medscape website at

http://www.medscape.com/viewarticle/768102_2 (login required, free account)

Retention in HIV Care: What the Clinician Needs to Know

by Thomas P. Giordano, MD, MPH

Retention in HIV Care, Volume 19 Issue 1 February/March 2011

This article summarizes a lecture by Dr. Giordano at the 13th Annual Clinical Conference for the Ryan White HIV/AIDS Program held in Washington, DC, in August 2010. Dr. Giordano explains how efforts to improve retention in care should incorporate informational, motivational, and behavioral skills components. He suggests practical steps that can be taken by clinics to improve retention. Available on the International Antiviral Society-USA (IAS-USA) website at

<https://www.iasusa.org/content/retention-hiv-care-what-clinician-needs-know>

Joint training for the peer-nurse team

A substantial portion of the training was dedicated to joint training of SPECTRuM peers and nurses. Training on how to work as a team, clarifying when the peer should work with the client and when the nurse should be called in, as well as motivational interviewing techniques, organization-specific training, and documentation were presented in joint training sessions. Below are some of the resources that were presented in these sessions.

Spectrum nurse technical assistance monthly site visit guide

Sessions 5-8 and Post-Session (Transition)

Part A: Talking Points (1.5 hours)



During the course of the 4 sessions, all of the items listed were discussed with SPECTRuM HIV nurses and peers. Timeline and frequency were driven by SPECTRuM HIV RN needs, status of project activities, and any issues/concerns that arose during implementation. The post-session was essentially a wrap-up session to tie up any loose ends and to discuss transition of patients from SPECTRuM intensive care coordination to standard HIV case management.

- Professional development needs
- RN role clarification
- RN/Peer role dynamic
- Integration of SPECTRuM program/staff with established HIV team
- Patient Recruitment Strategies and Identification of Entry Points
 - Internal/External
 - Informational and promotional materials development
 - Distribution & dissemination plan
- Clinical intake/assessment/service planning
- Access barriers/strategies to appointment adherence
 - Transportation, Location, Hours, Mode, Communication
- Focus on what motivates the patient/patient-centered approach: Do not ask “What’s the matter?”
Instead ask “What matters to you?”
- Identifying and broadening network of patient’s care provider team
 - Mental Health
 - Substance Use
 - Prison
 - Primary care & specialists
 - Home Care
 - Hospice & Palliative Care
 - ASOs
 - CBOs
 - Pharmacist
 - Social network (Family, friends, partners)
 - State agencies (DCF, DMH, etc)

RESOURCES STRATEGY 1: Training the Peer-Nurse Team

SPECTRuM nurse technical assistance monthly site visit guide (cont.)

- Team conferencing/Multidisciplinary team meetings
- Clinical supervision challenges/successes
- Late to care concerns: Hospice/palliative care/advanced directives/health care proxy
- Discharge planning from hospital/programs to SPECTRuM
- Specific challenges and strategies with regard to comorbid factors: mental health and substance use

Post-Session: Transition

- Transition planning from SPECTRuM to standard case management

Part B: PDSA or program activities progress/challenges/successes (1 hour) (See page 73 for an explanation of PDSA activities.)

- Helped SPECTRuM RN develop PDSAs
- Reviewed status of ongoing PDSAs
- Brainstormed new strategies for PDSAs

Part C: Case discussion/barriers/successes/strategies/next steps (1.5 hours)

Structured case discussion utilizing Case Review Form (next page). SPECTRuM nurses identified cases which were challenging or were examples of successful strategies to present. Technical assistance and feedback were provided accordingly, incorporating a lessons-learned and best-practices approach. Often, PDSAs were generated from these discussion affecting systems changes at the patient, provider and organizational level.

SPECTRuM nurse technical assistance case study presentation guide

Date: _____

Client ID: _____

Demographic Information:

Presenting Problem:

Medical History:

Substance Use History:

Mental Health History:

Psychosocial History:

Access to Care Barriers:

Medication Adherence Challenges:

Linkage/Retention Challenges:

Referrals:

Service Care Plan:

Provider Network:

Next Steps/Retention Strategies:

Case studies

The following case studies were used as a vehicle to train the SPECTRuM peer-nurse teams to work together to determine a course of action when working with an individual client.

CASE STUDY 1: DESTINY'S STORY

- 26 yr old Latina, MTF, homeless, crack cocaine abuser, sex worker, incarceration history, IDDM, PTSD, domestic violence
- PLWHA who had participated in van program brought patient to mobile clinic site at NEP
- Presented complaining of rectal bleeding; interested in STD screening due to unprotected sex with multiple partners
- Had not been engaged in care over 16 months; managed in resident practice of large medical institution
- AIDS diagnosis due to PCP; no current treatment
- Had burned bridge with local transgender program

CASE STUDY 2: JORGE'S STORY

- 45 yr. old Latino from PR, lifelong heroin abuser, incarceration history, chronic depression
- AIDS diagnosis due to CD4 of 130; has trouble remembering to take medication; no current treatment
- Presented complaining of inability to access suboxone program, buying them on street
- Had not been engaged in care over 8 months; managed in multidisciplinary team of large medical institution
- Very worried about upcoming court case, facing long sentence for drug-related charge due to multiple offenses
- Committed relationship for 3 years, no unsafe sex/needle use
- Recent two-week hospitalization for suicide attempt; using benzos with heroin, “went off deep end” - no OP mental-health care planned post discharge; waiting to see psychiatrist in one month

CASE STUDY 3: ARTHUR'S STORY

- 52-year-old African-American, incarcerated intermittently since age 16, presented at mobile health clinic held in public park
- Interested in STD testing due to possible exposure from partner. Initially hesitant but agreed to rapid HIV test which was reactive
- Past PCP care site contacted with patient's authorization; patient known to be HIV positive since 1998 but presumed dead by peers, had been lost to follow-up for 18 months
- Despite phone contact and offered medical escorts, did not keep appointments. Patient later disclosed HIV status
- Assessment identified patient in weekly substance abuse support program, and patient provided father's phone number as emergency contact

Case discussions and technical assistance

In Sessions 5-8, the SPECTRuM peer-nurse teams were invited to present their own challenging cases, using the case study presentation guide (p. 71) to collect information. The group analyzed the case, brainstormed possible interventions and came up with a preliminary solution. The team would then try that solution, record what happened, and then reassess the intervention to determine its effectiveness in a cycle of continuous improvement. Using a Plan-Do-Study-Act (PDSA) framework, the team would evaluate and enhance the intervention until they felt it was as effective as possible. More about the PDSA approach to process improvement can be found on the Health Resources and Services Administration (HRSA) website at <http://www.hrsa.gov/quality/toolbox/methodology/testingforimprovement/index.html> In one instance where the group felt additional expertise was needed, an outside consultant with knowledge and experience in working with clients with substance use issues was called in to help determine an appropriate course of action.

Client self-advocacy presentation

Client Self-Advocacy

SPECTRuM Project



1

Some Confusion



Some people think self advocacy is:

- an opportunity to control someone else
- an opportunity to get angry when you feel you have been treated unfairly
- an opportunity to be treated more special than someone else

Anyone has the opportunity to self-advocate

4

What is Self-Advocacy?

Self-advocacy is:

- The ability to speak-up
- To ask for needs and wants
- To share about thoughts and feelings
- To know and understand rights and responsibilities
- To seek help when needed
- To make informed choices



2

How do we Self-advocate?

Some steps to building self-advocacy in our clients

#1:

- Find out what the client expects or what motivates the client in any given situation
 - What does the client need/want/expect in this situation?
 - Why does the client need/want/expect this? (what is the motivation?)
 - What keeps the client from asking?
 - What does the client believe will happen if he/she has needs/wants/expectations?

#2:

- Practice with something easy
 - What is one small thing the client can expect? e.g. a question the client would like to ask the doctor or his/her employer
 - What is one thing the client expects from family members or a close friend - something the client can ask of them?

5

Why is Self-Advocacy Important?

Defines Expectations - when you speak up, you are able to articulate what you expect (this doesn't mean you will always get what you want, but you can always express it)

Control - when you are clear about what you expect, you have more control over decisions that affect you

Empowerment - with defined expectations and a clear understanding of control, you feel empowered, because you are in charge of yourself

3

Steps to Building Self-advocacy

#3

- Help a client think of a situation where they want to speak up for themselves

#4

- Help a client plan how they want to speak up
 - What does he/she want to say?
 - How do he/she want to say it?
 - What will this client need at the time of speaking up that will give this client confidence (a reminder in the form of an object, some notes)

6

Client self-advocacy presentation (cont.)

Steps to Building Self-advocacy

- #5 Have the client role play with you (provider) or a family member so that the client can practice
- #6 Anticipate with the client future situations where speaking up is important
- #7 Practice, practice, practice and talk about what worked and didn't work when the client spoke up

7

Case Example

Initial client information:
 Client was not taking his medication and repeatedly let his insurance lapse. Client took his medication after work (midnight), but wanted to play video games to relax and couldn't because the medication made him drowsy, so he stopped taking it. Client never opened mail and therefore had no knowledge when his insurance was expiring.

Current Status:
 Taught client that going through mail made a difference in planning - e.g. insurance translates into information for medical providers on upcoming appointments (they would have the most current information). Accompanied him when he applied to cooking school so that he could understand the concept of planning and execution of a plan. He is currently attending school, opens his mail and has a goal; being motivated has encouraged him to advocate for himself and better manage his care.

10



8

Other Case Examples

Discussion

11

Case Example

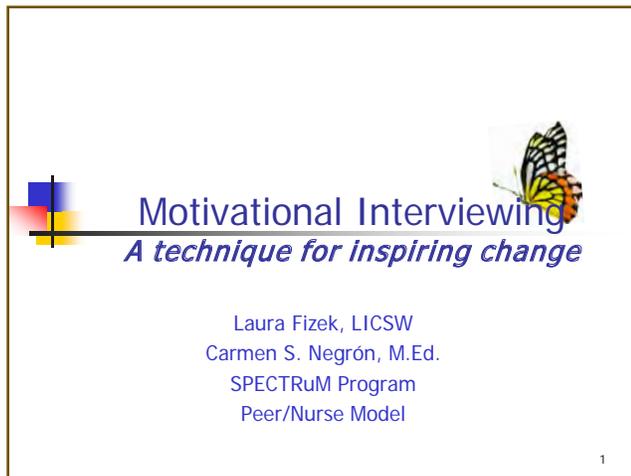
Female client with complex health issues (needing dialysis) who is dependent upon her son for her medical appointments and other supportive services; son is her current mouthpiece. She speaks English (although her second language), but seems to rely on her son for understanding. She is unable to advocate for even the smallest things (requesting the use of a phone during her dialysis). There is a question of her cognitive functioning. Gerry has requested some cognitive testing. She has been repeatedly denied PT1 transportation services. She missed her last doctor's appointment.

- What will happen when the son isn't there to manage her English?
- How could you get this client to practice self-advocacy?
- What are some possible new strategies to help her?

9

Motivational interviewing workshop

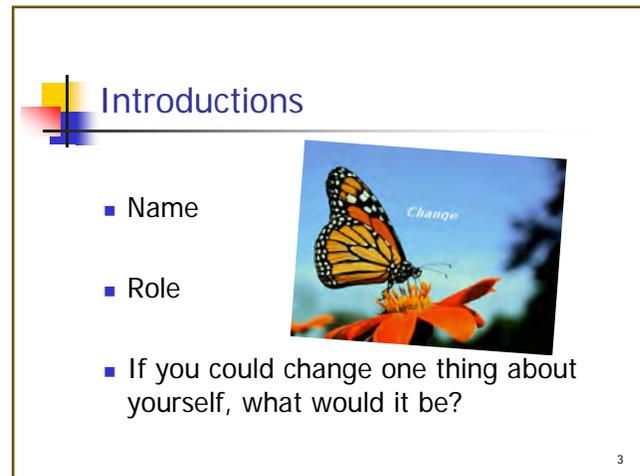
This technical assistance workshop offers an in-depth exploration of the principles and skills of Motivational Interviewing, a proven effective approach to working with clients toward changing behavior. The peer-nurse model is aimed at addressing the needs of those clients who are most at risk for either not engaging in care or falling out of care. Motivational Interviewing provides a way of working with clients that encourages client involvement in their own care and treatment. For more information about motivational interviewing techniques, please consult *Motivational interviewing: Helping people change* by Miller, W. R., & Rollnick, S. (Guilford press, 2012).



Motivational Interviewing
A technique for inspiring change

Laura Fizek, LICSW
Carmen S. Negrón, M.Ed.
SPECTRuM Program
Peer/Nurse Model

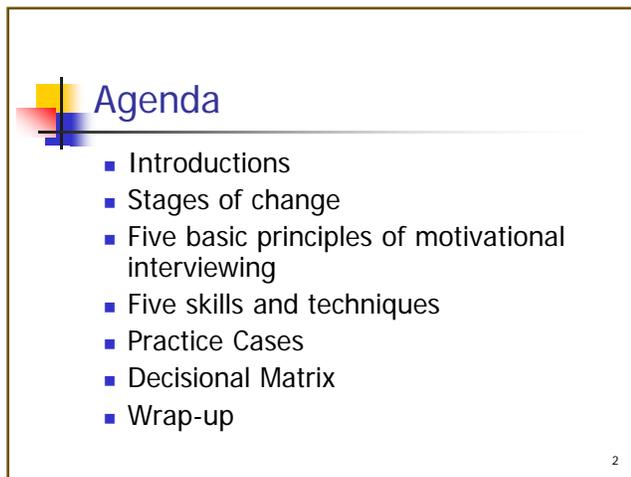
1



Introductions

- Name
- Role
- If you could change one thing about yourself, what would it be?

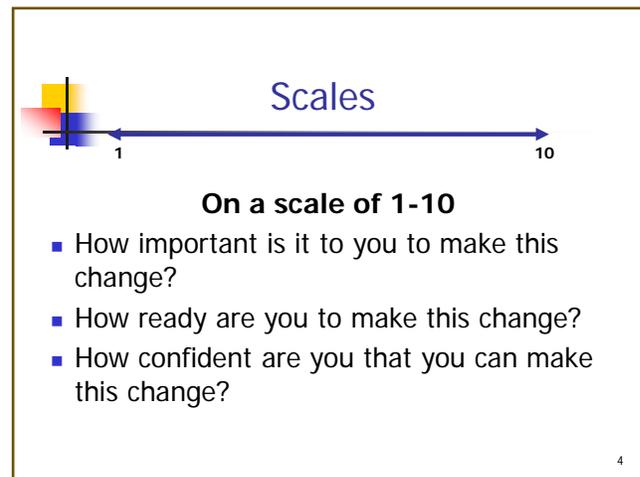
3



Agenda

- Introductions
- Stages of change
- Five basic principles of motivational interviewing
- Five skills and techniques
- Practice Cases
- Decisional Matrix
- Wrap-up

2



Scales

1 ————— 10

On a scale of 1-10

- How important is it to you to make this change?
- How ready are you to make this change?
- How confident are you that you can make this change?

4

Motivational interviewing workshop (cont.)

5 Rules for Being Human

1. You will learn lessons.
2. There are no mistakes – only lessons.
3. A lesson is repeated until it is learned.
4. If you didn't learn the easy lessons, they get *harder*. (Pain is one way the universe gets your attention.)
5. You'll know you've learned a lesson when your actions change.

From "Failing Forward" by John Maxwell.

5

What it is:

- A way of working with a client that...
 - ...allows the client to decide what changes they want to make.
 - ...puts the burden of change in the client's hand.
 - ...emphasizes the relationship as the primary means of making effective and lasting change.
- A frame of mind, rather than a concrete tool.
- A collection of skills and ideas you are probably already using, with your clients and in your own life.



8

What is Motivational Interviewing?



6



Change seats!

9

What it is *not*:

- Motivational interviewing is not a magic bullet.
- It is not mysterious.
- It will not make you a better worker overnight.
- It is not a set of "rules" or "how to" instructions.

7

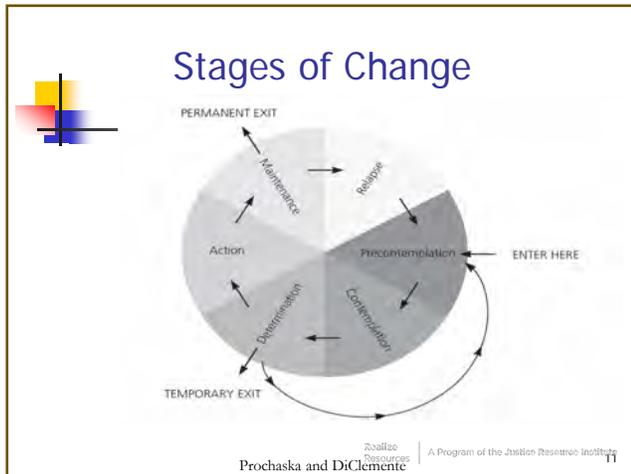
People change when they...

- ...hurt enough that they have to.
- ...learn enough that they want to.
- ...receive enough that they are able to.

From "Failing Forward" by John Maxwell

10

Motivational Interviewing Workshop (cont.)



Motivational interviewing *is not only a technique, but a set of basic assumptions that inform how we work with clients*

- Everyone needs coping skills and in general, people find a strategy that works for them even if it is not the healthiest.
- People want to get better (whatever that means for them).
- People are the experts in their own lives.
- Ambivalence is normal.
- You cannot make someone change.
- People will change when they are ready and when the circumstances are right for them.
- Everyone has internal motivation, impacted by external influences.
- Internal motivation is stronger than external motivation (coercion).
- Our job is to tap into people's internal motivation.

14

Stages of Change

Precontemplation:

Client is not even aware of problem, or does not think it is a problem
Provider's role is to increase client's awareness.

Contemplation:

Contemplation: Client begins to think about problem
Provider's role is to tip the balance and strengthen client's self-efficacy for change

Determination:

Client Decides that he/she wants to make a change and **MAKES A PLAN FOR CHANGING.** (It is very important not to skip this stage.)
Provider's role is to help client determine best course of action.

Action:

Client begins to institute change.
Provider's role is to support client in changing. (Don't make the mistake of jumping to this stage too quickly.)

Maintenance:

Client maintains new, desired change.
Provider's role is to help client identify and use strategies to prevent relapse.

Relapse

Client reverts to previous behavior or functioning.
Provider's role is to help client renew process, beginning with whatever stage client is in following the relapse. **RELAPSE IS EXPECTABLE AND NORMAL.**

Termination

Client is no longer concerned about relapse, and does not have to work at maintenance. Many people never reach this stage, which is fine. Provider's role is to acknowledge all the work client did, and celebrate a successful change effort.

(Adapted from Prochaska&DiClemente, 1982)

12

Confrontation of denial and motivational interviewing *are two very different approaches to the client*

Confrontational

- Acceptance of self and problem is essential to change
- Emphasis on personality pathology, reducing personal choice
- Resistance is seen as 'denial' and met with argumentation and correction

Motivational Interviewing

- Acceptance of labels seen as unnecessary for change
- Emphasis on personal choice and responsibility for deciding behaviors
- Resistance is seen as interpersonal behavior patterns and is met with reflection

15

Exercise

- How did you come to decide this was a change you needed – or wanted – to make?
- Who and what influenced your thinking?
- If you made changes, what were they?
- What did you need to put in place before you could make the change?
- Who did you tell?
- Who supported you? Who was not supportive?
- Were you able to maintain the change?

13

Motivational interviewing *is a client-centered approach to counseling to elicit behavior change by exploring and resolving ambivalence*

- Motivation to change is elicited from the client and not imposed by the worker.
- The client has the task of articulating and resolving his/her ambivalence.
- Persuasion is not an effective method for resolving ambivalence.
- The counseling style is generally a quiet and eliciting one.
- The counselor is directive in helping the client examine and resolve ambivalence.
- Readiness to change is not a client trait, but a fluctuating product of interpersonal interaction.
- The therapeutic relationship is more like a partnership or companionship than expert/recipient roles.

16

Motivational interviewing workshop (cont.)

Motivational interviewing *consists of five general principles*

- Express empathy
- Develop discrepancy
- Avoid argumentation
- Roll with resistance
- Support self-efficacy

17

Avoiding argumentation *instills trust*

- **Arguments are counterproductive.** Confrontation builds defensiveness, and people tend to dig in their heels further. If you make a statement to a client about his/her behavior you are in effect asking him/her to argue the other side.
- **Resistance is the provider's problem, not the client's.** If you encounter resistance, it signals that you are not doing work appropriate to the identified stage of change, and you are not accepting the client. When you meet resistance, do not try to overpower it. Change strategies.
- **Do not label clients.** It is unnecessary, and counterproductive, to label clients (e.g. "alcoholic", "addict", "in denial"). Behavior is important; labels are not.

20

Expressing empathy *engages the client*

- **Acceptance is key.**
Accept clients for who, what, and where they are, without trying to change them.
Acceptance does not necessarily mean agreement or approval.
Paradoxically, acceptance of people *as they are* frees them to change.
- **Empathy is not sympathy.**
The provider does not join the client in his or her perspectives, but rather responds to them as understandable, comprehensible, and valid.
- **Change is difficult.**
Provider recognizes (and helps the client to recognize) that if change were easy it would have happened long ago.

18

Rolling with resistance *makes room for self-determination*

- **Use the client's energy and momentum to your advantage.** Follow them to an outcome that works for the client in that particular moment.
- **Offer new perspectives.** Invite client to take what works and leave the rest.
- **Utilize the client's expertise.** If you encounter "Yes, but..." ask the client what solutions s/he sees.

21

Developing discrepancy *allows the client to make informed decisions*

- **Highlight discrepancy** between where the client is and where the client wants to be, using *the client's* statements.
- **Use ambivalence** to help client move through the process of change. Ambivalence is normal, and is a valuable tool.
- **Acknowledge and support** the arguments for change as the client has expressed them.
- **Gently point out consequences** of maintaining status quo. Ask how this behavior (or action) will hinder or help client in moving towards his or her stated goals.

19

Supporting self-efficacy *actualizes self-determination*

- **Self-efficacy** refers not only to the ability to do something for one's self, but the *belief* that one has the ability to carry out and succeed with a given task.
- **People with chronic disease** may be particularly at risk for low self-efficacy, and often feel powerless to change their lives, as well as hopeless about the outcome. People cannot change their behaviors until they fully believe in their ability to do so.
- **The provider's expectations** can have a powerful impact on the outcome. Avoid a self-fulfilling prophecy of failure. Instead, build a collaborative, mutual experience of success.

22

Motivational interviewing workshop (cont.)

Supporting self-efficacy *actualizes self-determination*

- **Use the success of others as a model** for positive change, and to encourage clients. Do not use these examples to pressure clients, but rather to support them.
- **If a particular approach fails, try another.** A wide range of options and approaches to change are available. As long as clients keep trying, they have not failed.
- **No one can change anyone else.** Remind clients that if they want to change, only they can do it. The work is hard, but the rewards are great.

23

Motivational interviewing *skills* *explore the meaning behind client statements.*

Reflective Listening:

- Train yourself to think reflectively
- Realize what you believe or assume that people mean is not necessarily what they really mean
- Reflective statements are checking out a client's reality in a neutral way
- It is a statement, not a question.

26

Motivational interviewing *includes 5 basic skill techniques*

- Open-ended questions
- Reflective listening
- Affirmations (support, encourage, recognize client issues)
- Summary statements
- Self-motivational statements

24

A wise man once said:

"Different stuff means different things to everyone."
Terry Francona



27

Motivational interviewing *skills open the door for exploration*

Open-ended Questions:

- ◊ *What would you like to happen?*
- ◊ *Who will be most affected by this change?*
- ◊ *What possibilities do you see?*
- ◊ *How have you made changes in the past?*
- ◊ *What concerns do you have?*
- ◊ *When have you struggled with this?*
- ◊ *How will you know if you have made the change?*
- ◊ *What would happen if you tried something else?*

Avoid "Why" questions, which tend to evoke a defensive response. Beware of the Question/Answer trap-interrogation type. Try not to ask Yes/No questions, although sometimes they are useful, and unavoidable.

25

Reflective listening example:

C: *I know the drugs are messing up my life, but I've never had sex when I'm not high.*
P: *You can't imagine having sex without using drugs.*
C: *Oh, I can imagine it – it would be horrible.*
P: *You think you won't enjoy sex if you are sober.*
C: *It's not a question of enjoying it. I'm not even sure I could do it.*
P: *You're concerned that if you're not high you wouldn't be able to have sex.*
C: *The drugs help me relax and feel good about myself.*
P: *You want to know that if you stop using drugs you'll still be able to relax and enjoy sex.*
C: *Yes!*

28

Motivational interviewing workshop (cont.)

Motivational interviewing

affirms the client's strengths and internal resources, and recognizes the client's struggles

Client strengths and internal resources:

- C:** *I told a good friend of mine that I couldn't get high, because I have an addiction problem*
- P:** *It sounds like it was important for you to be honest with your friend. How did that go for you?*
- C:** *I was scared that we wouldn't be friends anymore, but he was really supportive and before I told him, I wrote down all the reasons why I can't high right now – just like we talked about last week.*
- P:** *That's great. You really identified what was important to you and were able to share that with your friend*

29

Motivational interviewing

utilizes summary statements to reinforce what client has shared and to support client to move on

Summary statements reinforce the comments made and allow the provider to hold the client's ambivalence.

- C:** *I try to be careful, but I know something could happen and I might infect my partner. I wish I could tell him, because I don't want him to get sick, and I hate lying to him. But I'm so scared that he'll be angry with me or maybe want to leave me.*
- P:** *I can hear that you are trying to balance your love for your partner and your concern for his health, with your fear of his reaction.*

32

Motivational interviewing

affirms the client's strengths and internal resources, and recognizes the client's struggles

Recognize the client's struggle:

- C:** *I went out last night and all my friends were getting high and I didn't. That was really hard.*
- P:** *I know you have been struggling with making this kind of change socially and that's really difficult.*
- C:** *I want to be able to keep my friends, but they are all still using and I can't right now.*
- P:** *It sounds like you are really torn between your loyalty to your friends and your commitment to staying clean for right now.*

30

Motivational interviewing

utilizes summary statements to reinforce what client has shared and to support client to move on

Summary statements pull together the client's statements and allow forward movement.

- C:** *I have friends who are in AA and I've heard of acupuncture detox, but I don't know if I could take the needles. But I'm thinking maybe I need something more long-term, more intensive. It's so overwhelming to have all these choices; I don't know which way to turn.*
- P:** *There ARE a lot of options out there. You've named several: some you are familiar with, some less so. If you try to do it all at once it can be paralyzing. How about if we pick one and flesh it out a bit?*

33

A .300 batting average...

Two ways to look at it:

1) 70% of the time you fail.

OR

2) You need 3 hits in a game, and you usually get about 10 chances per game.



31

Motivational interviewing

elicits self-motivational statements

- *I feel like hell after I use a lot of crystal meth.*
- *My drinking might be a real problem for me.*
- *I am scared I am going to lose my job/partner/kids.*
- *I don't want to get Hep C on top of everything else.*
- *After my success last night, I am determined to change.*

34

Motivational interviewing workshop (cont.)

Decisional matrix

is an effective tool to address the client's ambivalence

- Benefits of status quo
- Costs of Status quo
- Benefits of change
- Costs of change



35



III.
I walk down the same street.
There is a deep hole in the sidewalk.
I see it is there.
I still fall in...it's a habit.
My eyes are open.
I know where I am.
It is my fault.
I get out immediately.

IV.
I walk down the same street.
There is a deep hole in the sidewalk.
I walk around it.

V.
I walk down another street.

38

Case Examples

- 35 year old Latina (female) has heard that once you start medication, you get sicker. She has been living with HIV for 10 years. She is thinking of going on medication, because her doctor says she needs to.
- 45 year old White male with history of substance use, shares that he is having sex with men, is HIV+, married and is contemplating telling his wife.
- 42 year old White female is using again and missed 2 appointments, but recently called you because she isn't feeling well and wants to meet with you.
- 36 year old Black male who was recently diagnosed and is struggling with accepting his status.

36

Motivational Interviewing

A technique for inspiring change



Questions
Comments
Thank you!

39

Autobiography in Five Short Chapters

by Portia Nelson

I.
I walk down the street.
There is a deep hole in the sidewalk.
I fall in.
I am lost... I am helpless.
It isn't my fault.
It takes forever to find a way out.

II.
I walk down the same street.
There is a deep hole in the sidewalk.
I pretend I don't see it.
I fall in again.
I can't believe I'm in the same place.
But, it isn't my fault.
It still takes a long time to get out.

37

Motivational interviewing tips

JRI put together this tip sheet as a reinforcement to the lessons learned during the Motivational Interviewing workshop.



Motivational Interviewing Tips *A technique for inspiring change*

What is Motivational Interviewing?

A way of working with a client that:

- allows the client to decide what changes they want to make.
- puts the burden of change in the client's hand.
- emphasizes the relationship as the primary means of making effective and lasting change.

A frame of mind, rather than a concrete tool.

A collection of skills and ideas you are probably already using with your clients and in your own life.

Stages of Change

Precontemplation:

Client is not even aware of problem, or does not think it is a problem
Provider's role is to increase client's awareness.

Contemplation:

Contemplation: Client begins to think about problem
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Determination:

Client decides that he/she wants to make a change and **MAKES A PLAN FOR CHANGING**. (It is very important not to skip this stage.)
Provider's role is to help client determine best course of action.

Action:

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Provider's role is to support client in changing. (Don't make the mistake of jumping to this stage too quickly before a feasible, realistic plan is made.)

Maintenance:

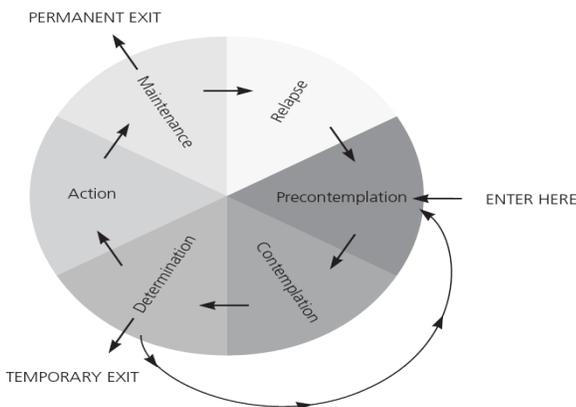
Client maintains new, desired change.
Provider's role is to help client identify and use strategies to support new, desired change and prevent relapse.

Relapse:

Client reverts to previous behavior or functioning.
Provider's role is to help client renew process, beginning with whatever stage client is in following the relapse. **RELAPSE IS EXPECTED AND NORMAL**.

Termination:

Client is no longer concerned about relapse, and works much less at maintenance. Many people never reach this stage, which is fine. Provider's role is to acknowledge all the work client did, and celebrate a successful change effort and new state of being.



Motivational interviewing tips (cont.)

5 General Principals

1. Express empathy
 - acceptance is key
 - empathy is not sympathy
 - recognize change is difficult
2. Develop discrepancy
 - highlight discrepancy
 - use ambivalence
 - acknowledge and support
 - gently point out consequences
3. Avoid argumentation
 - arguments are counterproductive
 - resistance is the provider's problem, not the client's
 - do not label clients
4. Roll with resistance
 - use the client's energy and momentum to your advantage
 - offer new perspectives
 - utilize the client's expertise
5. Support self-efficacy- the *belief* that one has the ability to carry out and succeed with a given task
 - use the success of others as a model to support, not pressure the client
 - if a particular approach fails, try another
 - remember no one can change anyone else.

5 Basic Skill Techniques

- Open-ended questions
 - Avoid "why" questions which tend to evoke a defensive response
 - Try not to use too many "Yes/No" questions
- Reflective listening
 - Realize what you believe/assume people mean may not necessarily be what they mean
 - Reflective statements are not questions. It is checking out a client's reality in a neutral way
- Affirmations (support, encourage, recognize client issues)
- Summary statements
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5 Rules for Being Human:

1. **You will learn lessons.**
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4. **If you didn't learn the easy lessons, they get harder. (Pain is one way the universe gets your attention.)**
5. **You'll know you've learned a lesson when your actions change.**

From "Failing Forward" by John Maxwell.



SPECTRuM supervision workshop

A supervision workshop was held for all SPECTRuM peer-nurse teams and their supervisors. The goals of this workshop were to help participants identify and understand best practices in supervising, being supervised, and managing a team model; understand and apply a SPECTRuM supervisory framework; and understand the value of the respective roles. Slides from this workshop can be found on the next page.

Workshop Description:

- Good and quality supervision is important because it sets expectations for work performance, develops the employee (skill, knowledge, job satisfaction)
- Skills are acquired through learning. This can be through training, mentoring, shadowing, hands-on experience and use
- Knowledge is acquired through resources: materials, training

Job satisfaction is something that a supervisor should always check-in about in terms of what works about the job and what doesn't. In this way, the supervisor is able to address issues before they become unmanageable, and meets the needs of the organization. Ideally, the supervisor and employee work in a collaborative way to achieve optimal work performance from the employee as well as build the capacity of the employee to grow while meeting important program goals for the organization.

This technical assistance workshop provides the framework for program managers supervising peers within the context of this new nurse/peer program model. There is special attention paid to supervising peers as well as the approach to supervising within a dyad team.

Presentation: SuperVision in support of the SPECTRuM project

SuperVision for the SuperVisor,
SuperVisee and for the SuperTeam

In support of the SPECTRuM Project

Laura Fizek, LICSW



1

Qualities of Good and Poor Supervision

- Individually draft a list of characteristics/qualities of good and poor supervision based on your past experiences
- Divide into 2 groups
 - Share your lists
 - Place on the stick figure where this affected you physically, psychologically, emotionally

4

Goals

- To identify and understand best practices in:
 - Supervising
 - Being supervised
 - Managing a team model
- To understand and apply a SPECTRuM supervisory framework
- To understand the value of the respective roles

2

Discussion

- In what ways were you effective at your task/job?
- In what ways were others in that environment supports or barriers?
- In what ways did supervision encourage you?
- In what ways did supervision discourage you?

5

Guidelines for the Day

3

Design the SPECTRuM Ideal Supervisory Structure

6

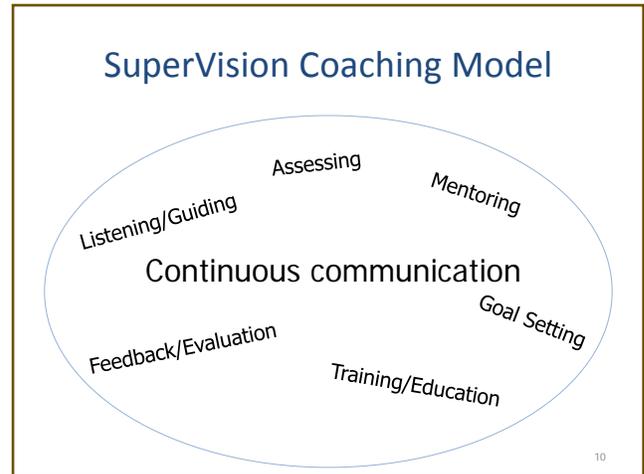
Presentation: SuperVision in support of the SPECTRuM project (cont.)

SPECTRuM Supervisory Structure

How does this operate within your program?

- How often do you meet?
- What occurs at those meetings?
- Who is present at the meetings?
- How do you set goals?

7

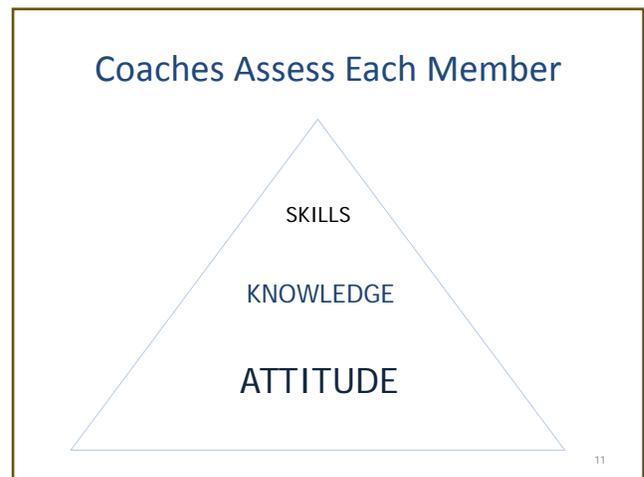


SuperVisor as a:
Coach

SuperVisee as a:
Key Player

SuperTeam as an:
Operation
(how we get it done)

8



Coaches Know How to Tap into Our Potential

- A coach is someone who is responsible for guiding people to winning results through a continuing process of discovery and thus working with each individual's strengths and challenges
- A coach needs to know who you are and what you can and cannot do, what your and the organization's goals are and how to help you achieve them
- A coach is able to support the team by building team strength and collaboration and reducing divisiveness

9

Expectations

- Assessment
- Mentoring
- Goal setting
- Training/Education
- Feedback/Evaluation
- Listening/Guiding

12

RESOURCES STRATEGY 1: Training the Peer-Nurse Team

Presentation: SuperVision in support of the SPECTRuM project (cont.)

Team Exercise

13

Components of a Well-Functioning Team

- Team recognizes strengths and gaps of others and understands each member's role and how it contributes to the solutions
- Team pays attention to own problem-solving process and the importance of ongoing communication about clients
- Team understands overall problems and goals and each does his/her part in finding solutions

16

Survival on a Deserted Island

1. Break out into teams
2. Each team is stranded on a tropical island
3. The island has a volcano, banana trees and coconut trees
4. Each team will get additional survival resources
5. The objective is to create a plan of survival
6. You must use ALL of your resources in the plan and everyone must participate
7. Document plan on newsprint

14

SuperVision Coaching Model

Continuous communication

- Assessing
- Mentoring
- Goal Setting
- Training/Education
- Feedback/Evaluation
- Listening/Guiding

17

The SPECTRuM Island

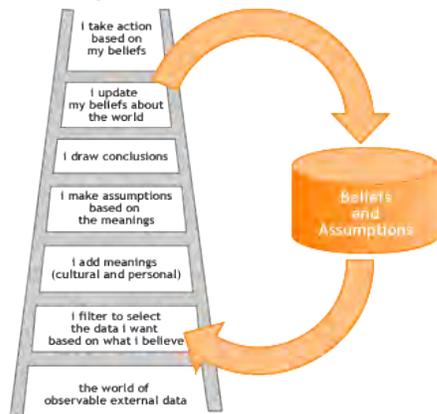
15

Importance of Listening and Guiding

18

Presentation: SuperVision in support of the SPECTRuM project (cont.)

Climbing the Ladder of Inference



19

The Importance of Feedback

Motivate

- Positive feedback can increase supervisee confidence and encourage individuals to continue at or above present level of performance
- Positive feedback encourages supervisees to take on challenges that they may otherwise forgo

Change

- Addressing issues/performance that need to be altered can increase feelings of confidence
- Creating a system where feedback is part of the supervisory relationship encourages self-efficacy

22

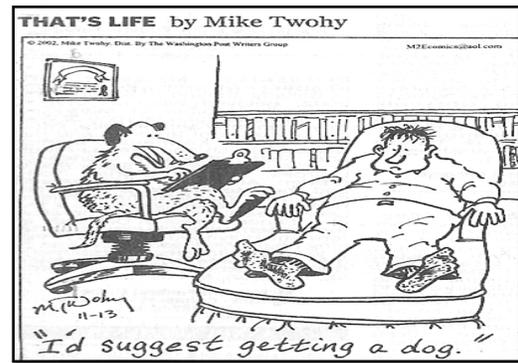
Three Ways to Improve Communication

- Reflection
 - Becoming more aware of our own thinking and reasoning
- Advocacy
 - Making our thinking and reasoning more visible to others
- Inquiry
 - Inquiring into other's thinking and reasoning



20

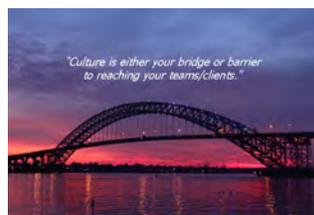
The Importance of Clarity



23

The Importance of Cultural Competency

- Culture/ethnicity
- Gender
- Sexual orientation
- Age
- Education
- Social class
- Physical and mental ability
- Learning style
- Personality
- Spiritual beliefs and practices



21

Specific Feedback

- You did a terrific job!
- I really liked the way you engaged the client when you met with him.
- The paperwork isn't filled out correctly.
- You have been late a lot!
- I was really impressed when you told the client that you had struggled with alcohol too.
- I could see that the client felt comfortable and was connecting with you as you were nodding while listening to her story.
- If the paperwork is missing the date, administration cannot process it and we don't get credit for the work we are doing.

24

SPECTRuM clinical supervision framework

Clinical Supervision for the Peer-Nurse Team

The following outlines the basic structure for recommended clinical supervision that should be provided for the nurse/peer team. It is recommended that the team be clinically supervised together to discuss cases and in the event that either the nurse or peer needs additional clinical time, the clinical supervisor will be available to support that request. Administrative supervision should be conducted within the parameters of the agency employing the nurse and the peer.

Recommended Structure:

- Meet with nurse and peer together
- Create guidelines and review confidentiality (initial meeting)

Basic Format:

- Check-in (a basic opening to the clinical supervision - to ask the nurse and peer how they are doing. This should be a regular agenda item)
- Discuss any client cases
 - o Relevant information
 - age, identified gender, ethnicity, race, language of choice
 - variables impacting the client's life
 - o Key issue(s) needing to be addressed
- How does this client (this work) affect you professionally/ personally?
- How does this client (this work) affect your nurse/peer team?
- What strengths does this client (this work) bring out in you and/or your nurse/peer team?
- What challenges does this client (this work) bring out in you and/or your team?
- What suggestions do you have to help you manage these challenges?
- What suggestions do you have to support and manage this client (this work)?

RESOURCES STRATEGY 1: Peer-nurse team services

SPECTRuM outreach protocol



In performing outreach calls to patients who are out of care, the following procedure will be followed:

Peer or nurse will make outreach call to reengage the patient in care

- (a) If the patient is reached, schedule appt if the patient was seen in last 6 months and contact and flag [staff member] to schedule intake with the patient if not seen in a year or more in clinic.
- (b) If the patient not reached, leave message and make follow-up call in one week.
- (c) If the patient does not respond after 2nd outreach call, send the patient letter.

Acuity assessment resources

The following tools were used to assess the acuity of client needs as part of the enrollment process and at intervals when conducting reassessments. For example, agencies complete the below SPECTRuM Acuity Tool for most clients within two weeks of enrollment, at the three-month mark, and at the six-month mark of service provision, at a minimum.

Massachusetts Department of Public Health (MDPH) and Boston Public Health Commission (BPHC) HIV/AIDS medical case management acuity tool*



HIV/AIDS Medical Case Management Acuity Tool Form
Massachusetts Department of Public Health
Boston Public Health Commission



Area of Functioning	Intensive Need (3)	Moderate Need (2)	Basic Need (1)	Self Management (0)
Adherence to Medical Care and Treatment & HIV Health Status				
HIV Care Adherence	<input type="checkbox"/> Has missed 2 or more consecutive HIV medical appointments in the last 6 months	<input type="checkbox"/> Has missed 1 or 2 (non-consecutive) HIV medical appointments in the last 6 months but has been seen by member of HIV medical team	<input type="checkbox"/> Has attended HIV medical appointments in the last 6 months as indicated by HIV medical provider	<input type="checkbox"/> Has attended all scheduled HIV medical appointments in the last 12 months as indicated by HIV medical provider
	<input type="checkbox"/> Requires on-going accompaniment or assistance with medical appointments due to limited language or cognitive ability	<input type="checkbox"/> Needs referral to or help accessing a culturally competent service provider (e.g. LGBT, linguistically appropriate, etc.)	<input type="checkbox"/> Needs assistance with making and keeping HIV medical appointments	<input type="checkbox"/> Does not require any assistance or reminders to schedule or keep medical appointments
Acuity Score:	<input type="checkbox"/> Has not been seen by HIV medical team in the last 6 months	<input type="checkbox"/> Requests accompaniments to medical appointments from MCM or other member of the care team		
Comments (include referrals needed):				

Area of Functioning	Intensive Need (3)	Moderate Need (2)	Basic Need (1)	Self Management (0)
Current HIV Health Status	<input type="checkbox"/> Has detectable VL and CD4 below 200	<input type="checkbox"/> Has detectable VL and is working towards viral suppression with the medical team	<input type="checkbox"/> Is on ARVs, in care, and being monitored by medical team, but unable to achieve viral suppression	<input type="checkbox"/> Is virally suppressed
	<input type="checkbox"/> Has current OI and is not being treated	<input type="checkbox"/> Has history of OI in last 6 months which are treated and/or client using prophylaxis (if indicated)	<input type="checkbox"/> Has no history of OIs in last 6 months	<input type="checkbox"/> Has no history of OIs in last 12 months
	<input type="checkbox"/> Has been hospitalized or visited the ER in last 30 days due to HIV related illness	<input type="checkbox"/> Has been hospitalized or visited the ER in last 6 months due to HIV related illness	<input type="checkbox"/> Has had no hospitalizations or visited the ER in last 6 months, but at least 1 hospitalizations or visit to the ER in the last 12	<input type="checkbox"/> Has no history of hospitalizations or visits to the ER in last 12 months due to HIV related illness
	<input type="checkbox"/> Newly diagnosed within last 6 months and concurrently diagnosed with AIDS	<input type="checkbox"/> Newly diagnosed within the last 6 months and/or is new to the MCM program		
Acuity Score:	<input type="checkbox"/> Demonstrates no understanding of HIV labs and lab results	<input type="checkbox"/> Demonstrates minimal understanding of HIV labs and lab results	<input type="checkbox"/> Demonstrates some understanding of HIV labs and lab results	<input type="checkbox"/> Demonstrates understanding/ Knows of HIV labs and lab results
Comments (include referrals needed):				

*An earlier version of this tool was used in the SPECTRuM intervention.

RESOURCES STRATEGY 1: Peer-Nurse Team Services

MDPH and BPHC HIV/AIDS medical case management acuity tool (cont.)

Area of Functioning	Intensive Need (3)	Moderate Need (2)	Basic Need (1)	Self Management (0)
Other Non-HIV Related Medical Issues	<input type="checkbox"/> Has been hospitalized or visited the ER for non-HIV related illness in last 30 days	<input type="checkbox"/> Has been hospitalized or visited the ER in last 6 months due to non-HIV related illness	<input type="checkbox"/> Has had no non-HIV related hospitalizations or visits to the ER in last 6 months, but at least 1 in the last 12	<input type="checkbox"/> Has no history of non-HIV related hospitalizations or visits to the ER in last 12 months
	<input type="checkbox"/> Has 2 or more non-HIV related illnesses (chronic or non-chronic) that impact health and care adherence	<input type="checkbox"/> Has a non-HIV related illness (chronic or non-chronic) that impacts health and care adherence	<input type="checkbox"/> Has no current non-HIV related medical issues, but past illnesses require monitoring by a medical provider	<input type="checkbox"/> Has no non-HIV related illnesses
	<input type="checkbox"/> Currently receiving treatment for non-HIV related medical conditions (e.g. chemo, dialysis, HCV, on-going dental complications, etc.) that impacts daily living	<input type="checkbox"/> Currently recovering from treatment for non-HIV related medical conditions (e.g. chemo, dialysis, HCV, on-going dental complications, etc.) that impacts daily living		
	<input type="checkbox"/> Requires assistance to make and keep non-HIV related medical appointments due to language or cognitive ability	<input type="checkbox"/> Needs referral to or help accessing a culturally competent service provider (e.g. LGBT, linguistically appropriate, etc.) for non-HIV related medical issues	<input type="checkbox"/> Requests assistance with reminders for non-HIV related medical appointments	<input type="checkbox"/> No assistance needed for reminders for non-HIV related medical appointments
Acuity Score:	<input type="checkbox"/> Requires accompaniments to specialty medical appointments due to language or cognitive ability	<input type="checkbox"/> Requests accompaniments to specialty medical appointments from MCM or other member of the care team	<input type="checkbox"/> Requests assistance with coordinating non-HIV related medical care	<input type="checkbox"/> No assistance needed with coordinating non-HIV related medical care
<i>Comments (include referrals needed):</i>				

Area of Functioning	Intensive Need (3)	Moderate Need (2)	Basic Need (1)	Self Management (0)
HIV Medication Adherence	<input type="checkbox"/> Misses HIV medication doses daily	<input type="checkbox"/> Misses HIV medication doses weekly	<input type="checkbox"/> Misses HIV medication doses monthly, or on occasion	<input type="checkbox"/> Rarely or never misses a dose of HIV medications
	<input type="checkbox"/> Needs and is not currently enrolled in directly-observed therapy (DOT) or other intensive adherence support	<input type="checkbox"/> Needs and is enrolled in DOT or other intensive adherence support		
	<input type="checkbox"/> Experiences adverse side effects that consistently impact adherence to HIV medication	<input type="checkbox"/> Experiences adverse side effects that occasionally impact adherence to HIV medication	<input type="checkbox"/> Experiences side effects, but manages them with no impact on adherence to HIV medication	<input type="checkbox"/> No side effect concerns reported
	<input type="checkbox"/> Demonstrates no understanding of correlation between medication adherence and achieving/sustaining viral load suppression	<input type="checkbox"/> Demonstrates minimal understanding of correlation between HIV medication adherence and achieving/sustaining viral load suppression	<input type="checkbox"/> Demonstrates some understanding of correlation between HIV medication adherence and achieving/sustaining viral load suppression	<input type="checkbox"/> Demonstrates full understanding of correlation between HIV medication adherence and achieving/sustaining viral load suppression
	<input type="checkbox"/> Demonstrates no understanding of basic health or prescription information (e.g. drug resistance, drug interactions, etc.) due language barriers or cognitive function	<input type="checkbox"/> Needs assistance to understand health and prescription information due to language barrier or cognitive function	<input type="checkbox"/> Needs some assistance to understand health and prescription information	<input type="checkbox"/> Manages health and prescription information with no assistance
	<input type="checkbox"/> Not on ARVS against medical providers advice	<input type="checkbox"/> Is starting new ARV treatment regimen	<input type="checkbox"/> Not on ARVs in consultation/support from medical provider	<input type="checkbox"/> On ARVs and does not need additional assistance
Acuity Score:	<input type="checkbox"/> Cultural beliefs around medication prevent client from taking medication as prescribed by medical provider			
<i>Comments (include referrals needed):</i>				

RESOURCES STRATEGY 1: Peer-Nurse Team Services

MDPH and BPHC HIV/AIDS Medical Case Management Acuity Tool (cont.)

Area of Functioning	Intensive Need (3)	Moderate Need (2)	Basic Need (1)	Self Management (0)
Insurance				
Health Insurance & HDAP Status	<input type="checkbox"/> Lacks health insurance (e.g. MassHealth/Medicaid, no access to employer-based health insurance, outside open enrollment period for private insurance, with no "qualifying event", etc.)	<input type="checkbox"/> Has health insurance and needs but lacks HDAP coverage	<input type="checkbox"/> Has health insurance, HDAP and/or other health benefits, but requires support to maintain coverage and complete re-certifications	<input type="checkbox"/> Has health insurance, HDAP and/or other health benefits and requires no support to maintain coverage and complete re-certifications
	<input type="checkbox"/> Is ineligible for Masshealth or other comprehensive insurance coverage (e.g. receives Health Safety Net)	<input type="checkbox"/> Client is uninsured and is awaiting enrollment (pending applications) in health insurance and/or other health benefits.		
Acuity Score:	<input type="checkbox"/> Has health insurance, HDAP and/or other benefits, but faces significant deductibles and/or medical co-pays.			
Comments (include referrals needed):				

Area of Functioning	Intensive Need (3)	Moderate Need (2)	Basic Need (1)	Self Management (0)
Sexual and Reproductive Health Status				
Sexual and Reproductive Health Status	<input type="checkbox"/> Does not or is unable to communicate with sexual partner(s) around sex and sexual health needs (e.g. negotiating condom use, PrEP use, partner's health status, etc.)	<input type="checkbox"/> Inconsistently communicates with sexual partner(s) around sex and sexual health needs (e.g. negotiating condom use, PrEP use, partner's health status, etc.)	<input type="checkbox"/> Requests support to communicate with sexual partner(s) around sex and sexual health needs (e.g. negotiating condom use, PrEP use, partner's health status, etc.)	<input type="checkbox"/> Consistently communicates with sexual partner(s) around sex and sexual health needs (e.g. can negotiate condom use, PrEP use, partner's health status, etc.)
	<input type="checkbox"/> Has not disclosed HIV status to sexual partner(s) and does not plan to	<input type="checkbox"/> Sometimes discloses HIV status to sexual partner(s)	<input type="checkbox"/> Has not disclosed HIV status to sexual partner(s) and requests assistance to do so	<input type="checkbox"/> Always discloses HIV status to sexual partner(s)
	<input type="checkbox"/> Demonstrates no understanding of HIV/HCV/STI transmission, and/or no understanding of correlation between HIV transmission and viral load suppression	<input type="checkbox"/> Demonstrates minimal knowledge of HIV/HCV/STI transmission, and minimal understanding of correlation between HIV transmission and viral load suppression	<input type="checkbox"/> Needs occasional assistance understanding HIV, HCV, STI transmission and/or assistance understanding correlation between HIV transmission and viral load suppression	<input type="checkbox"/> Demonstrates understanding of HIV, HCV, STI transmission, and/or understanding of correlation between HIV transmission and viral load suppression
	<input type="checkbox"/> Reports at least 1 STI in the past 6 months	<input type="checkbox"/> Reports at least 1 STI in the past 12 months	<input type="checkbox"/> No history of STI in the past 12 months	<input type="checkbox"/> Reports sexual abstinence
	<input type="checkbox"/> Engages in transactional sex (e.g. for money, drugs, a place to stay, etc.)		<input type="checkbox"/> No disclosure of HIV status to sexual partner(s), but maintains a suppressed viral load	<input type="checkbox"/> Sexual partner(s) currently on PrEP
Acuity Score:	<input type="checkbox"/> HIV+ female not on treatment and pregnant or desires pregnancy	<input type="checkbox"/> HIV+ female on treatment and is pregnant or desires pregnancy		
Comments (include referrals needed):				

RESOURCES STRATEGY 1: Peer-Nurse Team Services

MDPH and BPHC HIV/AIDS Medical Case Management Acuity Tool (cont.)

Area of Functioning	Intensive Need (3)	Moderate Need (2)	Basic Need (1)	Self Management (0)				
Mental Health								
Current Mental Health Status	<input type="checkbox"/>	Clinical diagnosis with no current mental health provider, no pending appointments, no desire and/or is resistant to seek treatment	<input type="checkbox"/>	Clinical diagnosis or otherwise engaged with a mental health provider, but inconsistent with appointment attendance and/or treatment adherence	<input type="checkbox"/>	Engaged with a mental health provider and is consistent with mental health treatment and/or appointments	<input type="checkbox"/>	No indication of need for clinical mental health assessment
	<input type="checkbox"/>	Currently awaiting treatment or appointment with mental health professional	<input type="checkbox"/>	Referral to a new mental health professional in the past 6 months	<input type="checkbox"/>	Receives MCM support to make and keep appointments with mental health professional	<input type="checkbox"/>	No support needed to make and keep appointments with mental health professional
	<input type="checkbox"/>	Consistent challenges with adherence to prescribed psychiatric medicines or treatment protocol	<input type="checkbox"/>	Moderate challenges with adherence to prescribed psychiatric medicines or treatment protocol (missed doses more than a few times a month)	<input type="checkbox"/>	Some challenges with adherence to prescribed psychiatric medicines or treatment protocol (occasional missed doses)	<input type="checkbox"/>	No challenges with adherence to prescribed psychiatric medicines or treatment protocol
	<input type="checkbox"/>	Indication of need for mental health support, clinical mental health assessment, and/or treatment and does not receive it	<input type="checkbox"/>	Needs referral to or help accessing a culturally competent mental health provider (e.g. LGBT, linguistically appropriate, etc.)				
Acuity Score:	<input type="checkbox"/>	Behavior relating to mental health status negatively impacts daily living, interactions with providers, and/or other social supports	<input type="checkbox"/>	MCM or other member of the care team is an integral part of mental health support (e.g. regular check-ins etc.)				
Comments (include referrals needed):								

Area of Functioning	Intensive Need (3)	Moderate Need (2)	Basic Need (1)	Self Management (0)				
Alcohol and Drug Use								
Current Substance Use	<input type="checkbox"/>	Chronic daily drug or alcohol use or dependence that consistently interferes with adherence to HIV care and treatment and/or activities of daily living and expresses no desire for treatment (e.g. methadone, Suboxone, detox, etc.)	<input type="checkbox"/>	Current or recent drug or alcohol use or dependence that sometimes interferes with adherence to HIV care and/or daily living	<input type="checkbox"/>	Current or recent drug or alcohol use does not interfere with adherence to care, treatment, and/or activities of daily living but MCM assesses a need for additional support or regular check-in	<input type="checkbox"/>	Current or recent drug or alcohol use that does not interfere with adherence to care, treatment, or activities of daily living.
	<input type="checkbox"/>	Intermittent engagement in drug and alcohol treatment (e.g. methadone, Suboxone, detox, etc.)	<input type="checkbox"/>	Currently in residential or inpatient treatment for drug or alcohol use	<input type="checkbox"/>	Currently receiving treatment for drug and alcohol use in an outpatient setting	<input type="checkbox"/>	Receives sufficient supports around past substance use and/or no indication of need for additional support
	<input type="checkbox"/>	Expresses a need or desire for drug or alcohol treatment (e.g. suboxone, methadone, detox, etc.) but has not yet received it	<input type="checkbox"/>	Currently on a wait list to receive treatment for substance use disorder	<input type="checkbox"/>	Currently attends 12-step groups (e.g. AA, NA, etc.)	<input type="checkbox"/>	No current or past issues with drug or alcohol use
	<input type="checkbox"/>	Imminent harm associated with substance use and no engagement/interest in harm reduction practices (e.g. sharing needles, naran, etc.)	<input type="checkbox"/>	Experiences harm associated with substance use with minimal ability to engage in harm reduction practices (e.g. sharing needles, naran, etc.)	<input type="checkbox"/>	Experiences harm associated with substance use with some ability to engage in harm reduction practices (e.g. sharing needles, naran, etc.)	<input type="checkbox"/>	No harm associated with current or past alcohol and drug use. Is able to engage in harm reduction practices (e.g. no needle sharing, carries naran, etc.)
Acuity Score:	<input type="checkbox"/>	Ongoing alcohol use in the context of liver disease (e.g., HIV/HCV co-infection etc.)						
Comments (include referrals needed):								

RESOURCES STRATEGY 1: Peer-Nurse Team Services

MDPH and BPHC HIV/AIDS Medical Case Management Acuity Tool (cont.)

Area of Functioning	Intensive Need (3)	Moderate Need (2)	Basic Need (1)	Self Management (0)				
Housing								
Current Housing Status	<input type="checkbox"/>	Currently lives in shelter or any place not meant for human habitation (e.g. street, car, etc.)	<input type="checkbox"/>	Has chronic challenges maintaining housing	<input type="checkbox"/>	Lives in permanent or stable/safe housing but needs short term rent or utility assistance to remain housed	<input type="checkbox"/>	Has stable and affordable housing that meets client's needs
	<input type="checkbox"/>	Current living situation has major health or safety hazards or limits the client's ability to care for themselves	<input type="checkbox"/>	Has difficulties managing ADLs (e.g. navigating stairs, showering) in current living situation	<input type="checkbox"/>	Requests assistance from MCM to complete paperwork to maintain eligibility for housing subsidies		
	<input type="checkbox"/>	Needs a referral to a supportive housing program and/or other in-home support services to remain safe in their home	<input type="checkbox"/>	Currently resides in a supportive housing program	<input type="checkbox"/>	Currently working with a MCM to maintain housing subsidy		
	<input type="checkbox"/>	Is expected to be released from incarceration in the next 3 months or was released from incarceration within the last 6 months	<input type="checkbox"/>	Lives in transitional/temporary housing or is doubled-up with no eminent loss of housing				
Acuity Score:	<input type="checkbox"/>	Faces imminent eviction or loss of current housing	<input type="checkbox"/>	Seeks to relocate in order to improve proximity to medical care, safety of housing environment, or access to services and supports	<input type="checkbox"/>	Currently working with a housing search and advocacy case manager		
Comments (include referrals needed):								

Area of Functioning	Intensive Need (3)	Moderate Need (2)	Basic Need (1)	Self Management (0)				
Legal								
Current Legal Status	<input type="checkbox"/>	Has urgent legal issues related to benefits access, discrimination, employment, health insurance coverage, housing, disability, eviction, or CORI	<input type="checkbox"/>	Has pending legal issues related to benefits access, discrimination, employment, health insurance coverage, housing, or disability (e.g. appeal for SSI)	<input type="checkbox"/>	Needs assistance completing standard legal documents	<input type="checkbox"/>	No current or recent legal issues
	<input type="checkbox"/>	Has time-sensitive need to complete standard legal documents (e.g., will, guardianship, etc.)	<input type="checkbox"/>	Needs linkage to services to address legal issues that impact ability to obtain needed services or benefits	<input type="checkbox"/>	Currently working with a provider to address legal issues	<input type="checkbox"/>	All desired legal documents are complete
	<input type="checkbox"/>	Has issues relating to immigration status						
	<input type="checkbox"/>	Currently on parole or probation						
Acuity Score:	<input type="checkbox"/>	Has outstanding warrants						
Comments (include referrals needed):								

RESOURCES STRATEGY 1: Peer-Nurse Team Services

MDPH and BPHC HIV/AIDS Medical Case Management Acuity Tool (cont.)

Area of Functioning	Intensive Need (3)	Moderate Need (2)	Basic Need (1)	Self Management (0)
Relationships and Support Systems				
Support Systems and Relationships	<input type="checkbox"/> Reports no close relationships, family, or supportive relationships	<input type="checkbox"/> Reports feeling isolated or unsupported in current relationships (e.g. family and friends)	<input type="checkbox"/> Reports having a support system, but identified need for regular check-ins from MCM	<input type="checkbox"/> Has satisfactory social support
	<input type="checkbox"/> Has not disclosed HIV status to any members of social support system due to stigma, language barriers, cultural beliefs around HIV, etc. which directly impacts social interactions	<input type="checkbox"/> Has disclosed HIV status to some members of support system which moderately impacts social isolation	<input type="checkbox"/> Has disclosed HIV status to most members of support system	<input type="checkbox"/> Has disclosed HIV status to all members of support system
		<input type="checkbox"/> Relies on MCM, peer, or other program staff for social support		
Acuity Score:	<input type="checkbox"/> Reports current or potential intimate partner violence and needs immediate intervention	<input type="checkbox"/> Has experienced intimate partner violence in the past that impacts current relationships, financial situation, housing status, etc.		<input type="checkbox"/> Past experience with intimate partner violence does not impact present care
<i>Comments (include referrals needed):</i>				

Area of Functioning	Intensive Need (3)	Moderate Need (2)	Basic Need (1)	Self Management (0)
Income				
Current Income/Personal Finance Management Status	<input type="checkbox"/> Has no stable income or benefits established and no identified source of financial support	<input type="checkbox"/> Income inadequate to meet basic needs at the end of every month for 3 or more months in a 6 month period	<input type="checkbox"/> Income occasionally (no more than 2 times in a 6 month period) inadequate to meet basic needs	<input type="checkbox"/> Has steady income; manages all financial obligations
	<input type="checkbox"/> Requires but does not receive public benefits such as SSI/SSDI and has no pending applications		<input type="checkbox"/> Requests support with benefits applications or other means to increase and manage income	<input type="checkbox"/> Receives benefits and requires assistance with maintaining benefits
	<input type="checkbox"/> Receives no public benefits such as SSI/SSDI and is ineligible to receive them due to immigration status			
	<input type="checkbox"/> Has immediate need for financial assistance to stay housed, maintain utilities, obtain food, or access medical care	<input type="checkbox"/> Expenses currently exceed income	<input type="checkbox"/> Requests assistance with budgeting	
	<input type="checkbox"/> Needs referral to representative payee	<input type="checkbox"/> Currently uses a representative payee		<input type="checkbox"/> No need for representative payee
Acuity Score:	<input type="checkbox"/> Application for benefits such as SSI/SSDI have been denied or are under appeal			
<i>Comments (include referrals needed):</i>				

RESOURCES STRATEGY 1: Peer-Nurse Team Services

MDPH and BPHC HIV/AIDS Medical Case Management Acuity Tool (cont.)

Area of Functioning		Intensive Need (3)	Moderate Need (2)	Basic Need (1)	Self Management (0)			
Transportation								
Current Transportation Status	<input type="checkbox"/>	Has limited or no access to transportation which impacts engagement in medical care, appointments, and other support services	<input type="checkbox"/>	Has PT-1 or agency transport vouchers/passes but requires MCM assistance to complete applications and/or maintain eligibility	<input type="checkbox"/>	Relies on PT-1 or agency supported transportation vouchers or family/friend	<input type="checkbox"/>	Has consistent and reliable access to transportation with no need for agency support
Acuity Score:	<input type="checkbox"/>	Has limited language or cognitive functioning that limits ability to coordinate transportation			<input type="checkbox"/>	Occasionally needs assistance with transportation to stay engaged in medical care		
<i>Comments (include referrals needed):</i>								

Area of Functioning		Intensive Need (3)	Moderate Need (2)	Basic Need (1)	Self Management (0)			
Nutrition								
Current Nutritional Status	<input type="checkbox"/>	Relies on food pantries, soup kitchens or other community food resources on a weekly basis	<input type="checkbox"/>	Relies on food pantries, soup kitchens, and other community food resources 1x per month or more	<input type="checkbox"/>	Relies on food pantries, soup kitchens, or other community food resources less than 1x per month	<input type="checkbox"/>	All nutritional needs are met and/or MCM assistance not needed to access food assistance
	<input type="checkbox"/>	Needs immediate linkage to medical care due to acute problems related to low body weight, poor appetite, nausea, vomiting, or other urgent health issues that impact nutritional status	<input type="checkbox"/>	Needs linkage to nutritional counseling to help manage chronic or non-urgent health issues that impact nutritional status	<input type="checkbox"/>	Needs information about nutrition, and/or food preparation to improve or maintain health		
	<input type="checkbox"/>	Needs a referral to obtain food related benefits (e.g. SNAP, WIC, etc.)	<input type="checkbox"/>	Receives food related benefits (e.g. SNAP, WIC, etc.) to meet nutritional needs for self or household	<input type="checkbox"/>	Needs assistance completing applications to maintain current food related benefits (e.g. SNAP, WIC, etc.)		
	<input type="checkbox"/>	Is ineligible for food related benefits (e.g. SNAP, WIC, etc.)	<input type="checkbox"/>	Relies on access to an agency food program in order to obtain adequate food				
Acuity Score:			<input type="checkbox"/>	Needs and is prescribed nutritional supplements to maintain health (e.g. Ensure)				
<i>Comments (include referrals needed):</i>								
Summary & Signatures								
Acuity Score:			Level of Need	(1-14) Basic Need				
Client Code:								
MCM Name:								
MCM Signature:								

RESOURCES STRATEGY 1: Peer-Nurse Team Services

Acuity assessment resources (cont.)

In addition to the above screening tool, the SPECTRuM project used several validated assessment tools which can be found on the Substance Abuse and Mental Health Services Administration (SAMHSA) website at <http://www.integration.samhsa.gov/clinical-practice/screening-tools>

CAGE-AID assessment tool

The below questionnaire used in the SPECTRuM project to assess substance use issues was adapted from the CAGE-AID questionnaire (the name of which is an acronym of its four questions: **C**ut down... **A**nnoyed... **G**uilty...**E**ye-opener - Adapted to **I**nclude **D**rug use).

Do you drink alcohol or use drugs? **Alcohol** **Drugs** **Both** **Neither**

If the client answers yes to using alcohol or drugs use the CAGE-AID assessment below. CAGE-AID is a quick questionnaire used to determine if an alcohol or drug assessment is needed.

In the last three months have you felt you should cut down or stop drinking or using drugs?

Yes **No**

In the last three month has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or using drugs?

Yes **No**

In the last three months have you felt guilty or bad about how much you drink or use drugs?

Yes **No**

In the last three months have you been waking up wanting to have an alcoholic drink or use drugs?

Yes **No**

Each affirmative response earns one point. A score of 1 indicates a possible problem; a score of 2 indicates a probable problem. Total Score:_____

If the client answers yes to two or more questions, a complete assessment is advised. Make appropriate referral. If the client has a score of 1 or higher, assess what the client is using and how much, and assess the impact the use is having on the client's adherence to HIV care and daily living. If client expresses interest in drug and/or alcohol treatment, make appropriate referral . Clients that answer no to all questions may still have needs related to substance use.

RESOURCES STRATEGY 1: Peer-Nurse Team Services

Acuity assessment resources (cont.)

GAD-7 assessment tool

The GAD-7 assessment was used in the SPECTRuM project to screen for anxiety. The Generalized Anxiety Disorder (GAD) 7-question screening tool identifies whether a complete assessment for anxiety is needed. Scores of 5, 10, and 15 are cut-off points for mild, moderate, and severe anxiety, respectively. When the score is greater than 10, further evaluation is recommended. The GAD-7 assessment can be found on the Substance Abuse and Mental Health Services Administration (SAMHSA) website at <http://www.integration.samhsa.gov/clinical-practice/GAD708.19.08Cartwright.pdf>

PHQ-9 assessment tool

The Patient Health Questionnaire (PHQ-9) is the most common screening tool to identify depression. It is available in Spanish, as well as in a modified version for adolescents. It can be found on the Substance Abuse and Mental Health Services Administration (SAMHSA) website at <http://www.integration.samhsa.gov/images/res/PHQ%20-%20Questions.pdf>

BMC communication and contact authorization form



METHOD OF CONTACT	YES/NO	MESSAGE	CONTACT INFORMATION
Home Phone	OK for agency to call? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, who may call?	Ok to leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what message may we leave?	() _____ - _____
Cell Phone	OK for agency to call? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, who may call? OK to text? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, who may text?	Ok to leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what message may we leave? If yes, what text message may we leave?	() _____ - _____
Work Phone	OK for agency to call? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, who may call?	Ok to leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what message may we leave?	() _____ - _____
Email	OK for agency to email? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, who may we email?	What may we say in the email?	Email Address:

RESOURCES STRATEGY 1: Peer-Nurse Team Services

Communication and contact authorization form (cont.)

Mail	OK for agency to send a letter? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, who may the letter be from?	What may we say in the letter?	Preferred mailing address:
Facebook	OK for agency to contact you on Facebook? <input type="checkbox"/> Yes <input type="checkbox"/> No	What may we say on the site?	Facebook name?

BMC enrollment email notification to staff

To: MDs, Nurses, Case Managers, Peer Navigators
CC: [Medical care team], Medical Director, Data Assistants
From: [peer or nurse]
Subject: SECURE: SPECTRuM Enrollment



The following patients were enrolled in SPECTRuM on the corresponding dates:

Name	MRN	MD/Nurse	CID Case Manager	CID Peer Navigator	Enrollment Date

Please note that I will be acting as the patients' case manager and peer and (along with [nurse name]) for the next six months and will perform all the necessary duties on behalf of the patient until they transition back into the CID clinic.
Please contact me if there are any questions.

Thanks!

[Peer signature]

[Peer name]
Program Coordinator-Peer Program
Medical Case Manager
SPECTRuM Peer Navigator and HIV Health Educator
Center for Infectious Diseases
Shapiro Center - 9th Floor
Suite 9B
Boston, MA 02118
T: 617-414-XXXX
M: 857-XXX-XXXX (for patients and emergencies)
Fax: 617-414-XXXX
Page: XXXX
[peer email]

BMC peer phone call scripts



Reminder calls script:

When person answers:

Hi, my name is (Peer name) from Boston Medical Center may I speak to (Patient name)?

- If the patient confirms you are speaking to them-->
 - How are you today? I am reminding you that you have an appointment with (Doctor, time and date).
 - o If patient can't make the appointment – reschedule in EWS
 - o If the patient says they are coming to the appointment you can take this opportunity to explain your role and if any issues arise you can ask the patient to meet with you in clinic during their appointment to discuss the issues
 - Document the conversation in Logician if any issues arrive

When you get a voice mail:

Hi, it's (Peer name) from Boston Medical Center reminding you that you have an appointment with [Doctor, time, date]. I hope to see you there. Please give me a call at 617-414-XXXX if you are having any issue getting here or need to reschedule. Thanks and have a great day.

No show call script:

When a person answers:

Hi, it's (Peer) from Boston Medical Center. How are you? We missed you at your appointment with Dr. [Dr. name] yesterday. Is everything OK? I would like to reschedule this for you. What is a good time and day? Is there anything we can help with that would make it easier for you to make your appointments?

When you get a voicemail

Hi, it's (Peer) from Boston Medical Center. We missed you at your appointment yesterday with Dr [Dr. name]. Please give me a call back at 617-414-XXXX to reschedule. We can talk about whatever would make it easier for you to make your appointments. Thanks and have a good day.

Reminders:

- Never mention HIV clinic: Only mention the doctor name (e.g., I am calling from Dr. Sullivan's office).
- Before calling the patient, check problem list and patient chart in Logician to ensure patient is HIV positive before every call.
- Do not leave a message if you do not know it is the number of the patient you are calling for
- Document every call in Logician and add the phone call order. If the phone is wrong or out of order document this also.

Boston Medical Center patient no-show letter

CID - Shapiro Center

Boston Medical Center
725 Albany Street, Suite 9B
Boston, MA 02118
Phone: 617-414-XXXX Fax: 617-414-XXXX



Date _____

Dear _____,

I hope this finds you well. We care about your health and would really like to hear from you. We missed you at your appointment with Dr. _____ on _____ at _____ am/pm. We are concerned with how you are doing.

We could not reach you by telephone to reschedule your appointment, so I am sending this letter to you.

Please contact me as at 617-414-XXXX or my colleague [Nurse's name] at 617-414-XXXX so we can see how you're doing and reschedule your doctor's appointments. Also, please let us know if your telephone number has changed so that we may update our records and stay in touch with you.

Thanks and have a great day.

[Peer name]
SPECTRuM Peer Navigator

[Nurse name], RN
SPECTRuM Research Nurse

Boston Medical Center patient no show letter SPECTRuM away from care long time—No phone

CID - Shapiro Center

Boston Medical Center
725 Albany Street, Suite 9B
Boston, MA 02118
Phone: 617-414-XXXX Fax: 617-414-XXXX



Date: _____

Dear _____,

I hope this finds you well. We care about your health and would really like to hear from you. We tried to reach you by telephone but were unable speak with you.

Please contact me at 617-414-XXXX or my colleague [Nurse name] at 617-414-XXXX so we can see how you're doing. If you have changed your telephone number, please let us know so we may update our records. If you are receiving care elsewhere, let us know. We just want to ensure you are receiving care somewhere and picking up your medications.

Thanks and have a great day.

[Peer name]
Medical Case Manager

Boston Medical Center patient no show letter SPECTRuM away from care long time—Bad address

CID - Shapiro Center

Boston Medical Center
725 Albany Street, Suite 9B
Boston, MA 02118
Phone: 617-414-XXXX Fax: 617-414-XXXX



Date: _____

Dear _____,

I hope this finds you well. We care about your health and would really like to hear from you. We could not reach you at your old address so we are trying this address we found on file that you provided in the past.

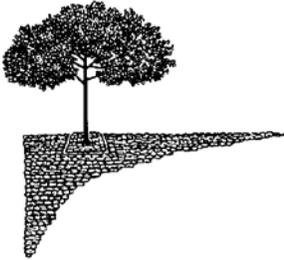
Please contact me as soon as possible at 617-414-XXXX or my colleague [Nurse name] at 617-414-XXXX so we can see how you're doing. If you are receiving care elsewhere, let us know. We just want to ensure you are receiving care somewhere and picking up your medications. Also, please let us know if your telephone number has changed so that we may update our records and stay in touch with you.

Thanks and have a great day.

[Peer name]
SPECTRuM Peer Navigator

[Nurse name], RN
SPECTRuM Research Nurse

Greater New Bedford letter to reestablish contact with client



Greater New Bedford Community Health Center
874 Purchase Street
New Bedford, MA 02740
Phone: 508-XXX-XXXX
Fax: 508-XXX-XXXX

5/29/15

Dear

I hope this letter finds you well! I have been trying to contact you by phone to no avail. The SPECTRuM team would like to know how you are doing, and would like to reassure you that we are available if you need any support. Your next appointment is 5/11 at 11:15. Please give us a call at (508) XXX-XXXX ext XXX. [Peer name]'s cell # is (508) XXX-XXXX. We look forward to hearing from you.

Sincerely,

[Nurse] and [Peer]

SPECTRuM Team

Holyoke Health Center reminder cards

Holyoke Health Center mails out the below “blue card” to clients as a reminder of their upcoming appointments.



**HOLYOKE
HEALTH
CENTER**

230 MAPLE STREET ❖ P.O. BOX 6260
HOLYOKE, MA 01041-6260
413-420-2200

This is to remind you that it is time for your:

- Physical Examination
- Follow Up _____
- Lab Test _____
- Immunizations _____
- Other _____

Please call our office now to schedule your appointment for:

Jan.	Feb.	Mar.	April	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.

Esto es para recordarle que es tiempo para su:

- Examen Fisico
- Rutina _____
- Prueba do Laboratorio _____
- Inmunización _____
- Otro _____

Favor de llamar a nuestra oficina para hacerle una cita:

Ener	Febr	Marz	Abri	Mayo	Juni	Juli	Agos	Sept	Octu	Novi	Deci

110 / 01 / 0248 / 06-06

UMMC HIV Clinical Care Center guidelines manual—Medical case management crisis management policy

SUBJECT: CRISIS MANAGEMENT POLICY

EFFECTIVE DATE: SEPTEMBER 1, 2011

SCOPE: UMMHC HIV CLINICAL CARE CENTERS

RATIONALE: To help insure the safety of HIV program staff who provide home visits, the following guidelines will be adhered to in order to minimize risk.



BACKGROUND:

Under very specific circumstances, UMMHC HIV staff will visit patients at home. Some of those circumstances include:

- a) Patient health status and inability to come to the clinic
- b) Significant social issues that make it difficult or impossible for the patient to leave the home environment
- c) Patient's inability to adhere to medication regimens or
- d) Patient providing care for a homebound family member or child.

Please refer to **Protocol for Home Visits for further information about the criteria and procedures for home visits**. Home visits must be authorized by the Clinic Chief or Clinical Director.

SAFETY AND CRISIS MANAGEMENT PROCEDURES:

Because home visits may occur in unfamiliar areas, the following guidelines will be used to anticipate and minimize risk during visits.

1. The program staff member who will be visiting the patient at home will obtain a signed consent form from the patient. The patient will indicate that he/she is authorizing the staff person to enter the home.
2. The patient will provide certain assurances, detailed in the consent form, that the staff person will not encounter any illegal or dangerous activity while in the home.
3. The patient will be informed that any violation of these requirements will mean immediate discontinuation of home visits.

Routine and Emergency Procedures for Home Visits

- Ensure that a responsible emergency contact (EC) person in the office is aware of the visit schedule and any alterations to the scheduled visit (e.g. running late, stuck in traffic).
- Agree on contact times. The home visitor should contact the responsible person upon arrival at the home and at the conclusion of the visit, once she is safely in her vehicle.

UMMC medical case management crisis management policy (cont.)

- Ensure that phone communication is available. Charge the battery of the cell phone fully. Pre-program into the staff's cell phones the responsible person's phone number and other emergency numbers. Carry a backup paper list of essential phone numbers.
- Keep both phones turned on during the visit. The EC must agree that she will be immediately available to answer the phone for the duration of the visit. Any other phone calls, texts or significant distractions that could result in a missed emergency call should be postponed until the home visit is concluded.

Routine:

1. Prior to leaving the office for a home visit, the HV Staff Person will designate another staff member (who will remain in the office) as her EC (Emergency Contact). They will each make sure that they have each other's cell phone number.
2. The EC must agree that she will be immediately available to answer the phone for the duration of the visit. Any other phone calls, texts or significant distractions that could result in a missed emergency call should be postponed until the home visit is concluded.
3. The EC should have access to the HV's details which include:
 - Make, model, color and registration number of car
 - Cell phone number
 - Home phone number
 - Names, addresses and telephone numbers of patient/ site being visited
 - Approximate times of visits
 - Agreed time for the field staff to make contact during the visit
3. Upon arriving at the patient's home, the HV will call the EC and let her know that she has arrived at the patient's home, and how long she plans to be there.
4. Once the HV has left the home and returned to her vehicle, the HV will call the EC to inform her of that fact.

Emergency/Crisis Management:

Identify a code word or phrase that indicates the existence of a hazardous situation. Have a plan in place that the code word or phrase will trigger an immediate response from the office contact person. Depending on the circumstances, this phrase can be used in either verbal contact or as a text message. In such instances, the emergency contact person will immediately call 911 and provide the appropriate information to dispatch.

RESOURCES STRATEGY 1: Peer-Nurse Team Services

UMMC medical case management crisis management policy (cont.)

If a field staff fails to make contact at the agreed upon time, the responsible person will:

1. Call the employee's cell phone.
2. If no answer, call the phone numbers (cell and home) of the patient being visited.
3. If no answer, the Emergency Contact person will immediately contact the police and report a suspicious incident.

Home visiting staff should make contact with the EC at the office as soon as safely possible.

It is always a good idea to keep your car keys and cell phone with you during a visit. If necessary, you can lock or barricade yourself into a room and call for help.

Prepared by: _____
[Name of preparer]

Reviewed by: _____
[Staff responsible] [Staff responsible]

Approved by: _____
[Authorizer] Date _____
[Title]

Promoting Safety:

- Dress to protect yourself. Wear shoes and clothes that make it easy for you to move quickly. Avoid wearing expensive jewelry or carrying a purse. Avoid accessories that could be dangerous such as necklaces or scarves.
- Carry a minimal amount of cash.
- Carry a noise-making device such as a whistle.
- Conduct visits during daylight hours.
- Maintain car doors locked. Avoid leaving items visible on the car seats during visits.
- Know the layout of the site you are visiting. Keep the door in sight during the visit. Identify locations where other people may be present and possible escape routes.
- Have knowledge of the activities of the neighborhood in advance and avoid visits when the risk may be higher such as times of increased drug or alcohol use.
- Know the location of the local police or fire department so that driving there for safety is an option. If being followed, pull into the parking lot and blow your horn until someone comes out.
- Avoid areas with poor visibility by others such as alleys or isolated buildings.
- Be aware of your personal behavior and the risk it may pose to others for example in domestic violence or child abuse situations.
- Be aware that your behavior may unintentionally trigger a response in another person that could not be predicted. Be prepared to respond with de-escalation techniques or escape.
- Keep your car keys and mobile phone on you. (You can barricade yourself in a room / toilet and use your phone in an emergency.)
- Report all incidents occurring in the field to your supervisor; reassess and/or discontinue home visits, as needed.

UMMC medical case management crisis management policy (cont.)

Tips to Consider if You are Faced with an Aggression Incident During a Home Visit:

- Never enter a house if there is yelling, screaming, breaking glass etc. coming from within – call the police.
- If an aggression incident occurs, remember to try and remain as calm as possible, speak slowly and calmly.
- Stay out of rooms such as kitchens because there are a variety of weapons that could be used .
- Try and keep a barrier (e.g., table, between you and the aggressor where practical).
- Slowly try to move toward an exit, or consider a room you can barricade yourself in and use your cell phone to call police.
- Try not to walk backwards as you risk tripping over.
- Don't stand face to face. (It makes you vulnerable to attacks.)
- Don't enter a home with someone who is under the influence of alcohol or drugs.
- Don't enter a home with someone who is inappropriately dressed.

Automobiles:

- Ensure the vehicle being driven is in good condition, with a full tank of gas and stocked with emergency supplies. Carry street directories and maps of the areas of visits.
- Avoid entering the trunk of the car; prepare the materials needed for the visit in advance and carry them with you.
- Lock your car doors as soon as you get in (to prevent car-jacking).
- Where practical do not park in the driveway (you could be blocked in) – but if you need to, think about reverse parking in, so you can simply drive out.
- In a cul de sac, park in the direction of the cul de sac exit.
- Approach your car with keys in hand.
- Check the car interior before entering.
- Keep doors locked at all times.
- Hide your purse/packages/valuables so they are not open to view.
- Avoid parking beside vans/trucks.

Continually assess the situation. **Trust your instincts.** If in doubt about the safety of the situation, be prepared to abandon or postpone the visit.

UMMC protocol for home visit

SUBJECT: Home-based Interventions for HIV Patients



GUIDELINE NUMBER:

EFFECTIVE DATE: July 1, 2011

PURPOSE: To insure continuity of or retention to care for HIV-infected patients who are experiencing serious mental or physical health issues.

SCOPE: UMMHC HIV Clinical Care Centers

RATIONALE: To insure continuity of care, the UMMHC HIV program will, only as necessary, offer limited home visits to its patients. This service will only last as long as deemed clinically necessary by the patient's Care Coordination Team.

BACKGROUND: Because of the highly unique nature of HIV disease, patients may, on occasion, require non-traditional service provision. When a patient becomes mentally or physically isolated and finds it difficult or impossible to visit the clinic, a member of the patient's Care Coordination Team may arrange to visit the patient in his/her home. With appropriate patient consent, and careful consideration for the safety of the staff person, home visits may be authorized for time-limited periods.

PROCEDURE:

Criteria for home care/visits will include:

- a) Patient health status and inability to come to the clinic
- b) Significant social issues that make it difficult or impossible for the patient to leave the home environment
- c) Patient's inability to adhere to medication regimens
- d) Assessment of a patient's living situation/environment or
- e) Patient providing care for a homebound family member or child.

Home-based interventions/visits will be time-limited; the nurse leading the patient's Care Coordination Team will be responsible for scheduling the home visits, assigning the most appropriate team members to the patient visit, and monitoring the effectiveness and necessity of continued home visits. Home visits should be approved by the Clinical Chief or the Clinical Director.

Staff who may be assigned home visits include the nurse practitioners; registered and licensed practical nurses; case managers/benefits counselors; Social Worker; and Peer Support staff.

RESOURCES STRATEGY 1: Peer-Nurse Team Services

UMMHC protocol for home visit (cont.)

Patients will be informed when home visits are implemented that they will be time-limited and will end once the situation is resolved. The Care Coordinator will consult with other team members on an ongoing basis, but will bear ultimate responsibility for both implementing and discontinuing home-based care.

Examples of services that may be provided in patients' home environments include:

Directly Observed Therapy (DOT): A trained staff person observes the patient as he/she takes prescribed medication every day. DOT provides intensive and daily support to patients, and is a resource for those persons who are having great difficulty adhering to an antiretroviral regimen independently but are willing to take HAART. Following the period of DOT, staff will show the patient the results of changes in the CD4 and viral load and establish a plan for the patient to continue independently.

Peer Support: Peer support may be helpful in providing home visits for HIV patients who may be feeling isolated or experiencing temporary set-backs with their health. In this instance, home visits will help to serve as a bridge back to mainstream care.

Mental Health Counseling: May be used when a patient is bed-ridden or terminally ill.

Referrals to ongoing home health services can be provided by contacting

Prepared by: _____
[Preparer's Name]

Reviewed by: _____
[Staff Responsible] [Staff Responsible]

Approved by: _____
Authorized signature] Date
[Title]

See related documents:
Consent for Home Visits
Crisis Management Guidelines

HHC guidelines for outreach and home visits

TITLE: Guidelines for Outreach and Home Visits	EFFECTIVE DATE: 8/28/14	POLICY #:
FUNCTION: Provision of Care	REVISION DATE:	PAGE #: 1 of 1

POLICY: All Holyoke Health Center (HHC) providers and clinical staff will follow the documented guidelines to do outreach or home visit a patient.



PURPOSE: To insure that HIV-positive and counseling and testing patients receive appropriate medical follow-up.

DEFINITION: OUTREACH- The processes of going beyond the usual means to contact a patient. This entails having HHC staff member go to the patient's home to deliver the necessary medical information.

PROCEDURE: Outreach or home visits should be done on HIV-positive patients or counseling and testing patients that HHC staff are unable to contact by phone or letter. Outreach and home visits should be done in teams of two people at all times for safety reasons. The Outreach Team must tell their supervisor where they are going and have their cell phone with them in case they need to call the clinic for appointments or in case of emergency. Reasons for doing outreach or a home visit include, but not limited to:

- Critical lab results
- Abnormal test results
- Patients that have fallen out of care
- Patients that are unable to come in for medical reasons

In non-urgent cases, a minimum of two attempts should be made to contact the patient. The nurse or case manager should first attempt to reach the patient by phone or mail if there is no phone available. The second attempt should be by mail (a certified letter if needed) prior to an outreach visit.

If the patient is not home a note for the patient to contact the nurse or case manager should be left for the patient. No confidential information should be left.

The staff member doing the visit should document the outcome of the visit in the electronic medical record.

Medical Director

Date

BMC request for home visit

CID - Shapiro Center

Boston Medical Center
725 Albany Street, Suite 9B
Boston, MA 02118
Phone: 617-414-XXXX Fax: 617-414-XXXX



Date: _____

Dear _____,

I hope this finds you well. We are leaving this letter for you to let you know that since we haven't been able to reach you for some time we wanted to visit your residence to make sure you are in good health.

Please contact [Peer name] at 617-414-XXXX or [Nurse name] at 617-414-XXXX so we can check in with you and assist you with anything you may need. Also, please let us know if your telephone number has changed so that we may update our records and stay in touch with you. We hope this home visit allows us to see you again, if not, we hope to hear from you soon.

Thanks and have a great day.

[Peer name]
SPECTRuM Peer Navigator

[Nurse name], RN
SPECTRuM Research Nurse

Transition resources

The resources below were used to help clients make the transition from the SPECTRuM program to medical case management.

SPECTRuM transition tip sheet

(tips for transitioning clients out of SPECTRuM)

***Note:** All information provided here are tips/suggestions. Please adapt/modify/add what works best for you, your site and your clients.

1. Start early

In any program where there is a transition that is known, it is very important to begin conversations about the transition early. You can then set the expectations that the SPECTRuM program is a time-limited, intensive program designed to support individuals to remain in the health care system and responsible for making their health care decisions that meets their individual needs

2. Focus on taking and owning responsibility for health care

What does it mean to take responsibility for one's health care? Do you make and keep your health care provider appointments? Do you ask your health care provider questions for clarification? Do you make informed choices about your health care (do you have all the information that you need? Where do you access information that you need?)

3. Use SMART goals to begin the transition process and throughout maintaining wellness habits

- Specific - am I very clear about what the goal is that I am trying to accomplish?
- Measureable - am I looking at what outcome I want for each goal and how do I know when I have gotten there?
- Attainable - is this goal doable in my life right now or am I asking too much of myself?
- Realistic - can this goal happen? What supports do I have in place to support this goal?
- Timely - does this goal make sense in the allotted time frame that I have set for myself

4. Create a health summary log stored in one place easily accessible

Building a file system to review your progress is key in seeing both how well you are doing and to correct any areas that aren't working as well for you; in addition, you can then ask your health care provider any questions that came up in between visits.

SPECTRuM transition tip sheet (cont.)

5. Create a health care transition plan

- Transition begins with the first visit and having a plan that support your independence is key in getting to that more independent place. What do you need in place to help you transition to needing a less intense service?
- A timeline can help with transitioning clients out of SPECTRuM. The timeline would give clients a way of seeing what step they are on and what steps are next. This way, they know what is about to come instead of wondering.

6. Create a contingency plan: what happens if something doesn't work out

Always have a 'backup' plan. The best laid out plans have a secondary, 'what if..' plan so if there is a change or slight setback, it is very temporary and you can get easily back on track.

7. Maintain wellness and good habits with supports and safety nets in place

Keeping a regular routine of wellness helps reduce frustration in the event of a setback, because maintaining a degree of personal health builds resilience when facing difficult situations.

8. Find other supports and create a network of supports that become part of your routine

Supports come in all different packages and sometimes, we assume that those closest to us might be the greatest supports. However, we all have our own agendas and if folks in your life are not providing the support you need, regardless of their intention, find others to serve that purpose.

9. Know your strengths and challenges in maintaining your health

Each of us has internal resources from which to draw and we often know our areas of vulnerability. It is important to recognize both, so that you can build upon those internal resources to enhance your strengths and pre-empt those challenges through early detection.

10. Seek help when you want and need it

Finding the right help at any given moment is key to maintaining a good transition plan so that you can stay on track and continue to thrive.

SPECTRuM transition tip sheet (cont.)

Dialogue Examples

Introducing the idea from the start:

- If you are interested, we offer an intensive-care program which is called SPECTRuM, that you can participate in. It is a 6-month program where you would meet regularly with the SPECTRuM peer and nurse. At the 6-month mark we will evaluate/measure how well you are doing to determine whether or not you will be still needing our services. If you are doing well, we will then transition you out of SPECTRuM into a less intensive program. You will be assigned to another peer and case manager. Although you will no longer be in the SPECTRuM program you can still meet with the peer. However, the peer will not contact you as much as they did before because you have taken control of your health. Our goal is to guide you and help you get to a place where you are in control of your health and doing well. Is this program something you are interested in joining?

Between initiation and 6-month mark (client is doing well but still in SPECTRuM):

- Although you are not at the 6-month mark to graduate, we see that you are doing really well and may be ready to graduate once we hit the 6-month mark.
- Your medication adherence and viral load/CD4 levels are improving. If you continue to improve you may be ready to transition out of SPECTRuM into a less intensive program (peer and case manager).

Transitioning the client out of SPECTRuM:

- Congratulations, you are ready to graduate on to the next level of your health maintenance. Now you are ready to take on more responsibility without the help of a peer.
- You have been able to use SPNS as a guide to help you on your way to help maintain good adherence. Now you can use what you learned and continue your care with little help from your peer.
- You are coming to all of your appointments. You are using SPNS to its full potential.
- Your viral load has dropped and your CD4 has gone up because you are taking your medication the right way. Like we informed you when we signed you up for SPNS, this was a way to help you get back on track with your viral load, and you did that. So we feel that we can graduate you from the SPNS project.
- Although you will no longer be in the SPECTRuM program you can still meet with the peer. However, the peer will not contact you as much as they did before because you have taken control of your health.
- We will work with you to determine what level of case management you will need and what best fits your needs. We will assign you to a peer/case manager that you feel comfortable with.
- Although we believe you are ready to move up on your own, how do you feel about your readiness to transition out of the SPECTRuM Program?

SPECTRuM transition tip sheet (cont.)

- Do you have any questions or concerns?
- We understand that you may feel a little nervous about transitioning, but we assure you that we will help you in the process of transitioning out. We will make sure you are assigned to a peer and case manager that best fits your needs. We will also help you with other concerns you may have (there may be a limit to what they can help with so it should be listed here)...support groups?
- Here are some resources/key points that you can take/access...(brochures, business cards, websites, contacts, advice etc.)
- We would like to celebrate and honor your moving forward by inviting you to join other SPECTRuM graduates at a luncheon that we will be hosting. The luncheon will give you the opportunity to meet others who are in the same situation as you and help support you as you move up.
- Just because you have graduated, it does not mean that you are forever cut off from our services. If at any time you feel that you are no longer in control of your health and need more support you can re-join the program.

What to say if the client is not ready to transition out of SPECTRuM at 6-month mark:

- Although you are not yet ready to transition, we would like to discuss the possibilities of transitioning...

Case manager and peer work model:

- With the peer and case manager model, we work together to see what the client needs. Then we see how each other can work together in trying to make it easier to get the task done. It might be for the peer to make the phone calls to other agencies.
- If the peer is meeting the client for the first time then this is a good time for the case manager to explain to the peer what the client is like and what to expect. Also to discuss if they have addiction, have been incarcerated, or if they have problems with disclosure. This understanding gives the peer a clearer idea of which path to take when working with the client. If the client really has other issues that should be met first then that is the way the peer would want to go. Housing, medical adherence, etc.
- The peer and case manager working together can make for an easier way to keep the client engaged. Working together can cause more interactions with the client. The client will receive more phone calls. Some patients may not like this so this is why the case manager lets the peer know how important the client is.

RESOURCES STRATEGY 1: Peer-Nurse Team Services

Sample transition letter to client

HOSPITAL LETTERHEAD

DATE

Dear PATIENT NAME,

As we have discussed with you already, you have completed the required 6 months participation in the SPECTRuM research project. Congratulations again! You have achieved a great deal over the past six months. We hope that you feel that you have accomplished many of the things listed below:

- Feeling more confident in attending your scheduled MD appointments
- Feeling more confident that you can manage taking your medications daily
- Feeling more confident in navigating your way around the various doctor's appointments and offices
- Feeling more confident is speaking with your doctor or nurse about things that concern you
- Feeling more confident in going to your case manager or peer and asking for assistance when needed
- Feeling more confident in seeking out the additional services you may need from other organizations.

We had hoped to personally introduce you to the case manager and peer you will be working with going forward, but it has been difficult to find a time that works best for you. As such, we are providing you with this letter with the name and telephone number of the case manager and peer you will be working with going forward. Their names are:

NAME AND TELEPHONE NUMBER

NAME AND TELEPHONE NUMBER

Medical Case Manager

Peer Navigator

However, we'll discuss all of this in more detail and get your feedback when we see you next. Please remember that your doctor will remain the same and you will continue to work with the nurse who works with your doctor. And remember, you can always attend the SPECTRuM Group Meeting the 2nd Wednesday of every month if you want to stay connected with us.

Continued success and we'll see you around the clinic.

All the Best,

[Peer Name], SPECTRuM Peer Navigator

[Nurse Name], RN, SPECTRuM Research Nurse

RESOURCES STRATEGY 1: Peer-Nurse Team Services

BMC Transition email to staff

To: MDs, Nurses, Case Managers, Peer Navigators
CC: [Medical Health Care Team] Medical Director, Data Assistants
From: [Nurse or Peer]
Subject: SECURE: SPECTRuM Enrollment



Hi Everyone:

The following patients have transitioned out of SPECTRuM as of _____:

Name	MRN	MD/Nurse	CID Case Manager	CID Peer Navigator	Transition Date

[Nurse name] and I may be still trying to schedule a time for these patients to meet their case manager and peer navigator, but we have already discussed transition with them and provided them with a letter with their case manager and peer's names and telephone numbers. We hope to introduce them when they come for their next MD appointment.

Please note that once transitioned, they will no longer receive case management, peer and nursing services from me and [Nurse name], but from the persons listed above. However, they are always welcome to attend our SPECTRuM Group Meeting the 2nd Wednesday of every month. Please contact me if there are any questions.

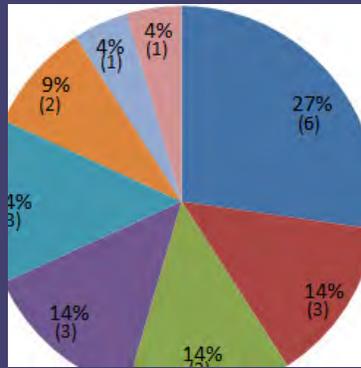
Thanks!

[Peer signature]
[Peer Name]
Program Coordinator – Peer Program
Medical Case Manager
SPECTRuM Peer Navigator and HIV Health Educator
Center for Infectious Diseases
Shapiro Center - 9th Floor
Suite 9B
Boston, MA 02118
T:
M: (for patients and emergencies)
Fax:
Page:
[peer email]

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For questions and comments on this manual and its resources, contact the Massachusetts Department of Public Health at 617-624-5300

This manual can be found in its entirety on the web at <http://www.mass.gov/dph/aids>



EXPANDING ACCESS, IMPROVING RETENTION IN HIV CARE: THE SPECTRuM PROJECT IMPLEMENTATION MANUAL

Strategy 2: Enhancing Surveillance Systems to Strengthen Retention in Care

Strategy 2: Enhancing Surveillance Systems to Strengthen Retention in Care.....	126
Role of the state health department.....	129
Role of health care providers	133
RESOURCES Strategy 2: Enhancing Surveillance Systems to Strengthen Retention in Care	138
SPECTRuM initiative intervention protocol #2	138
SPECTRuM surveillance site communication form	139
HHC detectable viral load tracker terms and definitions.....	140
HHC detectable viral load tracking sheet.....	141
UMMC client discharge/Drop out form	142
BMC process for updating the line list report and example of tracking spreadsheet	143
Sample community health center line list report.....	144

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May 2016

Overview

The SPECTRuM project involved two strategies used to test, implement, and evaluate system- and service-level interventions aimed at 1) maximizing timely linkage to care and treatment for individuals newly diagnosed with HIV, and 2) reengaging and supporting retention in care for HIV+ individuals who had fallen out of care, who were at risk of dropping out of care, and/or did not accomplish sustained viral suppression:

- Strategy 1: Intensive service provision provided by a peer-nurse team as an enhancement to routine HIV/AIDS Medical Case Management (MCM) interdisciplinary care teams operating within the existing HIV health care service delivery system
- Strategy 2: Communication between Massachusetts Department of Public Health (MDPH) HIV/STD Surveillance and health care providers regarding clients who may be out-of-care or who have not reached viral suppression based on HIV viral load and CD4 test results

SPECTRuM surveillance data communication sites

Boston Medical Center (BMC), Department of Infectious Disease: BMC is New England's largest safety net hospital, located in the heart of Boston. BMC's Center for Infectious Disease serves approximately 1,500 HIV+ individuals annually. The clinic provides HIV/AIDS medical case management; peer support; integrated HIV/HCV/STI prevention, screening and treatment; and linkage to care for individuals diagnosed with HIV in other hospital departments. Staff provide mental health and substance use treatment and also coordinate outside referrals for these services.

Brockton Neighborhood Health Center (BNHC): BNHC is a community health center in southeastern Massachusetts with over 160 HIV+ patients. The agency provides health care to a diverse population that includes many Black/African-American and non-US born individuals. BNHC operates under a Patient Centered Medical Home model and offers HIV/AIDS medical case management; peer support; integrated HIV/HCV/STI prevention, screening and treatment; mental health services; and referrals to specialty care.

Greater New Bedford Community Health Center (GNBCHC): GNBCHC is a community health center that provides comprehensive HIV care and social services to more than 350 clients annually in New Bedford and surrounding communities in southeastern Massachusetts. The health center provides HIV/AIDS medical case management; peer support; integrated HIV/HCV/STI prevention, screening, and treatment; and referrals for substance use treatment, mental health support, and other services as needed.

Holyoke Health Center (HHC): HHC is a federally qualified health center in western Massachusetts that provides comprehensive HIV services including primary care and medical case management to over 200 individuals annually. The health center provides integrated HIV/HCV/STI prevention, screening and treatment; mental health; and substance use treatment services.

Morton Hospital (Morton): Morton is a small hospital located in southeastern Massachusetts that is part of Steward Health Care System. Morton provides HIV care to approximately 140 individuals annually and also provides HIV/AIDS medical case management services and referral to behavioral health and specialty care. The hospital tends to attract patients from rural areas of the state, and the majority of patients are white/non-Hispanic.

UMass Memorial Medical Center, HIV Clinic (UMMC): A large hospital in central Massachusetts, UMMC serves mainly individuals who live in the city of Worcester and in surrounding communities. The HIV clinic serves approximately 800 clients annually and offers HIV/AIDS medical case management, mental health, and substance use treatment and also coordinates referrals to agencies throughout Worcester.

STRATEGY 2: Enhancing Surveillance Systems to Strengthen Retention in Care

Summary of roles and responsibilities of state health departments and health care providers in using laboratory data to support engagement in care and treatment

State health departments (HD)	Health care providers
<ul style="list-style-type: none"> • Collect and verify reported laboratory results for PLWH using all available sources (e.g., case report forms, electronic laboratory data systems). • Identify epidemiologists to work with the line lists. • Create and maintain a current list of ordering providers at each site. • Create and maintain a central dataset of client data, laboratory results, test dates, and ordering providers. • Generate a line list of PLWH without HIV laboratory test results reported in a given time-frame and a line list of PLWH with a detectable viral load. • Send line lists to sites via a secure system (e.g., encrypted jump drive). • Use follow-up data provided by sites to update the central dataset. • Provide aggregate data reports to providers on a regular basis. 	<ul style="list-style-type: none"> • Identify a staff member responsible for communication with the HD. • Develop a written protocol for verifying and updating information on the line lists, communicating with the HIV care team and the HD, and documenting activities. • Review line lists and compare data with electronic medical records and other client information available. • Communicate relevant client information to other members of the HIV care team. • Conduct follow-up activities to find clients who may need reengagement supports and to work with clients who may need assistance with their HIV treatment plans and/or medication adherence strategies. • Engage in regular communication with the HD by submitting follow-up client data to the HD and by participating in regular telephone calls.

The goal of Strategy #2 was to support engagement and retention in care and treatment for people living with HIV/AIDS (PLWH) by identifying individuals who did not have CD4 T-cell count or viral load laboratory results reported to MDPH HIV/STD Surveillance within the previous 180 days or longer (the “out-of-care” list), and individuals with a viral load above the limit of detection, based on particular lab assays (the “viral load” list). HIV/STD Surveillance provided lists of individuals in these categories to SPECTRuM sites on a monthly basis. The sites used the lists to prioritize clients for reengagement activities and/or follow-up

regarding treatment plans and adherence strategies and provided information about these efforts to HIV/STD Surveillance, also on a monthly basis.

This section of the manual describes key steps for implementing an effective strategy for sharing laboratory and follow-up data between state health departments and medical providers that offer HIV care in hospitals, health centers, and private practices. The respective roles of health departments and health care providers are described. Additional detail is available in the SPECTRuM Initiative Intervention Protocol #2 (see Resources, p. 138).



STRATEGY 2: Enhancing Surveillance Systems to Strengthen Retention in Care

Role of the State Health Department

Collect HIV laboratory results

This intervention is dependent upon the collection of HIV laboratory results by the state health department. In Massachusetts, all CD4 T-cell and HIV viral load laboratory result data are reported to Massachusetts Department of Public Health (MDPH) HIV/STD Surveillance, as required by state regulation that applies to all living HIV+ individuals who have had an initial case report form and subsequent viral load laboratory result reported to the MDPH since January 1, 2012. MDPH HIV/STD Surveillance internal laboratory database includes all individuals who are receiving care in Massachusetts regardless of their state of residence and/or where they may have been previously receiving care. Approximately 50% of laboratory reports are submitted through an electronic laboratory system, and the other half are reported on paper forms. MDPH HIV/STD Surveillance staff manually enter laboratory results that are reported on paper into a database that is uploaded to the internal laboratory database on a daily basis. Electronic laboratory results are extracted, cleaned, and uploaded into the internal laboratory database weekly.

Hire epidemiologists

Health department epidemiologists can help implement a range of activities associated with generating line lists reports (See Resources p. 139 for an example) and utilizing client data to monitor population health outcomes. MDPH HIV/STD Surveillance epidemiologists maintain the state HIV/AIDS

reporting system, collaborate with health care providers to insure the integrity of the surveillance database, conduct analyses of surveillance data, monitor trends in the HIV/AIDS epidemic, and present HIV/AIDS data for public use. The epidemiologists who engage in surveillance data communication with health care providers are responsible for maintaining updated lists of reporting providers, generating the line list reports, collaborating with providers to obtain and discuss follow-up data regarding individuals on the line lists, entering information into databases, evaluating data provided by the sites, implementing routine data quality control activities, and performing statistical analyses for MDPH staff, funders, sites, and the public.

Qualifications recommended for this role include knowledge of the principles, practices, and research methods followed in epidemiology; expertise in programming and statistical analysis; proficiency in Microsoft Office; ability to analyze epidemiological and research data; skills in presenting information clearly both orally and in writing; and ability to maintain collaborative professional relationships with providers.

Prepare list of ordering providers and facilities

Developing and maintaining a list of reporting providers and facilities is essential in order to create accurate line lists. HIV/STD Surveillance requests that health care providers designate one staff member

STRATEGY 2: Enhancing Surveillance Systems to Strengthen Retention in Care: Role of the State Health Department

to provide a current list of physicians who order HIV laboratory tests for their clients. This staff member is responsible for regular communication with HIV/STD Surveillance to update that site's list of ordering providers as needed (e.g., as residents rotate through the clinic or physicians initiate fellowships). HIV/STD Surveillance maintains this information in a spreadsheet format.

Create central data set

Generating line lists involves a labor-intensive but necessary process of accessing, verifying, and linking data from several data sources. This involves creating and maintaining a central dataset, which MDPH accomplishes by matching and merging information from three sources: 1) eHARS (Enhanced HIV/AIDS Reporting System), a mandated electronic reporting system from the Centers for Disease Control and Prevention, 2) the HIV/STD Surveillance internal laboratory database described above, and 3) a spreadsheet of ordering facilities and providers in Massachusetts, also described above.

The eHARS system contains information on all persons living with HIV who had an initial case report form reported to MDPH, and the internal laboratory database includes provider information that can be matched to individual laboratory results. These data-

Work with your state legal counsel and other stakeholders to ensure protection of client privacy and confidentiality

MDPH HIV/STD Surveillance worked with MDPH legal counsel to develop a policy describing the types of data that could be shared. Because HIV/STD Surveillance and the clinical sites did not share an electronic secure portal, HIV/STD Surveillance also worked with counsel to determine the process by which HIV/STD Surveillance could transfer, communicate, and receive data with clinic sites. For example, to ensure that data were secured and a seamless transfer process was in place, it was determined that only 1-2 MDPH epidemiologists would be responsible for accessing and managing the data, along with one designated individual at the agency level.

bases are merged on a monthly basis to create a more complete data set. This data set is then merged with the spreadsheet of ordering facilities and providers. This ensures that individuals are matched to the appropriate laboratories, and that information is provided to the correct ordering facility. After this step takes place, HIV/STD Surveillance is prepared to generate the line lists and send them to the sites.

Generate out-of-care and viral load reports

Health departments must work with health care providers to decide which data variables will be most useful in assessing retention in care and adherence to treatment, and which time frame they will use to determine that an individual may be out of care. In Massachusetts, MDPH HIV/STD Surveillance generates line list reports for each agency that include the following data:

- Client first and last name
- Client date of birth
- Physician first and last name
- Date of last laboratory test result reported
- For clients with detectable viral load laboratory results:
 - Date of viral load test result
 - Value of last detectable viral load test result
- For individuals whose names were included on the previous month's list: notes on the client's status that were submitted by the provider the previous month.

A partial screenshot of the form used by HIV/STD Surveillance and the sites to communicate line list data is included in Resources, p. 139.

MDPH decided to define "out-of-care" individuals as those without a CD4 or viral load test result reported to MDPH for 180 days. This enabled MDPH to main-

STRATEGY 2: Enhancing Surveillance Systems to Strengthen Retention in Care: Role of the State Health Department

tain consistency with the Health Resources and Services Administration (HRSA) performance indicator “HIV medical visit frequency” which recommends that clients have at least one medical visit in each 6-month period of a 24-month measurement period [<http://www.hab.hrsa.gov/deliverhivaidscares/coremeasures.pdf>]. MDPH used the laboratory test result data as a proxy for medical visits.

MDPH HIV/STD Surveillance quickly learned that using a 180-day time period will result in the creation of line lists that include individuals who are not truly out of care. Using the monthly follow-up data provided by the sites indicating the status of each individual on the line lists, MDPH HIV/STD Surveillance determined that many of the individuals on the out-of-care line list were scheduled for an upcoming appointment, recently had a lab completed, or had another reason for not being out of care. MDPH HIV/STD Surveillance consistently found that only 25 - 30% of individuals on the line lists were truly out of care.

Due to lags in laboratory reporting, variations in appointment scheduling, and other factors, it is essential to have some method for carefully reviewing the line lists to verify client status, including communication with sites. State health departments and medical providers may want to consider experimenting with various “out-of-care” time frames to maximize accuracy and reflect the needs of their jurisdictions.

Send out-of-care and viral load data reports

Health departments must determine the intervals at which they will send line lists reports to medical providers. MDPH decided to send the reports to sites on a monthly basis. HIV/STD Surveillance sends the reports to agencies in a spreadsheet format via encrypted jump drives. Each site has designated a staff person to receive the reports. Agencies are responsible for ensuring that these individuals have access to a computer and have administrative rights

to utilize the data.

Receive follow-up data from agencies

It is essential to decide what types of data will most accurately help the state health department monitor population health outcomes and update its internal data resources. In Massachusetts, agencies provide follow-up data to HIV/STD Surveillance two weeks after receiving the line lists and document the following information about individuals on the line lists:

- Individual is not a client at the site, moved, was discharged, or died
- Client has an upcoming appointment scheduled
- Client missed an appointment
- For individuals on the out-of-care list:
 - o If the client had a lab test, the date of the test
 - o Client is not out of care
- For individuals on the viral load list:
 - o Client started antiretroviral therapy (ART) <3months ago
 - o Client has been on ART >3 months
 - o Client is not on ART
- Notes on the status of the client

MDPH uses this information to assess aggregate health outcomes of individuals accessing HIV care at these sites and to update its internal data prior to generating the next set of line lists.

Over a period of several months, MDPH HIV/STD Surveillance worked with the sites to streamline the first line lists that were generated. For example, as sites reviewed their internal client data and sent updated information to HIV/STD Surveillance, staff removed individuals who were known to have transferred care or who were discharged for other reasons. It was also noted that several of the same individuals were

STRATEGY 2: Enhancing Surveillance Systems to Strengthen Retention in Care: Role of the State Health Department

appearing on the line lists every month after sites had completed the follow-up that they determined to be necessary. For example, some sites communicated to HIV/STD Surveillance that a subset of individuals on their viral load lists were adherent to their ART regimens despite not achieving viral suppression. HIV/STD Surveillance decided to maintain an objective approach to generating the line lists and kept recurring clients on the line lists but placed the names of these individuals in a separate section of the reports. Health departments must decide whether or not to keep clients who fall into these categories on the reports they produce for sites.

Provide regular reports to providers

Providing agency data reports to sites allows members of their HIV care and service team to see the aggregate results of the client data they submit to HIV/STD Surveillance. This can support the team's care retention and treatment adherence efforts and can

provide a motivational tool with respect to continued efforts to enhance care and service provision. HIV/STD Surveillance shares quarterly reports with each site that include charts showing the status of clients on the out-of-care list and the viral load lists. The out-of-care reports show the distribution of individuals on the line lists, including the percentage of those “truly out of care” and the reason individuals are determined to be not truly out-of-care (e.g., individuals with upcoming appointments, those no longer clients at the clinic, etc.). The viral load reports indicate the percentage of individuals who were new to the list and the percentage of clients who had been on previous lists. (See the Resources section: Sample community health center line list report on p. 144 for an example.) These reports help both MDPH and sites to monitor their progress.



STRATEGY 2: Enhancing Surveillance Systems to Strengthen Retention in Care

Role of Health Care Providers

Establish protocols for maintaining client contact information and securing permission to locate clients who may be out of care

Sites can implement a variety of strategies to document accurate client contact information and to request client permission for agency staff to contact clients if they are determined to be out of care. In Massachusetts, sites request updated contact information and relevant permissions during intake, medical visits, and medical case management reassessments. Agencies also establish written agreements with internal and external entities to facilitate communication regarding clients who may be out of care. Standard approaches include the following:

- Documentation of inactive telephone numbers in client records to preserve opportunities for successful contact when previous inactivity may be related to fluctuations in phone payments;
- Request for the following information:
 - o Websites and mobile phone applications used and permission to contact the client on social media;
 - o Emergency contacts and permission to communicate with them if the client is unable to be contacted directly;
 - o Contacts at local health and social service

providers and permission to contact them if the client is unable to be contacted directly;

- o Permission to conduct home visits if the client is unable to be contacted directly.

- Agreements with the following organizations:
 - o On-site pharmacies, to determine whether clients have picked up their most recent prescriptions; and
 - o Local county jails, to request notification when clients are reincarcerated or have upcoming release dates.

Identify an agency staff member to work with line list reports and communicate with the health department

It is important to designate one key staff member to receive and review the line lists from the health department, provide follow-up information to the health department, and communicate pertinent information relevant to the line lists to other members of the HIV care team. This individual's responsibilities include the following activities:

- Receive the line list from Massachusetts Department of Public Health (MDPH) HIV/STD Surveillance;
- Update the list of ordering providers;
- Gather information from chart records and HIV team members about clients;

STRATEGY 2: Enhancing Surveillance Systems to Strengthen Retention in Care: Role of Health Care Providers

- Resolve discrepancies and communicate information back to MDPH HIV/STD Surveillance; and
- Coordinate with the HIV clinic staff to develop action steps.

Ideal experience for individuals in this role includes expertise in clinical data quality management and familiarity with HIV medical care and clinic opera-

tions. The ability to navigate the agency's medical record system is essential to facilitating accurate and timely follow-up. Solid communication skills are beneficial due to the frequency and content of information sharing with other members of the HIV team including physicians, nurses, and medical case managers, in addition to state health department epidemiologists. MDPH found that sites with a large client volume needed a full-time data manager dedicated to the responsibilities of this position.

BMC: Using data to reengage those lost to care

At Boston Medical Center, the data manager for the HIV team coordinates the review and communication of line list data and follow-up activities within the internal HIV team and between BMC and MDPH. The data manager accesses the medical record numbers for each client on the out-of-care list and consults their EMRs for information regarding engagement in care. If the EMR does not indicate a recent or upcoming appointment, the data manager sends a message to the peer-nurse team via the EMR to initiate the outreach protocol. Once the peer and nurse assess the client's status, they send a message back to the data manager with information necessary to update the line list. On a monthly basis, the data manager also sends the clinic's HIV physicians a list of the clients who are truly out of care or who have not achieved viral suppression. The data manager maintains a monthly report to track referrals of clients on the out-of-care list to other members of the HIV care team, including the peer, nurse, and medical case managers.

Using the line list has enabled BMC to reengage many patients into care. For example, one client on the out-of-care line list had not been seen by clinic providers in the previous 11 months. The data manager shared this information with the peer and nurse team, and the peer was able to contact the client via telephone. During their conversation, the client described having a negative experience in the emergency room. The peer reassured the client that this experience would not take place in the clinic, scheduled an appointment that was convenient for the client, and met with him when he arrived at the clinic. The peer flagged the client's EMR to inform the doctor about the client's report of his encounter in the emergency room.

Develop a written protocol for verifying and updating information on the line lists and for documenting follow up activities

Establishing a written protocol for working with the line lists clarifies each step involved and the responsible parties for accomplishing each step. Protocols address the types of information to be reviewed, processes for accessing this information, methods for communicating line list data to others on the HIV care team, and the mechanism for providing follow-up information to the health department. To maximize the ultimate effectiveness of the protocol, members of the HIV care team are invited to provide input into its development. After protocols are finalized, all HIV care team members should be oriented to the content. See Resources pp. 142-143 for mechanisms used to provide follow-up information to the health department.

Review line list reports, compare data with internal resources, and communicate with the HIV care team

Agencies follow their written protocols to review internal data (e.g., electronic medical records, pharmacy records, Ryan White data collection systems) that provide additional information about individuals on the line lists. Once the information in the line list reports is reviewed in the context of the additional client data available, relevant

STRATEGY 2: Enhancing Surveillance Systems to Strengthen Retention in Care: Role of Health Care Providers

information is communicated with the HIV care team. Initial communication often takes place by flagging client electronic medical records. In addition, HIV care team staff typically discuss the status of clients on the line list reports during routine case conferences.

Conduct follow-up activities related to care reengagement and treatment plans/adherence

Communicating a list of clients who are “truly out of care” prompts a range of follow-up activities which are best outlined in a protocol developed and implemented by site staff. In Massachusetts, the first step typically involves contacting the client via telephone using the most recent contact number available, in addition to inactive numbers if necessary. Staff consult client electronic health records for updated contact information that clients may have provided while attending medical visits with other providers or while visiting the Emergency Department. After two unsuccessful call attempts, agencies often send clients a postcard or letter (potentially certified). If there is no response, agency staff may attempt a home visit. See Resources, pp. 105 - 118, for samples of letters to clients and home visit protocols.

With appropriate client permission documented, sites also communicate with other clinical and social service providers to access information about the status of their clients. This provides valuable information that may indicate whether the client continues to live or work in the area and whether the client is maintaining a connection to medical care. If the client has authorized the use of social media, as referenced above, staff may search for clients online. Agencies also check arrest logs in local newspapers to attempt to find information about clients.

Once contact is made, agencies attempt to reengage clients into care by offering information, practical strategies to help manage barriers to care, and emotional support.

GNBCHC’s client charts provide clues to out-of-care status

At Greater New Bedford Community Health Center, the SPECTRuM nurse, peer, and program supervisor meet weekly to review and verify the out-of-care list, share information, and develop strategies to locate and reengage clients. The nurse consults electronic health records and completes a “mini” chart review to identify possible reasons why clients may be on the list. This protocol has helped the health center determine which clients were truly out of care and facilitate reengagement for these individuals, including one client who had not attended an appointment during the previous three years.

BMC: Strategies for reestablishing contact with clients on the out-of-care list

Boston Medical Center discovered that although finding clients can be challenging and time consuming, patience and determination can yield successful results. BMC staff had made repeated attempts to contact a client who had been on the line list for several months. Just before making the determination to stop attempting to contact this individual, the SPECTRuM peer made one more attempt to call the client. The client answered the telephone, thanked the peer for calling, and stated that the client was having a “really hard time.” As a result of this connection, the peer was able to support the client in reengaging in care.

Providing lists of clients with detectable viral load assists sites with assessing potential adherence and/or treatment challenges among their clients and also reminds sites about clients who require follow-up or who may need a check-in. In Massachusetts, one site’s data manager performs the initial reconciliation of line list data with internal records and then sends an updated list of clients with detectable viral loads to their physicians, who then follow up with their clients. At another site, the individual responsible for receiving the line lists data sends the detectable viral load list to an adherence nurse who reviews the clients’ EMRs to review historical laboratory test results, and then follows up with the clients as appropriate.

STRATEGY 2: Enhancing Surveillance Systems to Strengthen Retention in Care: Role of Health Care Providers

HHC: Strategies for working with clients on the viral load line list

Using the data from the MDPH HIV/STD Surveillance line list, Holyoke Health Center developed a “Viral Load Detectable Tracker” (see Resources, pp. 140-141). This system helps nurses and medical case managers enhance their capacity to work with clients who have not achieved viral suppression.

Clients with a viral load of >200 copies/mL are assigned to one of two categories: 1) those prescribed and taking ART, and 2) those not prescribed ART or prescribed but not taking ART. The nurses and medical case managers then follow up with providers and clients to identify possible reasons for lack of viral suppression such as resistance, missed doses, or adjustment to a new regimen. This information allows the staff to develop individualized care plans for each client to address that individual’s specific needs.

As an example, in January 2015, HHC found that among the clients who were on medications and who had detectable viral load laboratory results reported to MDPH, 37% were new to medications, 21% were lost-to-follow-up, 14% were not taking prescriptions, 14% were missing doses, and 14% needed labs. At this time, the average viral load among the clients on the line list was 41,186 copies/ml. After individualized care plans were implemented, the average viral load for the same group of individuals had decreased to 22,108 copies/mL.

BMC: Sample results from the out-of-care line list

Below are examples of data associated with Boston Medical Center’s monthly line list reports, based on laboratory data reported to HIV/STD Surveillance as of January 15, 2015:

- Among the 36 clients truly out of care on the May 2014 out-of-care line list, nine individuals (25%) had a new lab reported to HIV/STD Surveillance within three months of the list date, and 15 individuals (42%) had a new lab reported within six months of the list date.
- Among the 37 clients truly out of care on the June 2014 out-of-care line list, 12 individuals (32%) had a new lab reported to HIV/STD Surveillance within three months of the list date; and 18 individuals (49%) had a new lab reported within six months of the list date.

Engage in regular communication with the health department

Agencies provide follow-up data to the health department according to the established protocol. For Massachusetts, this involves documenting the status of each individual on the line list and submitting the information to MDPH HIV/STD Surveillance two weeks after receiving line list reports.

To follow up on the out-of-care line lists, agencies document dates of recent and/or upcoming labs; dates of upcoming appointments; client move, clinic discharge, transfer of care, or death; an indication that current laboratory testing schedule is consistent with clinician treatment plan; agency attempts to contact clients; successful contact attempts; missed recent appointments; scheduled medical and/or social service appointments; and referrals to other services.

To follow up on the viral load line lists, agencies document whether individuals have been on an anti-retroviral therapy (ART) regimen for more or less than three months, if they are not on ART, not interested in ART, not adherent to their ART regimen, or whether they are typically adherent to their ART regimen but are experiencing a temporary “blip” due to issues such as a change in regimen or temporary lapse of insurance.

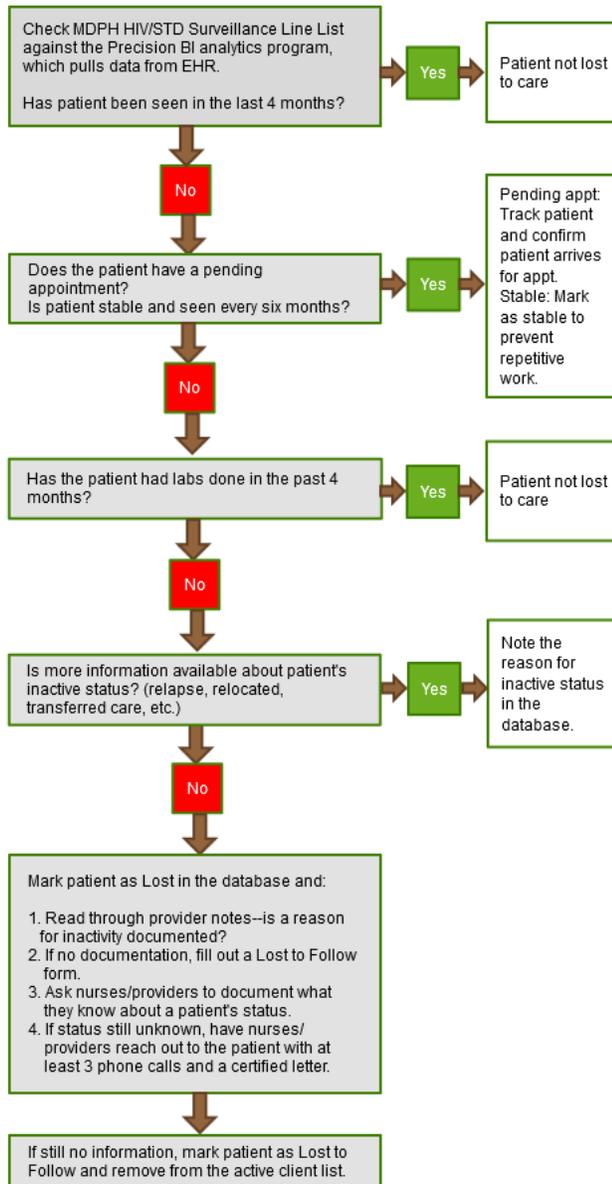
Sites participate in monthly calls with HIV/STD Surveillance epidemiologists to review the line lists, reconcile data, and address questions. Deciding when to remove an individual from the line list can present a challenge, particularly for sites with clients who cycle in and out of clinical care on a regular (often seasonal) basis. To document these types of situations, agencies include descriptive notes to MDPH on their follow-up reports.

Conclusion

Developing and maintaining a regular system of communication between health departments and medical sites regarding client engagement in care and treatment refines client data that, in turn, helps agencies prioritize and implement reengagement and

STRATEGY 2: Enhancing Surveillance Systems to Strengthen Retention in Care: Role of Health Care Providers

UMMC: Process for creating and maintaining the lost-to-care list



Maintaining the list

The Lost to Follow list is dynamic. Here are the steps to maintain it:

1. Once/month, when each list is updated, save as a new file with the current date (for research/data purposes)
2. Use past lists to cross check against analytics-based searches to eliminate redundancies. Eliminate:
 - Patients not seen in 4+ months, who have documented reason in a previous lost list
 - Returning patients with recently attended/pending appts after being marked inactive on earlier list.

treatment adherence interventions. Agencies use line list information to improve the accuracy and completeness of internal client data systems, support quality improvement activities, monitor care retention and treatment adherence at the client and clinic level, and target resources to an active client population. The lists can be useful for clinical sites that do not have the capacity to generate routine reports related to engagement in care and treatment and for sites with advanced medical record and reporting systems, which can benefit from the ability to cross-reference internal data. For MDPH, communication helps staff maintain updated HIV surveillance data, generate accurate HIV continuum of care analyses, and assess care engagement and treatment adherence at an agency level. Collectively, these benefits support a shared system goal of improving viral suppression rates among people living with HIV.



RESOURCES: Strategy 2

Strategic Peer-Enhanced Care and Treatment Retention Model (SPECTRuM) Initiative

Intervention protocol #2¹

Staff from the Massachusetts Department of Public Health, Bureau of Infectious Disease and Laboratory Sciences, Office of HIV/AIDS met regularly to provide guidance to the organizations conducting the interventions. They set down guidance and processes for the intervention in this document which was periodically revised based on consensus upon review of proposals for improvements from the sites.

This document describes the data collection forms and protocol for completing the reporting forms. It provides a summary of the forms that were used to submit data to the Massachusetts Department of Public Health.

The Intervention Protocol is available on the Massachusetts Department of Public Safety website at <http://www.mass.gov/dph/aids>

¹MDPH Bureau of Infectious Disease HIV/AIDS and STD Surveillance Program and Office of HIV/AIDS. Strategic Peer Enhanced Care and Treatment Retention Model (SPECTRuM) Initiative, Intervention Protocol #2. September 2014.

SPECTRuM surveillance site communication form

The line list template is an Excel spreadsheet through which each SPECTRuM site provided to the MDPH HIV/AIDS Surveillance Program data for patients who were lost to care or at risk for poor health outcomes for a given period. More information about this tool and how it was incorporated into SPECTRuM Strategy 2 can be found beginning on p. 129. Below is a partial screenshot of the template.

For more information and updates on how the Health Department communicates with sites regarding HIV laboratory data, contact the Massachusetts Department of Public Health at 617-624-5300.

1	Q7 Not a patient at site; Moved/Discharged from practice															
2	SITE NAME															
3	DATE MDPH SENT REPORT TO SITE															
4	DATE REPORT CREATED:															
5	In the Notes field, indicate important information not captured in one of the columns including: incarcerated; moved out of state; deceased; institutionalized; entered substance abuse program; lost to follow-up (i.e., >4 months since contact, no pending appointment, and multiple attempts at contact).															
6	Patients with a detectable viral load															
7	FIRST NAME OF CLIENT	LAST NAME OF CLIENT	DATE OF BIRTH	Physician Last Name	Physician First Name	Date of detectable VL lab result	Value of last detectable VL	Date of Last Line List Appearance (if applicable)	Notes from Last Line List (if applicable)	Started ART <3 months ago	On ART >3 months ago	Not on ART	Patient not interested in taking ART	Patient not adherent to ART regimen	Viral "blip"; patient normally adherent to ART	Has an upcoming appointment
8																
9																
10																
11																

HHC detectable viral load tracker terms and definitions

Detectable Viral Load Tracker Terms and Definitions



Detectable Viral Load- Latest viral load result is >200 copies/mL

Included Patients- Any active HIV+ patient that had a detectable viral load as their latest result

Excluded Patients- Any active HIV+ patient that had a suppressed viral load as their latest result, patients that were inactive before the start of the measured month, patients that were deceased before the start of the measured month or during the measured month

Data Collection- Data is collected 1 month after the measured month. For example, January's data is collected in the beginning of February, to see which patients had a detectable viral load in January and prior to January. The results will be recorded in the tracker and will be counted towards the average viral load for the beginning of the month (January). If a patient gets updated labs during the month of February, the updated lab result will be recorded in the tracker and will be counted towards the average viral load for the end of the month (January). If a patient had a detectable viral load in the beginning of the month, when data is collected, and had an updated suppressed viral load lab result, the results will be recorded and counted towards the average viral load for the end of the month. This patient will not be recorded in the tracker for the following month.

Detectable Viral Load Tracker Categories:

Meds- Patients that are prescribed ART and have active ART scripts, regardless if the patient is taking them and/or getting them refilled.

No Meds- Patients that are not prescribed ART and do not have active ART scripts

Reasons for Viral Load:

Not taking prescribed meds- Patient is not taking the ART that was prescribed to him/her

Lost to follow-up- Patient has not shown up to scheduled appointments to discuss patient's HIV diagnosis and detectable viral load

Miss doses- Patient reports that s/he is taking prescribed ART but is missing recommended doses, i.e., skipping days

Need updated labs- Patient is due to have his/her labs

Restarted meds- Patient was taking ART at some point but stopped. Patient has started to take the prescribed ART again

New on meds- Patient has never been on ART before and is starting to take ART

RESOURCES STRATEGY 2

HHC detectable viral load tracker terms and definitions (cont.)

Med resistance- Patient’s HIV is resisting the prescribed ART

Refuses meds- Patient refuses to take ART and does not wish to be prescribed ART

Not ready for meds- Due to patient’s circumstances, patient is not mentally and/or physically ready to be prescribed ART

Unknown- Patient does not get Infectious Disease care at HHC and the status of the patient’s health has not been communicated to HHC staff by ID provider or patient

Average Viral Load- The average viral load results for each month by patients that are prescribed ART, patients that are not prescribed ART, and both for the beginning and end of each month

“+” Patients that are new to the detectable viral load list, either by being a new patient, being a reconnect, or the patient’s latest viral load result was detectable

“-” Patients that had an undetectable viral load result when his/her labs were updated during the month

HHC detectable viral load tracking sheet

Below is an example of the spreadsheet used to track clients with a detectable viral load that was used at Holyoke Health Center.

	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V
1	Name	Viral Load	CD4 Count	Last Lab Date	Case Manager	Nurse Case Manager	ID Provider	Prescribed HAART	Notes	DOT	Pill Box	Reminder Calls	Adherence Counseling	Mental Health Referral	Substance Abuse Referral	Housing	Visiting Nurse	Transportation	Med Delivery	Case Management	Reason for VL
2	Client name 1																				
3	Client name 2																				
4	Client name 3																				
5	Client name 4																				
6																					
7																					
8																					

UMMC client discharge/Drop out form

SPECTRuM staff at UMass Memorial Medical Center filled out the below form when a client on the line list was determined to be lost to care and no further information is available despite repeated attempts to make contact with the client. See the insert on p. 137 for a description of the process of creating the out-of-care list at UMMC.

Patient Discharge / Drop Out Form



Patient Information

Patient Name:	MR #:
Provider Team:	Clinic:
Genuwin Code:	Last Appt Date:
Primary Phone #:	Other Phone #:

Patient Status

Patient made an appointment	Date of Appt:
Moved out of area	Where?
Changed provider within area	Why?
Incarcerated	Where?
Institutionalized	Where?
Unable to contact	
Deceased	Death Date:

Lost to Follow Outreach Attempts

Date & Time	Patient Response	Staff Initials
Call 1		
Call 2		
Call 3		
Certified Letter		

BMC process for updating the line list report and example of tracking spreadsheet



Below is the process the Boston Medical Center SPECTRuM team used to update the line list report:

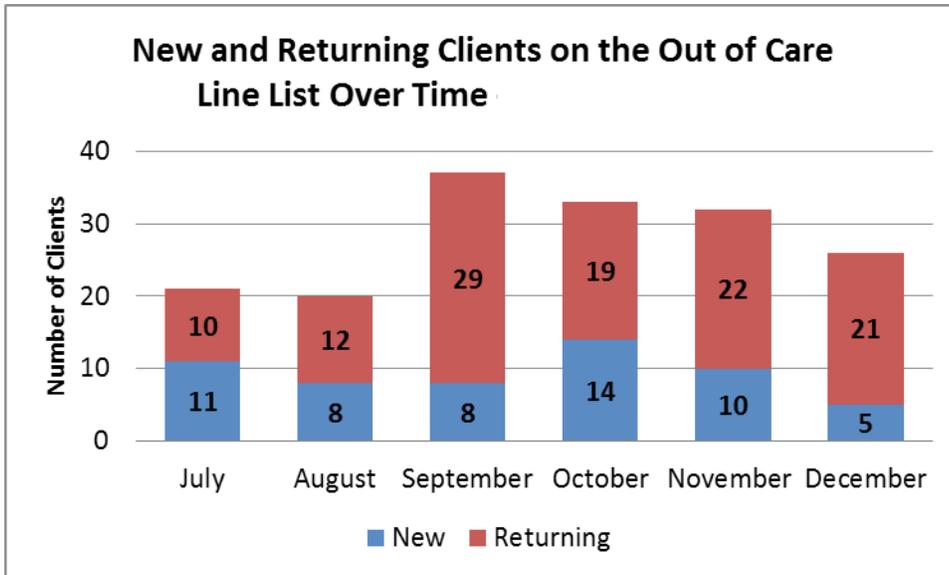
1. Once the Excel spreadsheet is downloaded from the encrypted drive, the data manager compares the data to an EMR dataset that the hospital’s IT department provides. This allows the data manager to get the client’s medical record number (MRN), which is essential for doing chart reviews in the electronic medical record (EMR). For those who don’t have matching MRNs, there may be spelling mistakes. These are individually looked up in the hospital registration system.
2. The data manager mostly focuses on the “out of care” list and does individual chart reviews on each client, gathering information on whether the client is truly out of care by checking if the client has an upcoming appointment or recently had a viral load drawn.
3. If the client is truly out of care, the data manager sends an internal message in the EMR to the case manager or the SPECTRuM team to perform the outreach protocol (2 phone calls followed by a letter). The staff then sends a message back to the data manager with the relevant information so the line list comments can be updated.
4. The names of the truly out-of-care clients and all clients that are on the detectable viral load list are sent individually to the physicians on a monthly basis via email.

Month/Year Line list received	SPECTRuM Referrals	# successfully making appt for pt	# enrolled	%	MCM referrals	# successfully making appt for pt	%	Total hrs spent
May-13	14	14	2	100%	20	10	50%	12
Jun-13	7	6	3	86%	11	4	36%	6
Jul-13	3	2	1	67%	16	10	63%	6
Aug-13	0	0	0		7	2	29%	8
Sep-13	0	0	0		17	11	65%	5
Oct-13	0	0	0		10	7	70%	5
Nov-13	0	0	0		10	8	80%	7
Dec-13	0	0	0		13	5	38%	4
Jan-14	0	0	0		14	11	79%	6
Feb-14	0	0	0		7	3	43%	5
Mar-14	12	6	2	50%	4	2	50%	7
Apr-14	2	1	3	50%	11	9	82%	5
May-14	8	7	4	88%	5	4	80%	6
Jun-14	0	0			4	3	75%	4
Jul-14	0	0			5	5	100%	4
Aug-14	0	0	2		12	5	42%	5
Sep-14	0	0	1		14	5	36%	5
Oct-14	0	0			15	5	33%	6
Nov-14	0	0	1		8	6	75%	4
Dec-14	3	2		67%	10	8	80%	6
Jan-15	4	3		75%	10	0	0%	7
Feb-15	2	2	1	100%	9	4	44%	6
Mar-15	2	2		100%	14	8	57%	5
Apr-15	2	0		0%	14	9	64%	6
	59	45	76%	76%	260	144	55%	

Example of BMC’s spreadsheet to track clients appearing on the monthly line list received and referred to the SPECTRuM program.

Sample community health center line list report for January 2015

Includes line list data from July 1, 2014 – December 31, 2014



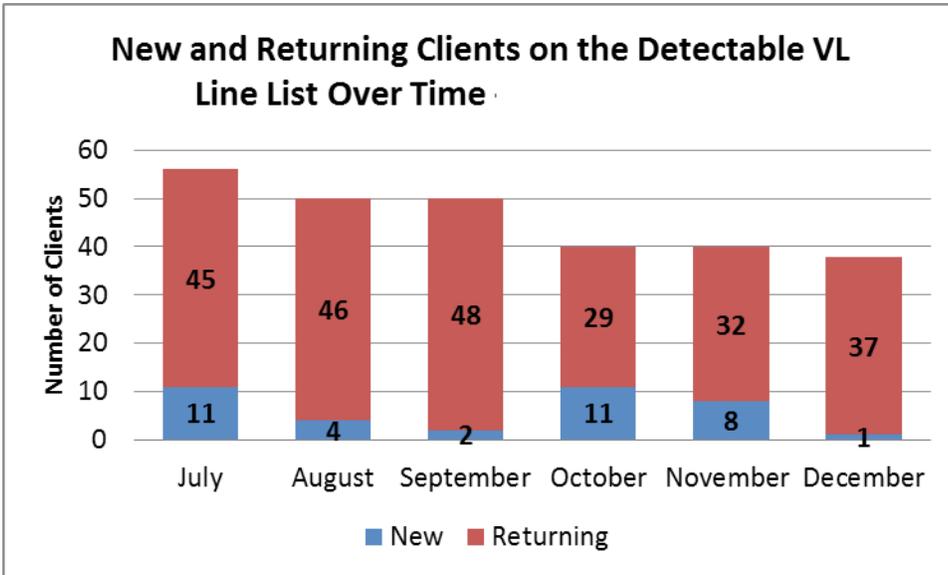
	July	August	September	October	November	December
New	52%	40%	22%	42%	31%	19%
Returning	48%	60%	78%	58%	69%	81%

New Patients: Patients who appeared on the line list for the first time

Returning Patients: Patients who had appeared on previous line lists

RESOURCES STRATEGY 2

Sample community health center line list report (cont.)

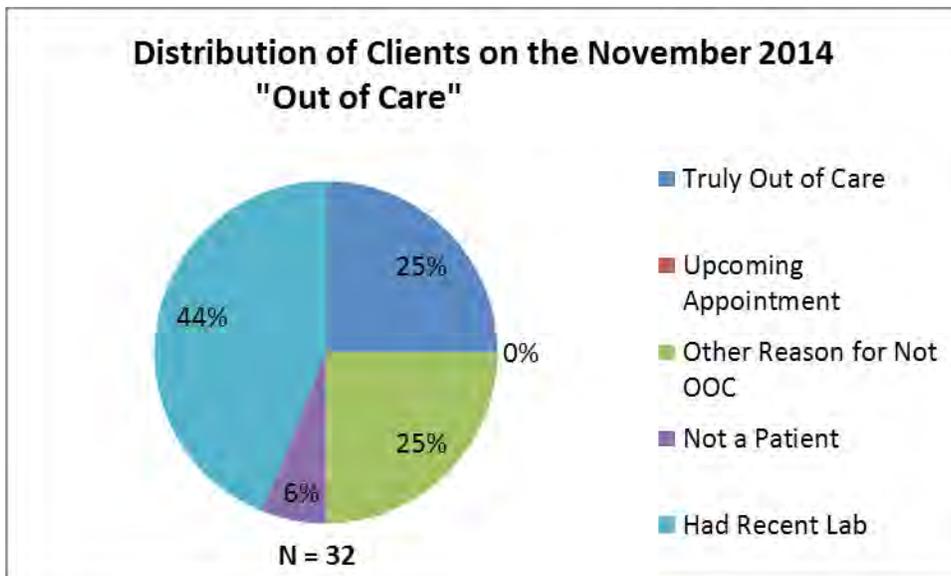
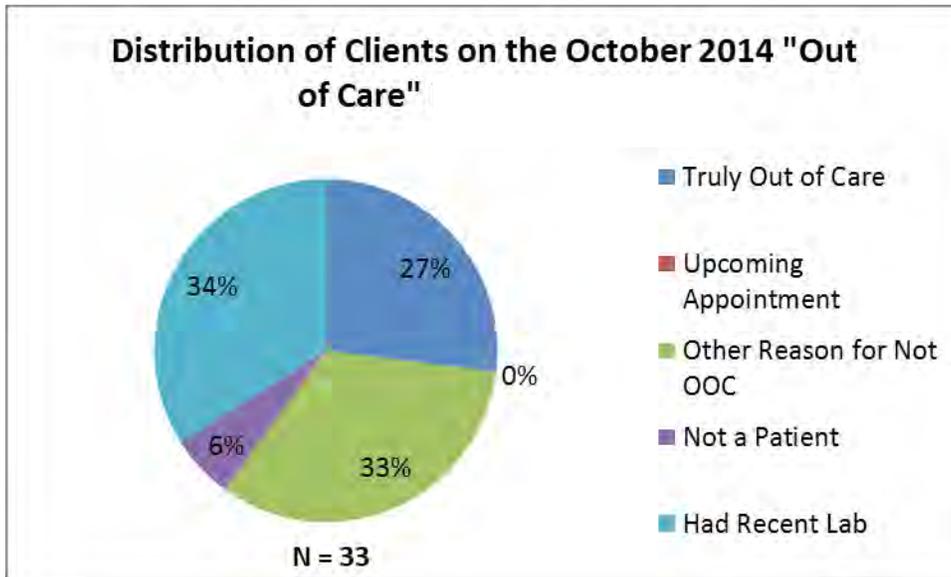


	July	August	September	October	November	December
New	20%	8%	4%	27%	20%	3%
Returning	80%	92%	96%	73%	80%	97%

New Patients: Patients who appeared on the line list for the first time

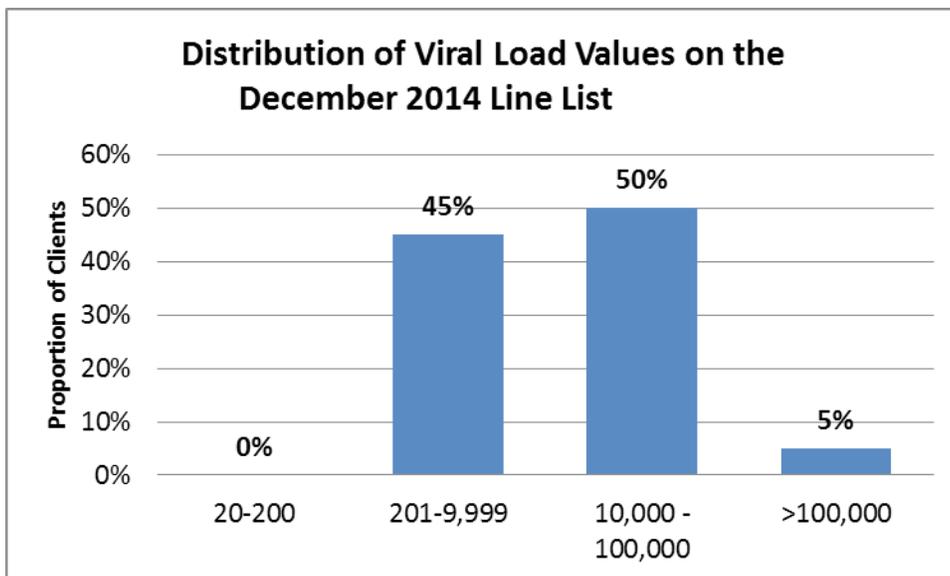
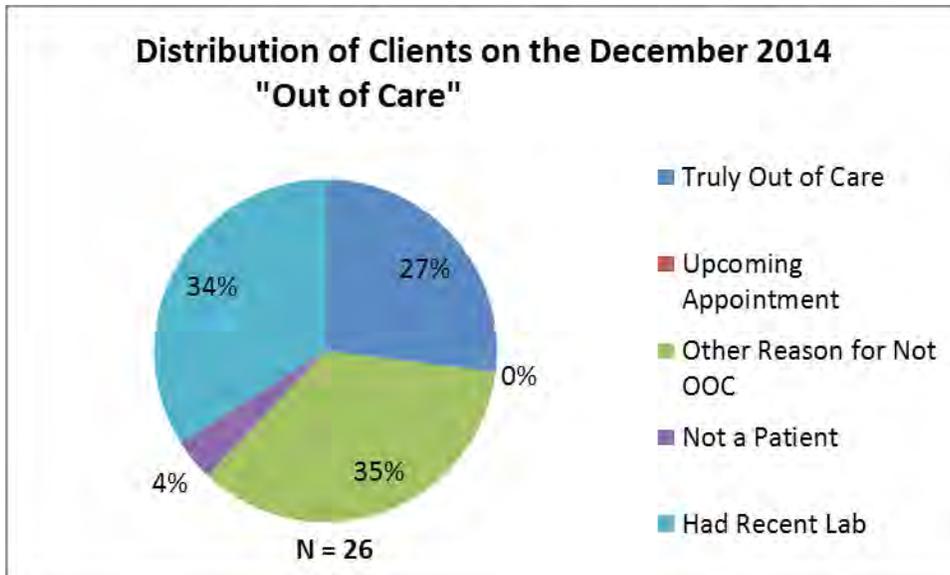
Returning Patients: Patients who had appeared on previous line lists

Sample community health center line list report (cont.)

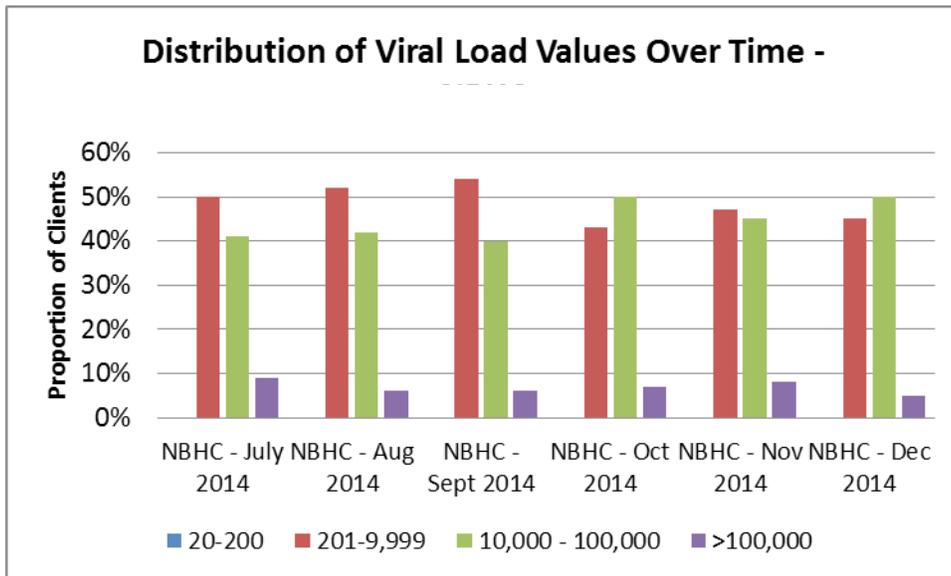


RESOURCES STRATEGY 2

Sample community health center line list report (cont.)



Sample community health center line list report (cont.)



	20-200	201-9,999	10,000 - 100,000	>100,000
July 2014	0%	50%	41%	9%
Aug 2014	0%	52%	42%	6%
Sept 2014	0%	54%	40%	6%
Oct 2014	0%	43%	50%	7%
Nov 2014	0%	47%	45%	8%
Dec 2014	0%	45%	50%	5%

Out of Care Line List

Among the 9 patients **truly out of care** on the **May 2014 “Out of Care Line List”**, 1 individual (11%) had a new lab reported to the MDPH HIV/AIDS Surveillance Program within 3 months of the list date; 2 individuals (22%) had a new lab reported within 6 months of the line list date (based on labs reported to MDPH as of January 15, 2015).

Among the 15 patients **truly out of care** on the **June 2014 “Out of Care Line List”**, 7 individuals (47%) had a new lab reported to the MDPH HIV/AIDS Surveillance Program within 3 months of the list date; the results were the same when examined with a 6-month time frame (based on labs reported to MDPH as of January 15, 2015).

Detectable VL Line List:

Among the 57 patients on the **May 2014 “Detectable Viral Load Line List”**, 36 individuals (63%) had an undetectable viral load reported to the MDPH HIV/AIDS Surveillance Program (based on the most recent viral load lab reported to MDPH as of January 15, 2015).

Among the 53 patients on the **June 2014 “Detectable Viral Load Line List”**, 29 individuals (55%) had an undetectable viral load reported to the MDPH HIV/AIDS Surveillance Program (based on the most recent viral load lab reported to MDPH as of January 15, 2015).

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For questions and comments on this manual and its resources, contact the Massachusetts Department of Public Health at 617-624-5300.

This manual can be found in its entirety on the web at <http://www.mass.gov/dph/aids>

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