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**Identify People Living With HIV/AIDS and Link Them to Quality Care and Treatment Services**

CDC estimates that approximately 250,000 Americans living with HIV/AIDS are unaware of their status, are not receiving care and treatment services for their HIV disease and may be unknowingly transmitting HIV to partners.<sup>1</sup> In order to accomplish the important task of identifying these individuals, continued, appropriate scale-up of existing HIV testing and screening efforts, targeted in a cost-effective and appropriate manner, is essential. HIV-positive individuals identified through these efforts must be linked into programs that provide the necessary information for them to make choices about their risk-taking behavior and about appropriate care and treatment services. In addition to the individuals that do not know their HIV status, CDC estimates that about one third of Americans living with HIV/AIDS who are aware of their status are not receiving care and treatment.<sup>2</sup> Through increased outreach and HIV testing and screening efforts, some of these individuals can be “re-linked” into prevention and care programs, as appropriate.

One of our nation’s greatest successes in fighting this epidemic has been the increasingly effective treatment with lifesaving antiretroviral medications of persons living with HIV/AIDS. Thankfully, this has led to greatly improved health status for most of those living with HIV/AIDS. With individuals adhering to effective and ever-improving treatment regimens, viral loads are lower, resulting in a much lower probability that the virus will be transmitted to others. For the sake of individual health, as well as reducing the probability of HIV transmission, we must ensure that newly diagnosed HIV-positive individuals (and those who know their status but have dropped out of care) are linked to care and treatment services, regardless of the status of their health care coverage. Systems like Medicare and Medicaid, the AIDS Drug Assistance Program, as well as

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all other parts of the Ryan White Program, particularly primary care, must be funded accordingly and have appropriate policies in place that ensure linkages between HIV testing efforts and care and treatment.

This month's *Prevention Bulletin* profiles state programs that link people living with HIV/AIDS into care and treatment services, as well as one state's efforts to link young people living with HIV/AIDS into care and treatment services. A national program targeting linkages into care and treatment is also profiled.

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#### References:

1. Revised Recommendations for HIV Testing in Adults, Adolescents and Pregnant Women in Health-Care Settings, *MMWR Reports and Recommendations*, September 22, 2006/ 55(RR14);1-17. Accessed on 4/23/08 from:  
<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm>
  2. HRSA HIV/AIDS Bureau, *Tools for Grantees: Engaging People in Care/The Issue: PLWH Not In Care*, accessed on 4/23/08 from:  
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- 

#### Profiles Linking People With HIV/AIDS To Care And Treatment Services

To highlight the successes and challenges faced by health departments in connecting prevention and care and treatment services, NASTAD solicited information from the Michigan and Virginia health departments. These two programs point out that linking people to care and treatment services is essential, but at the same time, a complex task that requires open communication between several systems within the state public health system.

##### *Michigan's Linkages to Care and Treatment Services*

*NASTAD spoke with Patrick Yankee, Manager of the Continuum of Care Unit in the Michigan Department of Community Health's HIV/AIDS Prevention and Intervention Section, about their efforts to link people to care and treatment services.*

**NASTAD:** How does your program interact/collaborate with your state's prevention program? What barriers exist? How does your program collaborate to connect clients from HIV testing into care?

**Michigan:** Both the HIV prevention and care programs reside within the same organizational unit of the Michigan Department of Community Health, so communication and collaboration between the programs is ongoing. This occurs in management meetings and is fostered by a variety

of overlapping activities among professional staff. Many agencies (sub-grantees) receive both HIV prevention and care resources, but inherently, each program has different requirements. This reality often causes staff to focus on specific rules or conditions for each federally-funded activity. For example, standards for providing counseling, testing and referral (CTR) services require that all sites funded by the Michigan Department of Community Health (MDCH) have specific procedures and referral agreements in place for referrals to care services for newly diagnosed persons. Additionally, the MDCH uses a Counselor Assisted Referral Form (CARF) that is completed during post-test counseling (with the consent of the client) and sent to local case management agency, which provides follow up in a specific amount of time.

**NASTAD:** In terms of linkages and access to care, how have the new requirements of the Ryan White Program impacted your AIDS Drug Assistance Program (ADAP)? Do you think these mandates are working to improve your program?

**Michigan:** We enroll an average of sixty new persons per month on ADAP. Approximately 50-60 persons a month gain eligibility for Medicaid or other coverage and, thus, leave ADAP. We have not yet observed a direct impact on ADAP based on these new requirements.

**NASTAD:** How are your clients linked to substance abuse and/or mental health services?

**Michigan:** Primarily via case management agencies under contract with MDCH. Michigan's Standards of Care of Case Management requires a comprehensive assessment of life areas, including the need for substance abuse or mental health services. Michigan uses a system of coordinating agencies throughout the state that serve as gate-keepers, conduct substance abuse assessments, and place eligible persons into appropriate treatment (either paid by third party insurance, Substance Abuse and Mental Health Services Administration, or other funds). Mental health treatments are less easy to procure, given the limited availability of community mental health services. Depending on need, a combination of services is coordinated by the primary care physician (if prescription treatment is indicated) and local mental health counselors, under agreement with Ryan White-funded providers.

**NASTAD:** What linkages does your program provide to STD treatment?

**Michigan:** Many Ryan White Program services are provided by local health departments, who also provide STD treatment. Outside of that, the primary linkage to this service would again be through a primary care

physician. All case managers receive training on basic STD information and treatment during Case Management Certification Training, which is a requirement of receiving Ryan White Program funds.

**NASTAD:** Do you have any words of advice for others wishing to improve linkages to care?

**Michigan:** Michigan has integrated specific expectations around linkages to care for newly diagnosed persons at publicly funded HIV Counseling, Testing and Referral (CTR) sites. This topic is covered specifically in certification training for HIV Test Counselors. Michigan requires that referrals to care services for newly diagnosed persons be entered into the HIV Event System (HES) at all publicly funded sites. The use of a specific form called the Counselor Assisted Referral Form (CARF) has been an effective tool to facilitate the referral to case management services to newly diagnosed persons. The experience in Michigan is that the process requires that providers (both CTR and case management) need to be encouraged to document the use of this form and to use it consistently. Also, since the referral is voluntary, the CTR staff must present the process clearly so that the client has a clear understanding of what can be expected.

Michigan's experience in the area of linkages for formerly incarcerated persons who are eligible for community-based HIV services upon release has taught us that a centralized system for referrals coming from correctional facilities helps assure that persons are more consistently linked to care upon release. Michigan uses a central intake line at a community-based organization to receive these referrals from any of the forty-three facilities in the state. An intake worker designated for this purpose collects relevant information from the facility and patient, and facilitates the linkage to the appropriate HIV services agency/clinic in the state when the prisoner is to return upon release. While recidivism remains a challenge among this population, our experience is that these persons benefit greatly from the services that can be arranged through this process.

*Linking Prevention and Care and Treatment Services in Virginia*  
 NASTAD spoke with Faye Bates, Coordinator, AIDS Drug Assistance Program, Virginia Department of Health, Division of HIV/STD and Pharmacy Services, to learn about how Virginia connects people living with HIV/AIDS to care and treatment services.

**NASTAD:** How does your program interact/collaborate with your state's prevention program? What barriers exist? How does your program collaborate to connect clients from HIV testing into care?

**Virginia:** The Virginia Department of Health, Division of Disease Prevention includes both the Health Care Services Unit, which administers the Ryan White Part B grant activities and state-funded HIV services, and the HIV Prevention Program, under the Community Services Unit, that administers grants for HIV education, counseling, testing and referral in the community. The two units collaborate on a public hearing process that is held in the fall. This facilitates sharing of information about people living with HIV/AIDS (PLWHAs) and providers in service delivery and prevention activities. In addition, along with education and service providers, clients, state agency representatives, clergy and private citizens, both work units participate in the HIV Community Planning Committee to develop a comprehensive HIV prevention plan for Virginia. The Division of Disease Prevention also has the Field Services Unit that coordinates HIV/STD prevention counseling, testing, referral, and partner services. Referrals for Ryan White-funded services are received through STD clinics and testing sites. Program Coordinators representing all Division programs collaborate to conduct site visits with local health district staff in order to enhance communication and improve service delivery.

Two contractors are funded for prevention activities through the Community Services section, and Part B Minority AIDS Initiative (MAI) activities through the Health Care Services section. The prevention contracts provide education, counseling, testing and referral services and the contracts under Health Care Services provide outreach and linkage to the AIDS Drug Assistance Program (ADAP) and medical care. The MAI contracts provide outreach to at-risk populations linking to ADAP and primary medical services.

**NASTAD:** In terms of linkages and access to care, how have the new requirements of the Ryan White Program impacted your ADAP? Do you think these mandates are working to improve your program?

**Virginia:** Virginia does meet the mandate that 75 percent of its ADAP funding go toward core services. Virginia ADAP Services are available to all eligible clients in Virginia regardless of where they live in the state or under which Ryan White part the services are funded through. Through a substantial supplemental award, Virginia ADAP was able to add the new classes of antiretrovirals to the formulary to comply with formulary mandate. The expansion of the formulary allowed a number of psychotropic drugs to be moved from the non-ADAP formulary to the ADAP formulary so that more funds are available for mandated core services.

**NASTAD:** How are your clients linked to substance abuse and/or mental

health services?

**Virginia:** Substance abuse and mental health services are provided through contractual relationships implemented by the five regional HIV consortia in the state. Services are provided through Community Services Boards, which are the public mental health and substance abuse treatment programs, or through private providers. Seeking and retaining providers remains a challenge for this service.

**NASTAD:** What linkages does your program provide to STD treatment?

**Virginia:** Each health district in Virginia has clinics for HIV/ STD screening, counseling and STD treatment. Newly diagnosed HIV-positive individuals are identified through these clinics and referred to Ryan White-funded services, if eligible. As Virginia is an integrated STD/HIV program, the same health counselors conduct STD/HIV case investigations and partner follow up.

The Virginia Department of Health recently entered into an agreement with a major medical center in Eastern Virginia to provide funding through Ryan White Part B for the treatment of STD to HIV-positive individuals seen in their infectious disease clinic. This agreement will ensure that Ryan White-eligible HIV-positive clients will receive treatment for STD identified during their clinic visit.

#### **Linking High-Risk Youth to Care and Treatment Services**

*To highlight the successes and challenges faced by community-based organizations (CBO) in providing care and treatment services to youth in high-risk settings, NASTAD spoke with Cambridge Cares about AIDS (CCA) to learn how such organizations are linking young people to services at the community level. Monique Tula, Director of Prevention and Education and Ayala Livny, Program Manager of Youth on Fire (YOF), described their continued efforts to evolve CCA's capacity to provide comprehensive programs and services.*

*Cambridge Cares about AIDS (CCA) is a CBO that was established in response to the HIV/AIDS epidemic and its disproportionate impact on poor minority communities. Founded on *harm reduction* principles, CCA provides direct prevention, education, advocacy and support services to more than 3000 adults and youth, 70 percent of whom are racial and ethnic minorities. Accordingly, CCA offers non-judgmental, culturally appropriate programs and services that make basic resources available to youth participating in their programs. These services include food, shelter, basic medical care, mental health and substance use counseling and treatment, financial assistance, clothing, immigration assistance and*

other social supports.

CCA's Prevention and Education (PE) program emphasizes the importance of building supportive relationships in order to promote positive behavior change. These services are provided through the several sub-programs. In particular, PE's YOF is a multidimensional program serving youth who are the most vulnerable and at greatest risk of HIV and STD infections. Developed in 2000 as a response to the needs expressed by homeless youth who congregated in Harvard Square, YOF operates as a drop-center for homeless youth. This program uses a three-tier service delivery system, with the first tier serving basic needs and the second tier offering support services through case management to assist youth in addressing housing needs, enrolling in school and gaining access to counseling and treatment services. The third tier of services provides young people opportunities for leadership and growth through opportunities to serve on committee panels and participation in a speaker's bureau. This program is based on a harm reduction philosophy that works to establish a hierarchy of goals and successive steps toward reduction of risk or a risk-free lifestyle.

Each year, YOF serves 250 youth between the ages of 14 and 24. Ninety-five percent of the program's participants are between 17 and 24 years of age, and 58 percent are male, 38 percent female and four percent identify as transgender. Forty percent of participants aged 17 to 24 self-identify as lesbian, gay, bisexual or queer. Although racial and ethnic representation is evenly divided among white and minority youth, YOF staff has noticed an increase in the number of youth of color seeking services over the past several years. In addition, 40 percent of these youth have a history of involvement with social services and 30 percent report having been in jail or prison.

To understand the broader context in which CCA provides services, it is important to note that in the State of Massachusetts, less than half a percent of the population between ages of 13 and 24 tested positive for HIV. Of this number, eight percent live in the Greater Boston area, but, despite these numbers, few HIV positive youth seek the services offered by YOF.

In addition to the counseling and testing services provided through case management, YOF offers comprehensive services in designated "safe places" through collaboration with the Sidney Borum Health Center (SBHC). This partnership with a community health center operated by the Justice Resource Institute (JRI) enables YOF to provide basic, triaged medical services with the help of a visiting physician.

As one of its strategic priority objectives, CCA intends to become a licensed satellite health clinic in order to provide more intensive medical services, including STD testing. This clinic would allow YOF to address significant health disparities among homeless youth who have a difficult time accessing treatment and care services and whose medical conditions often go untreated.

The agency's challenges in ensuring that their services are youth-friendly and culturally appropriate cannot be fully appreciated without contextualizing them in terms what takes place at the state level. In Massachusetts, 48 percent of HIV infection cases are among young men who have sex with men (YMSM). Despite improvements in chlamydia screening for youth and young adults, there have been sharp increases in the number of chlamydia cases. In 2005, it was reported that 71 percent of all new chlamydia cases occurred among youth between the ages of 17 to 24, while 51 percent of all gonorrhea infections occurred in youth between 14 and 24 years of age.

This alarming trend is evidence that a large segment of the youth population remains uninformed and untreated and continues to engage in unsafe sexual behaviors. At the local level, CBOs providing care and treatment services targeting youth have the following barriers and challenges in common: 1) young people have higher risk due to cognitive and emotional developmental factors; 2) socio-cultural influences impact youth as much as the general population; 3) unemployment or underemployment—leads to their inability to pay for services; 4) many youth lack transportation and health insurance; and 6) lack of confidentiality, which fosters discomfort using facilities and services designed for adults. Any program serving youth must acknowledge these fundamental challenges if they are to have any significant impact.

In an effort to tackle these barriers and provide culturally appropriate services, the previously mentioned satellite health clinic will be instrumental in addressing the care and treatment obstacles faced by youth in need of medical attention. The new clinic will offer free comprehensive health services and assistance in enrolling into MassHealth, the state's public health insurance program. YOF stresses the importance of offering factual information to youth without judgment, such as the opportunity to learn about safe needle practices or hormone treatment, particularly for transgender youth. Ultimately, CCA feels that service providers need to challenge the fundamental myths associated adolescent thinking—immunity, infertility and immortality. "Providing 'safe places' for youth living in high risk environments forces us to consider the language we use, our staff composition and how we communicate messages about safe sex," say CCA's Tula and Livny.

Despite efforts to address the needs of homeless youth, CCA staff recognize that there still are significant challenges around determining what is culturally appropriate, particularly considering that youth often are hesitant to engage this type of service agency. These youth often perceive public service agencies as belonging to the same systems that failed them in the past. As many in this population frequently report having a history of psychological and emotional trauma through abuse and neglect, this program has the added challenge of disarming youth and instilling trust. CCA engages youth with relationship building activities designed to help establish rapport and foster trust. For youth and adults, CCA recently launched *Phoenix Rising*, a program borne out of the increased recognition that youth coping behaviors for trauma often involve substance use/abuse and/or mental illness. CCA also stresses training for all staff on confidentiality protocols and is currently in the process of re-configuring its office space to promote private and confidential communication between youth members and our staff.

*For more information on [Cambridge Cares about AIDS](#), follow the link. For more information about CCA's Prevention and Education or Youth on Fire programs, contact [Monique Tula](#) or [Ayala Livny](#).*

**American Academy of HIV Medicine (AAHIVM) Spearheads Efforts to Facilitate Follow up Care for Newly Diagnosed HIV-Infected Patients**  
The American Academy of HIV Medicine (AAHIVM), a national non-profit organization representing nearly 1,500 front-line HIV care providers, is spearheading efforts to assist primary care providers by identifying effective strategies for arranging follow up care for their newly diagnosed HIV-infected patients. These efforts, supported by a cooperative agreement from the Centers for Disease Control and Prevention (CDC), Division of HIV/AIDS Prevention, are intended to ensure effective follow up care strategies and tools are available to providers so that they can successfully implement the CDC's [Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health care Settings](#).

AAHIVM regularly convenes a workgroup of stakeholders representing a broad spectrum of professionals and organizations dedicated to promoting early diagnosis of HIV infection and accessible, ongoing, quality care for people with HIV or AIDS. Representatives from government agencies, state and local health departments, national organizations, health insurance plans, hospitals, universities and other health care settings meet regularly to discuss and provide input on the development of effective follow up care materials that will be shared with primary care providers who are planning for, or are currently providing, routine HIV testing in their practice.

AAHIVM and the workgroup are currently working on two activities that will serve as tools to help primary care providers ensure follow up care. First, the workgroup plans to research and develop an inventory of best practices or models for arranging follow-up care after a patient has been diagnosed with HIV infection. The focus of this activity is to make available a useful “how-to” document or tool kit for providers who want to offer HIV testing to all their patients but need practical information on how to assure that HIV-infected patients get appropriate follow up care. This effort will look at best practices in a number of settings, with an emphasis on the identification of best practices among primary care physicians in private practice that are not affiliated with an HIV clinic or other HIV care program.

Second, AAHIVM and the workgroup plan to develop referral guides for six communities that do not otherwise have this type of resource. The referral guides will be targeted to medical providers such as internists and family practitioners and will include easily accessible information they may need on sources of HIV primary care and other supportive services such as substance abuse treatment, mental health services and case management in their area. These six sites will serve as pilots, with the hope of developing guides for other jurisdictions in the future.

*As AAHIVM and the workgroup move forward with on the development of the referral guides, collaboration with local and state health departments and other relevant organizations will be necessary and of great assistance. For more information, contact [Rachael Dombrowski](#) at AAHIVM, (202) 659-0699, ext. 16.*

### **Conclusion**

These profiles point out the significant headway that CDC, health departments, CBOs and national partners have made in our collective endeavor to identify individuals living with HIV/AIDS who are unaware of their status and link them into appropriate and effective care and treatment services. Funding must continue to flow to these services. However, it is equally important to remember that early diagnosis efforts must not supplant a full scale-up of other interventions that have the potential to prevent new infections. With limited resources and extensive need, services must fit together in logical and effective ways in order to reduce redundancy, streamline programming and strengthen a synergistic response to reaching those in need of services. In addition, we must continue to support the integration of services at the client level, including integration of HIV, viral hepatitis, STD and TB programs, to maximize the health benefits of individuals.

### **Meeting and Planning Calendar**

Capacity Building Opportunities: For a searchable database of CDC-supported capacity building trainings and events, please visit the [Capacity Building Branch's Group Events Management System site](#).

May 18, 2008

HIV Vaccine Awareness Day. For more information, visit the [event website](#).

May 19, 2008

World Hepatitis Day. For more information, link to the [newsletter](#).

May 19, 2008

National Asian and Pacific Islander AIDS Awareness Day. For more information, visit the [event website](#).

May 22-25, 2008

20th Annual National Conference on Social Work and HIV/AIDS, Washington, D.C. For more information, visit the [conference website](#).

June 3 - 4, 2008

10th HIV/AIDS Conference: Unity & Diversity the Challenge for Change, Des Moines, IA. For more information, visit the [conference website](#).

June 11-14, 2008

HIV Prevention Leadership Summit (HPLS), Detroit, MI. For more information, visit the [conference website](#).

June 20, 2008

2008 Viral Hepatitis Health Leadership Summit, Baltimore, MD. For more information, visit the [conference website](#).

June 27, 2008

National HIV Testing Day. Sponsored by NAPWA. For more information, visit: [www.NAPWA.org](http://www.NAPWA.org)

July 28-29, 2008

2008 National Conference on Latinos and HIV/AIDS, Miami, FL. For more information, visit the [conference website](#).

August 3-8, 2008

XVIII International AIDS Conference, Mexico City, Mexico. For more information, visit the [conference website](#).

August 25-28, 2008

Ryan White HIV/AIDS Program Training and Technical Assistance Grantees

Meeting and 11th Annual Clinical Update, Washington, D.C. Convened by HRSA.

September 18-21, 2008

United States Conference On AIDS (USCA), Miami Beach, FL. For more information, visit the [conference website](#).

September 29-October 1, 2008

National Hepatitis Technical Assistance Meeting, Washington, D.C. For more information, contact [Chris Taylor](#).

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### Credits, Feedback and Input

The *NASTAD Prevention Bulletin* is edited by NASTAD staff and is written by staff and prevention experts from around the country. NASTAD's production of the *Bulletin* is made possible through funding provided by CDC's Division of HIV/AIDS Prevention (DHAP) in the National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention.

If you have an idea or program that you would like to include in the *Bulletin*, please contact [Dave Kern](#) or [Lynne Greabell](#) (202/434-8090). NASTAD welcomes feedback to issues presented in *Bulletin*. To submit commentary, please e-mail us at [NASTAD@NASTAD.org](mailto:NASTAD@NASTAD.org).

Electronic versions of the *Bulletin* are available on our [webpage](#).

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