Tackling Health Disparities & Inequities:

Interventions, Strategies & Considerations for Successful Linkage, Viral Suppression & Retention Among Newly Diagnosed Young Black Men Who Have Sex With Men (MSM)

Emma Nelson
Linkage to Care Specialist
Froedtert & The Medical College of Wisconsin
Milwaukee, WI
DISCLOSURES:

I have no relevant financial relationships with commercial interests to disclose.
PRESENTER INFORMATION:

- Educational Background
- Work History/Duration in the Field
- Current Role
- Policy/Program Development
- Certifications/Training
OVERVIEW:

1) The Problem:
   - Disproportional Rates of New HIV Infection &
   - Disproportional Rates of Successful Linkage, Engagement, Viral Suppression, and Retention Amongst Young Black MSM

2) Understanding the Problem: Factors that influence disproportionate health outcomes for Young MSM of Color

3) Tackling the Problem: Pilot Intervention: Wisconsin’s SPNS “Linkage to Care” Initiative

4) Strategies & Lessons Learned from LTC Pilot Program Intervention

5) Other Approaches/Strategies/Considerations

6) On-going Challenges
OBJECTIVES:

1. Explore social determinants of health and other systems of oppression that contribute to health disparities and inequities across the HIV care continuum.

2. Analyze disproportionately high rates of new HIV infections and disproportionately lower rates of successful linkage, viral suppression, and retention in care among young black men who have sex with men (MSM).

3. Assess Wisconsin’s “Linkage to Care” Initiative, an innovative intervention tailored to tackle HIV-related health disparities and inequities among young black MSM.

4. Discuss other considerations in providing successful integrative care, including trauma informed care, cultural humility, stigma and shame resilience, motivational interviewing, and educational-focused interventions.

5. Provide tools and resources for HIV care providers.
FRAMEWORK:

Using goals outlined in The 2020 National HIV/AIDS Strategy as a framework, this presentation will explore HIV among young black men who have sex with men. Specifically, it will touch on 3 central goals of the National HIV/AIDS Strategy:

1) Reducing New HIV Infections
2) Increasing Access to Care & Improving Health Outcomes
3) Reducing HIV-Related Health Disparities and Inequities.

Other considerations in providing successful integrative care will also be discussed, including trauma informed care, cultural humility, stigma and shame resilience, motivational interviewing, and educational-focused interactions. HIV care providers will also be provided tools and resources to better serve this community.
Goal 1: Reducing New HIV Infections

The HIV epidemic is concentrated in key populations and geographic areas. The 2020 Strategy calls for interventions that prioritize communities where HIV is most concentrated:

- Gay, bisexual, and other men who have sex with men of all races and ethnicities (noting the particularly high burden of HIV among Black gay and bisexual men)
- Black women and men
- Latino men and women
- People who inject drugs
- Youth aged 13 to 24 years (noting the particularly high burden of HIV among young Black gay and bisexual men)
- People in the Southern United States
- Transgender women (noting the particularly high burden of HIV among Black transgender women)
Goal 2: Increasing Access to Care and Improving Health Outcomes for People Living with HIV

2.A) Establish seamless systems to link people to care immediately after diagnosis and support retention in care to achieve viral suppression that can maximize the benefits of early treatment and reduce transmission risk.

2.B) Take deliberate steps to increase the capacity of systems as well as the number and diversity of available providers of clinical care and related services for people living with HIV.

2.C) Support comprehensive, coordinated patient-centered care for people living with HIV, including addressing HIV-related co-occurring conditions and challenges meeting basic needs, such as housing.
National HIV/AIDS Strategy:

Goal 3: Reducing HIV-Related Disparities and Health Inequities:

3.A) Reduce HIV-related disparities in communities at high risk for HIV infection.

3.B) Adopt structural approaches to reduce HIV infections and improve health outcomes in high-risk communities.

3.C) Reduce stigma and eliminate discrimination associated with HIV status.
THE PROBLEM:

Health Disparities & Inequity Among Young Black MSM

--Disproportional Rates of New HIV Infection Among Young Black MSM

--Disproportional Rates of Successful Linkage, Engagement, Viral Suppression, and Retention Among Young Black MSM
Disproportional Rates of New HIV Infections Among Young Black MSM.

Disproportional Rates of Successful Linkage, Engagement, Viral Suppression, and Retention Amongst Young Black MSM

- The state of Wisconsin reflects national trends in regards to health disparities and inequities in this population.
NEW HIV DIAGNOSES IN WISCONSIN: DEMOGRAPHICS

The 2016 “Wisconsin HIV Surveillance Annual Review” from the Wisconsin Division of Public Health AIDS/HIV Program presents data on people newly diagnosed with HIV.

- **By Sex:**
  - 6 times as many males as females (2016)
  - HIV rate increased among young males (ages 13-29), and declined among older males (2007-2016)

- **Gender:**
  - Increase in transgender transmissions, primarily among young people of color (2016).

- **Race/Ethnicity:**
  - 65% of new diagnoses were racial/ethnic minorities, despite making up only 17% of the population in WI (2016).
  - HIV dx rate for males was 13-fold higher in Blacks, 5-fold higher in Hispanics, and 2-fold higher in Asians and American Indians compared to Whites (2012-2016).
New HIV Diagnoses in Wisconsin: Demographics

- **Age:**
  - Median age at diagnosis was 31, but varied considerably by risk exposure group (2016)
  - Median age at diagnosis was 29 for MSM (2016)

- **Transmission Category:**
  - After adjusting for unknown risk, MSM account for 80% of new diagnoses (2016)
  - Number of new diagnoses among MSM remains stable, while rates among high risk heterosexual contact and people who inject drugs have declined (2007-2016).

- **Geography:**
  - Residents in 30 of 72 counties in Wisconsin were diagnosed with HIV, however, distribution was uneven.
  - Milwaukee County: 52%; Dane County: 10%; Kenosha County: 4.5%; Racine County: 4%; Department of Corrections and all other counties: 3% (2016).
Trends among New HIV Diagnoses in Wisconsin:

- 80% attributed to male-male sexual contact (MSM)
  - Reflecting national trends, MSM continue to be the population most affected by HIV in Wisconsin.

- 1 in 2 MSM were under 30
  - Young MSM accounted for 40% of all new diagnoses in Wisconsin

- 53% were in Milwaukee.
NUMBER AND RATE OF NEW HIV DIAGNOSES, WISCONSIN, 2007-2016

<table>
<thead>
<tr>
<th>Year of Diagnosis</th>
<th>Number of Diagnoses</th>
<th>Rate per 100,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>276</td>
<td>4.9</td>
</tr>
<tr>
<td>2008</td>
<td>242</td>
<td>4.3</td>
</tr>
<tr>
<td>2009</td>
<td>283</td>
<td>5.0</td>
</tr>
<tr>
<td>2010</td>
<td>253</td>
<td>4.4</td>
</tr>
<tr>
<td>2011</td>
<td>246</td>
<td>4.3</td>
</tr>
<tr>
<td>2012</td>
<td>223</td>
<td>3.9</td>
</tr>
<tr>
<td>2013</td>
<td>250</td>
<td>4.4</td>
</tr>
<tr>
<td>2014</td>
<td>221</td>
<td>3.8</td>
</tr>
<tr>
<td>2015</td>
<td>227</td>
<td>3.9</td>
</tr>
<tr>
<td>2016</td>
<td>221</td>
<td>3.8</td>
</tr>
</tbody>
</table>
Number of HIV diagnoses by age and sex, Wisconsin, 2016

- **Female**
- **Male**

<table>
<thead>
<tr>
<th>Age at Diagnosis (Years)</th>
<th>Number of Diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-19</td>
<td>17</td>
</tr>
<tr>
<td>20-24</td>
<td>45</td>
</tr>
<tr>
<td>25-29</td>
<td>32</td>
</tr>
<tr>
<td>30-34</td>
<td>24</td>
</tr>
<tr>
<td>35-39</td>
<td>14</td>
</tr>
<tr>
<td>40-44</td>
<td>12</td>
</tr>
<tr>
<td>45-49</td>
<td>17</td>
</tr>
<tr>
<td>50-54</td>
<td>8</td>
</tr>
<tr>
<td>55-59</td>
<td>13</td>
</tr>
<tr>
<td>60+</td>
<td>7</td>
</tr>
</tbody>
</table>
Percentage of New HIV Diagnoses among Whites and Persons of Color, Wisconsin, 1982-2016

![Graph showing the percentage of new HIV diagnoses among Whites and Persons of Color from 1982 to 2016.](image)
HIV Diagnosis Rate by Sex and Race/Ethnicity, Wisconsin, 2012-2016

Sex

Rate per 100,000 Population

Male

- Black: 41.3
- Hispanic: 15.8
- Asian: 1.1
- White: 5.7
- American Indian: 3.1

Female

- All males: 7.3
- All females: 9.5
- Hispanic: 5.1
- Asian: 2.5
- White: 0.4
Percentage of HIV Diagnoses by Sex and Estimated Transmission Category, Wisconsin, 2016

- Male-Male Sexual Contact‡
- Heterosexual Contact
- Injection Drug Use

<table>
<thead>
<tr>
<th>Category</th>
<th>Percent of New Diagnoses Within Each Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>80%</td>
</tr>
<tr>
<td>Male</td>
<td>94%</td>
</tr>
<tr>
<td>Female</td>
<td>86%</td>
</tr>
</tbody>
</table>

Legend:
- Male-Male Sexual Contact‡
- Heterosexual Contact
- Injection Drug Use
Number of HIV Diagnoses by County of Residence at Diagnosis, Wisconsin, 2016
NEW HIV DIAGNOSES IN MILWAUKEE

New HIV Diagnoses in Milwaukee 2016:

- **Sex:**
  - 5 times as many males as females

- **Race/Ethnicity:**
  - 92% are Persons of Color (POC), despite POC making up only 55% of the Milwaukee population.

- **Age:**
  - Median age at diagnosis was 28, but varied considerably by risk exposure group
  - Median age at diagnosis was 25 for MSM

- **Transmission Category:**
  - 81% are MSM
HIV Diagnoses in Milwaukee

- 8 Milwaukee Zip Codes account for over ½ of all new HIV diagnoses.

- HIV Diagnosis Rate: Milwaukee Compared to Other Geographies:
  - US: 12.3
  - Wisconsin: 3.8
  - Wisconsin (Excluding Milwaukee): 2.3
  - Milwaukee County: 12.0
  - City of Milwaukee: 17.3
UNDERSTANDING THE PROBLEM

FACTORS THAT IMPACT HEALTHCARE ENGAGEMENT & OUTCOMES FOR YOUNG BLACK MSM LIVING WITH HIV

- Social Determinants of Health (SDOH)
- Systems of Power and Oppression
- Cultural Humility
UNDERSTANDING THE PROBLEM: FACTORS IMPACTING DISPARITIES/INEQUITIES:

Factors that Impact Healthcare Engagement & Outcomes for Young Black MSM Living with HIV:

- Social Determinants of Health (SDOH)
- Systems of Power & Oppression
- Cultural Humility
UNDERSTANDING THE PROBLEM:
SOCIAL DETERMINANTS OF HEALTH:

Social Determinants of Health (SDOH):
“Social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries.” (World Health Organization)
UNDERSTANDING THE PROBLEM:
SOCIAL DETERMINANTS OF HEALTH:

A “place-based” organizing framework, reflecting 5 key areas of social determinants of health (SDOH), was developed by The Office of Disease Prevention & Health Promotion: “Healthy People 2020.”

These five key areas (determinants) include:
1.) Economic Stability
2.) Education
3.) Social and Community Context
4.) Health and Health Care
5.) Neighborhood and Built Environment

• Each determinant interacts with the other four
• All affect the health of the individual
# Social Determinants of Health

<table>
<thead>
<tr>
<th>Economic Stability</th>
<th>Neighborhood and Physical Environment</th>
<th>Education</th>
<th>Food</th>
<th>Community and Social Context</th>
<th>Health Care System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment</td>
<td>Housing</td>
<td>Literacy</td>
<td>Hunger</td>
<td>Social integration</td>
<td>Health coverage</td>
</tr>
<tr>
<td>Income</td>
<td>Transportation</td>
<td>Language</td>
<td>Access to healthy options</td>
<td>Support systems</td>
<td></td>
</tr>
<tr>
<td>Expenses</td>
<td>Safety</td>
<td>Early childhood education</td>
<td>Social engagement</td>
<td>Community competency</td>
<td></td>
</tr>
<tr>
<td>Debt</td>
<td>Parks</td>
<td>Vocational training</td>
<td>Discrimination</td>
<td>Provider linguistic and cultural competency</td>
<td></td>
</tr>
<tr>
<td>Medical bills</td>
<td>Playgrounds</td>
<td>Higher education</td>
<td>Health outcomes</td>
<td>Quality of care</td>
<td></td>
</tr>
<tr>
<td>Support</td>
<td>Walkability</td>
<td></td>
<td></td>
<td>Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations</td>
<td></td>
</tr>
</tbody>
</table>

**Health Outcomes**

- Mortality,
- Morbidity,
- Life Expectancy,
- Health Care Expenditures,
- Health Status,
- Functional Limitations
UNDERSTANDING THE PROBLEM: SOCIAL DETERMINANTS OF HEALTH:

1.) Economic Stability

- Poverty
- Employment
- Food Insecurity
- Housing Instability
UNDERSTANDING THE PROBLEM: SOCIAL DETERMINANTS OF HEALTH:

2.) Education

- High School Graduation
- Enrollment in Higher Education
- Vocational Training
- Language and Literacy
- Early Childhood Education and Development
UNDERSTANDING THE PROBLEM: SOCIAL DETERMINANTS OF HEALTH:

3.) Social and Community Context

- Social Cohesion
- Civic Participation
- Discrimination
- Incarceration
UNDERSTANDING THE PROBLEM: SOCIAL DETERMINANTS OF HEALTH:

4.) Health and Health Care

- Access to Health Care
- Access to Primary Care
- Health Literacy
Understanding the Problem: Social Determinants of Health:

5.) Neighborhood and Built Environment

- Access to Foods that Support Healthy Eating Patterns
- Quality of Housing
- Crime and Violence
- Environmental Conditions
UNDERSTANDING THE PROBLEM: SYSTEMS OF POWER & OPPRESSION

Privilege is a set of unearned benefits, rights, and access granted to people based on their membership in certain groups (i.e. white privilege, male privilege, class privilege). Privilege can include benefits all people ideally should have access to, like basic human rights, but can also encompass “bonuses” that nobody necessarily needs to survive but some folks are granted nonetheless. Nobody can actively rid themselves of their privilege, even if they work against the systems that grant it to them.

**Must recognize privilege in client relationships.

Oppression is the heady mix of power and prejudice that is often defined through privilege as its “losing end.” It’s the marginalization of people due to their membership in a certain group or, more accurately, the exclusion of people from systems of privilege due to their lack of membership in a social group (i.e. people of color not having access to white privilege, women not having access to male privilege, and poor people not having access to the privilege of wealth).

Institutional Power: The ability or official authority to decide what is best for others. The ability to decide who will have access to resources. The capacity to exercise control over others.
UNDERSTANDING THE PROBLEM: SYSTEMS OF POWER & OPPRESSION

Four Levels of Oppression/”isms”:
Oppression (the “ism’s”) happens at all levels, reinforced by societal norms, institutional biases, interpersonal interactions, and individual beliefs.

- Individual — feelings, beliefs, values.
- Interpersonal — actions, behaviors and language.
- Institutional — rules, policies, legal system, education system, public policy, hiring practices, media images.
- Societal/Cultural — collective ideas about what is “right.”
# Matrix of Oppression

<table>
<thead>
<tr>
<th>Social Identity</th>
<th>Privileged Social Group</th>
<th>Border Social Group</th>
<th>Oppressed Social Group</th>
<th>Ism</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race</td>
<td>White People</td>
<td>Biracial People</td>
<td>Asian, Black, Latino, Native People</td>
<td>Racism</td>
</tr>
<tr>
<td>Sex</td>
<td>Bio Men</td>
<td>Transsexual Intersex People</td>
<td>Bio Women</td>
<td>Sexism</td>
</tr>
<tr>
<td>Gender</td>
<td>Gender Conforming Bio Men and Women</td>
<td>Gender Ambiguous Bio Men and Women</td>
<td>Transgender, Genderqueer, Intersex People</td>
<td>Transgender Oppression</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>Heterosexual People</td>
<td>Bisexual People</td>
<td>Lesbians, Gay Men</td>
<td>Heterosexism</td>
</tr>
<tr>
<td>Class</td>
<td>Rich, Upper Class People</td>
<td>Middle Class People</td>
<td>Working Class, Poor People</td>
<td>Classism</td>
</tr>
<tr>
<td>Ability/Disability</td>
<td>Temporarily Abled-Bodied</td>
<td>People with Temporary Disabilities</td>
<td>People with Disabilities</td>
<td>Ableism</td>
</tr>
<tr>
<td>Religion</td>
<td>Protestants</td>
<td>Roman Catholic</td>
<td>Jews, Muslims, Hindus</td>
<td>Religious Oppression</td>
</tr>
<tr>
<td>Age</td>
<td>Adults</td>
<td>Young People</td>
<td>Elders, Young People</td>
<td>Ageism/Adultism</td>
</tr>
</tbody>
</table>
Understanding the Problem: Cultural Humility

Cultural Humility:
The ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important to the person/client.

Cultural humility is different from other culturally-based training ideals because it focuses on self-humility rather than achieving a state of knowledge or awareness.
UNDERSTANDING THE PROBLEM: CULTURAL HUMILITY

Three Dimensions of Cultural Humility:

1) Lifelong learning & critical self-reflection —
To practice cultural humility is to understand that culture is, first and foremost, an expression of self and that the process of learning about each individuals’ culture is a lifelong endeavor, because no two individuals are the same; each individual is a complicated, multi-dimensional human being.

- Coming from a place of knowing that we don’t know
- Being able to accept our own limitations
- Encouraged to be curious tied to that place of not knowing
- Openness – we can feel open to those around us who want to learn about us
- All leads to lifelong learning and ongoing critical self-reflection
- We hold ourselves accountable for constant learning and curiosity to understand those around us
- Frees us from feeling that we have to be experts on others and their culture
UNDERSTANDING THE PROBLEM: CULTURAL HUMILITY

2) Recognizing and challenging power imbalances for respectful partnerships — while working to establish and maintain respect is essential in all healthy and productive relationships, the root of effective social work practice is in acknowledging and challenging the power imbalances inherent in our practitioner/client dynamics.

- We attempt to recognize when we are in a position of power and make attempts to neutralize this imbalance
- We notice when there is a power imbalance in systems and acknowledge this difference, also taking responsibility to point out and advocate

3) Institutional Accountability — organizations need to model these principles as well (from micro, to mezzo and macro practice)

- At an institutional level, we need to encourage this philosophy/culture
- If the system has embraced this philosophy, it will be much easier for the individuals to feel safe with the practice
TACKLING THE PROBLEM: PILOT INTERVENTION

SPNS “LINKAGE TO CARE” INITIATIVE
Pilot Intervention: 
Linkage to Care Initiative:

HRSA Special Project of National Significance.

- SPNS Program supports the development of innovative models of HIV care to quickly respond to the emerging needs of clients served by the Ryan White HIV/AIDS Program.
- Objectives:
  - Test linkage interventions in six states (LA, MA, NC, NY, VA, WI)
  - Evaluate effectiveness of interventions and disseminate findings.

Wisconsin SPNS Initiative: “Linkage to Care”:

- Only 46% of people living with HIV (PLH) in Wisconsin have suppressed viral load.
- An estimated 1 in 3 Black MSM in Wisconsin is living with HIV, compared to 8% of Hispanic MSM and 3% of White MSM.
- Wisconsin’s Linkage to Care intervention was designed to increase linkage and retention in HIV-related medical care among the most highly impacted populations, specifically young, Black MSM.
PILOT INTERVENTION: CARE CONTINUUM

- At High Risk for HIV
- Living with HIV
- Diagnosed and Living with HIV
- Linked within 3 Months of...
- In Care
- Retained in Care
- Virally Suppressed
- Virally Suppressed among Those...

Estimated Based on Surveillance Data
Pilot Intervention: Linkage to Care Specialists:

Linkage to Care Specialists (LTCS):

- Diverse educational and professional backgrounds
- Bachelors & Masters Degrees in Social Work & Public Health; Licensed Clinical Social Workers.
- Training:
  - HIV Counseling, Testing & Referral (CTR)
  - Motivational Interviewing
  - Medical Case Management
  - HIV Prevention Counseling
  - Insurance & Benefits Programs
  - Screening, Brief Intervention & Referral to Treatment (SBIRT)
  - Continuing education through the State HIV/AIDS Training System.
  - Other relevant trainings, conferences, meetings, continuing ed
Pilot Intervention: Linkage to Care Specialist

Role of LTCS in HIV Care:

- Setting: Work within HIV medical clinics and community-based organizations.

- Care Coordination & Support: Provide and coordinate services, referrals and appointments, attend appointments with clients, and help navigate health care systems.

- Education-Focused: System Navigation and Health Literacy

- Close Collaboration with Multidisciplinary Team
PILOT INTERVENTION: LINKAGE TO CARE VS. TRADITIONAL CASE MANAGEMENT:

Similarities to Traditional Case Management:

Service provision via assessment, individualized service plan development, and making referrals for needed services.

- Conduct initial assessment
- Develop individual care-plan, with period evaluation
- Continuously monitor client to assess the efficacy of the care plan
- Regularly assess client’s needs and personal support systems
- Ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care (primarily in clinical setting)
- Provide treatment adherence support to ensure readiness for and adherence to complex HIV treatments (primarily in clinical setting)
- Conduct client-specific advocacy and review utilization of services
PILOT INTERVENTION: LINKAGE TO CARE VS. TRADITIONAL CASE MANAGEMENT:

Differences from Traditional Case Management:

- **Barrier-Focused:** Scope is narrow and specialized, focusing on barriers that have prevented ongoing engagement in medical care, such as mental health or other comorbidities, substance use, transportation difficulties, and housing instability.
- **Acuity/Service Level:** Intervention specifically designed to target complex and high needs populations.
- **Caseload Size:** LTCS carry caseloads of only 15-20 clients.
- **Duration of Service:** LTCS work intensively with clients for approximately 6-12 months, transitioning to traditional case management or self-management (depending on needs/barriers to care).
- **Referrals:** Designed to accept referrals from any site and follow patients for care at any clinic.
- **More Field Work Opportunities**
- **Use of Motivational Interviewing**
<table>
<thead>
<tr>
<th>Activity</th>
<th>Case Management</th>
<th>Patient Navigation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Core Service Elements</strong></td>
<td>• Conduct initial assessment</td>
<td>• Make and follow-through with referrals for services</td>
</tr>
<tr>
<td></td>
<td>• Develop individual care-plan, with period evaluation</td>
<td>• Assist with obtaining benefits</td>
</tr>
<tr>
<td></td>
<td>• Continuously monitor client to assess the efficacy of the care plan</td>
<td>• Assist with obtaining stable housing</td>
</tr>
<tr>
<td></td>
<td>• Regularly assess client’s needs and personal support systems</td>
<td>• Provide high level of emotional support for all clients</td>
</tr>
<tr>
<td></td>
<td>• Ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care (primarily in clinical setting)</td>
<td>• Provide high degree of HIV health education</td>
</tr>
<tr>
<td></td>
<td>• Provide treatment adherence support to ensure readiness for and adherence to complex HIV treatments (primarily in clinical setting)</td>
<td>• Monitor laboratory values, in addition to medication and refill monitoring and coordination</td>
</tr>
<tr>
<td></td>
<td>• Conduct client-specific advocacy and review utilization of services</td>
<td>• Provide appointment reminders for all types of services</td>
</tr>
<tr>
<td><strong>Daily Activities</strong></td>
<td>• Make and follow-through with referrals for services</td>
<td>• Attend appointments of varying types with clients</td>
</tr>
<tr>
<td></td>
<td>• Assist with obtaining benefits</td>
<td>• Focus on disease self-management</td>
</tr>
<tr>
<td></td>
<td>• Assist with obtaining stable housing</td>
<td>• Monitor laboratory values</td>
</tr>
<tr>
<td></td>
<td>• Provide emotional support for higher acuity clients</td>
<td>• In addition to medication and refill monitoring and coordination</td>
</tr>
<tr>
<td></td>
<td>• Provide lower degree of HIV health education</td>
<td>• Provide appointment reminders for all types of services</td>
</tr>
<tr>
<td></td>
<td>• Monitor laboratory values</td>
<td>• Attend appointments of varying types with clients</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Focus on disease self-management</td>
</tr>
<tr>
<td>Activity</td>
<td>Case Management</td>
<td>Patient Navigation</td>
</tr>
<tr>
<td>-------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Eligibility Criteria</td>
<td>Individuals with acuity levels 1-3</td>
<td>Newly diagnosed, new to care, at risk of falling out of care, out of care, post-incarcerated; sometimes supplemented with acuity score</td>
</tr>
</tbody>
</table>
| Referral Source   | • Publicly funded testing sites  
• Partner Services  
• Clinic  
• Inmate discharge planner  
• Other service providers  
• Inpatient (some) | • Publicly funded testing sites  
• Partner Services  
• Clinic  
• Inmate discharge planner  
• Other service providers  
• Inpatient  
• Case managers |
| Case Load         | ≥30, plus Brief Services                                                        | 15-20                                                                              |
| Client Communication | • Acuity-based minimums (1-quarterly, 2-monthly, 3-2x/month)  
• Mostly client initiated | • No minimum requirement, but frequent contact is expected  
• Mostly navigator initiated  
• Work-sponsored cell phones |
| Place of Service  | • Office  
• Clinic  
• Inpatient (some) | • Office  
• Clinic  
• Inpatient  
• Field (community-based visit, testing sites) |
WHAT WORKS?

OUTCOMES & LESSONS LEARNED:

SUCCESSFUL INTERVENTIONS AND STRATEGIES FROM THE “LINKAGE TO CARE” INITIATIVE
Pilot Intervention: Outcomes: Perspectives & Lessons Learned:

- Client Perspective: Linkage to Care Specialists provided multiple forms of social support:
  - Mitigated negative feelings associated with HIV stigma
  - Increased motivation to adhere to medical care
  - Increased comfort with medical care
  - Challenge: Reluctance to transition out of LTC

- Collaborative process led to better integration of care and prevention services.

- Setting client expectations up front was critical to success and eases transition out of the program.

- Numerous best practices were identified from the LTC Initiative and incorporated into newly developed Medical Case Management Practice Standards
  - Motivational Interviewing
  - Use of text messaging and community contact/visits.
  - More focus on behavior change rather than just referral to other services
HIV Care Outcomes Among Linkage to Care Specialist Clients and Control Subjects

- **Linkage to Care within 90 Days**: 80.6% (75/93) for Linkage to Care Clients vs. 64.4% (199/309) for Controls.
- **Engagement in Care**: 74.3% (199/268) for Linkage to Care Clients vs. 47% (126/268) for Controls.
- **Viral Suppression**: 66.0% (177/268) for Linkage to Care Clients vs. 45.5% (122/268) for Controls.
Retention in Care ≥ 6 Months After LTC Intervention: Linkage to Care Specialist Clients and Control Subjects

- Controls: 62.5% (15/24)
- Linkage to Care Clients: 83.3% (20/24)
LTC Initiative: Outcomes, Lessons, Successful Interventions and Strategies

- Utilization of Motivational Interviewing
- Communication/Contact Methods
- System Navigation
- Health Literacy & HIV Education
- Harm Reduction Approach Relationships
- Relationships: Trust & Rapport Building
LTC Initiative: Outcomes, Lessons, Successful Interventions and Strategies: Motivational Interviewing

Motivational Interviewing:
“A directive, client-centered counseling style for eliciting behavior change by helping clients explore and resolve ambivalence.” The goal of motivational interviewing is to "help patients identify and change behaviors that place them at risk of developing health problems or that may be preventing optimal management of a chronic condition"

“Spirit” of MI:
- Competence Worldview: Belief that people are competent, possess self-knowledge, attitudes, and capabilities that can effect change.
- The Essential Foundation Partnership: You and the client are equal experts
- Acceptance: Absolute worth, accurate empathy, autonomy support, affirmation
- Compassion: Beneficence, caring, focus on the other
- Evocation: The client’s wisdom is most important
Motivational Interviewing Processes:
There are 4 Processes in Motivational Interviewing. They are not all necessarily sequential or linear, and may require jumping backwards and forwards depending on where the person is at.

1. **Engaging:** The process starts with **engaging**: without engagement there can be nothing

2. **Focusing:** MI is *directional* (as opposed to directive), with a trajectory toward a common goal (with engagement comes the process of **focusing**)

3. **Evocation:** Once we identify and agree on a goal with the person, we move to the process of **evoking** change talk to enhance motivation for change

4. **Planning:** Commitment language signals a person’s readiness for the process of **planning** key strategies and supports to mobilize change
LTC Initiative: Outcomes, Lessons, Successful Interventions and Strategies: Motivational Interviewing

Foundation Skills of Motivational Interviewing: OARS
The OARS skills are used in different ways throughout the processes of MI.

1. Open-ended questions help us to get to know the whole person – closed questions gather focused information

2. Affirmations offer a neutral observation of a person’s strengths, resources, efforts, values – and statements of affirmation are more motivational than praise

3. Reflective listening communicates understanding and attention.

4. Summary statements offer an opportunity to gather together diverse aspects of a problem, issue or conversational journey, and can also link back to previous material or ideas, and/or further exploration and dialogue.
LTC Initiative: Outcomes, Lessons & Successful Interventions and Strategies: Communication Methods

Unique Communication/Contact Methods:

Direct Contact Methods:
- Face to Face Encounters
  - Clinical Visit Settings: Outpatient Clinics, Inpatient Hospital Settings, Other Medical Clinics/Facilities, Mental Health & AODA Facilities, Health Departments, Testing Sites.
  - Home/Community Visit Settings: Home/Near Home, Gas Station, Coffee Shop, Fast Food Restaurants, Library
- Phone Calls, Texting, Traditional Mail (letters and cards), MyChart Messages, Apps

Collateral Contact Methods:
- Multidisciplinary Teams, Community Organizations & Providers; Family/Emergency Contacts; Inmate Searches; Social Media

**Healthcare System Navigation:**
- New to Care & Healthcare Systems
- Benefits: Insurance, Assistance Programs
- Stigma/Confidentiality
- Language & Cultural Considerations
- Clinic Operations (provider, scheduling considerations)

**Navigation of Community Programs & Resources:**
- Medical Care (HIV, Primary, Specialty)
- Mental Health/Behavioral Health Care
- AODA Treatment & Groups
- Dental & Optical Care
- Support Groups & Social Programs
- Benefits Programs (Insurance, Disability)
- Employment Resources
- Housing (Emergency Shelter Programs, Rental Assistance Programs)
- Food Assistance Program (state benefits, local pantries and meal sites)
- Transportation
LTC Initiative: Outcomes, Lessons & Interventions and Strategies: Health Literacy & HIV Education

Health Literacy & HIV Education:
“The degree to which individuals have the capacity to obtain, process, and understand basic information and services needed to make appropriate decisions regarding their health.” (Institute of Medicine)

- Health Literacy:
  - Adapt Different Learning Styles
  - Language

- HIV 101:
  - History/Context
  - Basic Concepts of HIV
  - Use of Visuals (handouts, animations, drawings, online tutorials)
  - Provide HIV 101 books, credible online resources.
  - Changing the way we talk about HIV:

- Adherence Counseling:
  - ARV Treatment Advances
  - Utilization of Use of Pharmacy Services & Pharmacy Collaboration
  - Adherence Tools
LTC Initiative: Outcomes, Lessons & Interventions and Strategies: Health Literacy & HIV Education

Health Literacy & HIV Education:

- Talking About Sex:
  - Environment: Safe & Non-judgmental
  - Gender Affirming & Sex Positive
  - Language
  - Trigger Warnings: Sexual abuse/Trauma screening

- Sexual History:
  - 5 Ps: Partners, Practices, Protection, Past History, Prevention of Pregnancy

- Prevention/Safer Sex Education
  - Buffet of Options
  - Barrier Methods (Proper Use, Accessibility)
  - Treatment as Prevention
  - PrEP
  - Testing Sites/Community Clinics
  - Health Department/Partner Services (Discreet Partner Notification and Testing)
LTC Initiative: Outcomes, Lessons & Successful Interventions and Strategies: Harm Reduction

Harm Reduction Approach:

- Environment: non-judgmental, patient-centered, focus on minimizing risk, utilize motivational interviewing strategies.

- Prevention/Safer Sex Counseling:
  - Methods/Options
  - Access
  - Demonstrations

- AODA/Injection Drug Users (IDU):
  - Access to Clean Needle Exchange Programs & Overdose Prevention Resources
  - Demos: Safer Injection, Overdose Prevention Services
  - Treatment & Support Resources
LTC Initiative: Outcomes, Lessons & Successful Interventions and Strategies: Relationships

Relationships: Trust & Rapport Building

Client/Patient Interviews and Evaluation:
- Mitigated negative feelings associated with HIV stigma
- Increased motivation to adhere to medical care & increased comfort with medical care
- Caused reluctance to transition out of LTC

Rapport & Trust:
- Cultural Humility & Honesty
- Power Dynamics
- Flexibility (Patient-centered)
- Be an Ally
- Support System: Time/Intensity of Relationship
- Trust/Rapport may have long-term pay off (readiness for care)
ADDITIONAL APPROACHES, STRATEGIES & CONSIDERATIONS FOR SUCCESSFUL LINKAGE, ENGAGEMENT, VIRAL SUPPRESSION, AND RETENTION

- Trauma Informed Care
- Stigma/Shame Resilience Theory
- Confidentiality/Privacy
**Additional Approaches, Strategies & Considerations: Trauma Informed Care**

**Trauma Informed Care:**
According to SAMHSA’s concept of a trauma-informed approach, “A program, organization, or system that is trauma-informed follows SAMHSA’s four “Rs”: 

- **Realizes** the widespread impact of trauma and understands potential paths for recovery
- **Recognizes** the signs and symptoms of trauma in clients, families, staff, and others involved with the system
- **Responds** by fully integrating knowledge about trauma into policies, procedures, and practices
- Actively seeks to **resist re-traumatization**
Additional Approaches, Strategies & Considerations: Trauma Informed Care

Trauma Informed Care:
SAMHSA’s 6 key principles of a trauma-informed approach:

1.) Safety—Throughout the organization, staff and clients should feel physically and psychologically safe.

2.) Trustworthiness and transparency—Organizational operations and decisions are conducted with transparency and the goal of building and maintaining trust among staff, clients, and family members.

3.) Peer support and mutual self-help—Both are seen as integral to the organizational and service delivery approach and are understood as key vehicles for building trust, establishing safety, and empowerment.

4.) Collaboration and mutuality—There is true partnering between staff and clients and among organizational staff from direct care staff to administrators.

5.) Empowerment, voice, and choice—Throughout the organization, and among the clients served, individuals’ strengths are recognized, built on, and validated, and new skills developed as necessary.

6.) Cultural, historical, and gender issues—The organization actively moves past cultural stereotypes and biases, considers language and cultural considerations in providing support, offers gender-responsive services, leverages the healing value of traditional cultural and peer connections, and recognizes and addresses historical trauma.
ADDITIONAL APPROACHES, STRATEGIES & CONSIDERATIONS: STIGMA & SHAME

Stigma:
- Internalized Stigma (sexual & gender identity; family and culture)
- External /Societal Stigma

“Shame” Defined:
“the intensely painful feeling or experience of believing we are flawed and therefore unworthy of acceptance and belonging.” (Dr. Brene Brown)

Components of Shame:
- It is universal
- A force in development of **moral** and **social** behavior.
- Most find shame difficult to talk about.
- The less we talk about shame, the **more powerful** shame becomes.
Categories of Shame: [Grounded Theory]
- Appearance & Body Image
- Parenting
- Mental Health & Physical Health
- Sex
- Religion (Religious Cultural Norms)
- Being Stereotyped or Labeled
- Money & Work
- Family
- Addiction
- Aging
- Trauma
- Culture

Shame Web:
A web of layered, conflicting, and competing expectations that are, at the core, products of rigid socio-cultural expectations. The sociocultural expectations are narrow interpretations of who some is “supposed to be,” based on their identity. The concept of a shame web illustrates how options are limited and expectations are far-reaching, reinforced at every turn and woven through numerous experiences and relationships.
Shame Resilience Theory (SRT):

- Shame Resilience Theory proposes that the great majority of the emotions, thoughts, and behaviors demonstrated by those experiencing shame are efforts to develop shame resilience by decreasing the feelings of being trapped, powerless, and isolated and to increase the opportunities to experience empathy by increasing connection, power, and freedom from the shame web.

- SRT proposes that shame resilience is best understood on a continuum that represents, on one end, the main concerns of participants: feeling trapped, powerless, and isolated. Located on the opposite end of the continuum are the concepts participants viewed as the components of shame resilience: empathy, connection, power, and freedom.
Shame Resilience Theory
By Brené Brown

1. Ability to Recognise and Understand our Shame Triggers
2. High Levels of Critical Awareness
3. Ability to Reach Out and Tell Your Story
4. Ability to Speak Shame
Countering Shame: Shame Resilience:
A skill which empowers us to become freer of shame’s hold. As Dr. Brene Brown found in her research with hundreds of individuals, it is enhanced by following these 4 steps:

1.) Recognizing our Shame and Shame Triggers:
Shame triggers are the situations, comments, comparisons that can cause each of us to fall into a spiral of shame – activating our sense of not being good enough and not belonging. Shame triggers are unique to each person. Our shame triggers often are embedded in us by society and our family of origin.

2.) Practicing Critical Awareness:
Critical awareness is the belief we can increase our personal power by understanding the links between our personal experience and the larger societal systems and attitudes. In Shame Resilience, practicing critical awareness is exploring how our personal shame triggers relate to or are formed by societal expectations and ideals. Critical awareness lets us make our own decision on the standards which are appropriate for ourselves.
3.) Reaching Out:
Is the attitude and action of taking what we each learn in building shame resilience and sharing it with others who want to hear and creating change through living it in our society. Reaching out renews our own shame resilience by actively moving us out of isolation and into the vulnerability of sharing our stories with appropriate others. It creates connections.

4.) Speaking Shame:
Is the skill of being able to speak about shame in those moments when others or our society might trigger it. It requires the ability to express our feelings and the strength to ask for what we want. It is the skill which will keeps us from shutting down in the moment or from acting out and shaming the other.

*Allows us to become the author of our own story, rather than the subject.
Additional Approaches, Strategies & Considerations: Confidentiality/Privacy

Confidentiality/Privacy

- HIPAA:
  - Provider Understanding & Compliance
  - Education to Patient/Client

- Considerations:
  - Clinic Environment & Practices:
    - Waiting room, rooming procedures, reminder calls, mail, emergency contacts
  - Clinical Location: Where to get care?
  - Community Locations: Where to meet in the community?
  - Support System: Who knows status?
  - Materials: What to bring or provide to patients?
On-Going Challenges
CHALLENGES:

- LTC Transitions/Discharges
  - Reluctance Transition
  - High Acuity

- Contact-related Discharges:
  - Maintaining Contact Information
  - Negative Toll on LTCS
  - Long-term Payoffs: Effort spent fostering trust and rapport impacts (eventual) re-engagement.

- Compassion Fatigue & Vicarious Trauma
  - Self Care
  - Support (Colleagues, Supervisor, Leadership, Clinic Team)
  - On-going Evaluation (strategies, approach and service delivery).
RESOURCES/CITATIONS:

National HIV/AIDS Strategy:

Health Disparities and Inequities & Social Determinants of Health:


**RESOURCES/CITATIONS:**

**Wisconsin HIV Data & Linkage to Care Initiative**
Wisconsin HIV Data & Linkage to Care Initiative


Several Topics Related to HIV:

- Center for AIDS Intervention Research http://www.cair.mcw.edu/
- Centers for Disease Control and Prevention (CDC) http://www.cdc.gov
- National Center for Health Statistics (NCHS) http://www.cdc.gov/nchs
- Health Resources and Services Administration (HRSA) http://www.hrsa.gov
- Kaiser: https://khn.org/search/hiv
RESOURCES/CITATIONS:

Cultural Humility:
- [https://thesocialworkpractitioner.com/2013/08/19/cultural-humility-part-i-what-is-cultural-humility/](https://thesocialworkpractitioner.com/2013/08/19/cultural-humility-part-i-what-is-cultural-humility/)

Trauma-Informed Care:

Stigma/Shame Resilience Theory:
- [http://theresiliencycenter.com/resources/](http://theresiliencycenter.com/resources/)

Self Care:
- University of Buffalo: [https://socialwork.buffalo.edu/resources/self-care-starter-kit.html](https://socialwork.buffalo.edu/resources/self-care-starter-kit.html)
- The Resiliency Center: [http://theresiliencycenter.com/resources/](http://theresiliencycenter.com/resources/)
- [www.olgaphoenix](http://www.olgaphoenix)
RESOURCES/CITATIONS:

Motivational Interviewing:
- MI Website: http://motivationalinterviewing.org/

HIV Education & Harm Reduction:
- CDC: https://www.cdc.gov/std/treatment/sexualhistory.pdf
- National Association of Social Workers: https://www.socialworkers.org/Practice/HIV-AIDs/HIV-AIDS-Related-Resources.aspx
- SAMHSA
- HIVMentalHealth.edc.org
- NASW HIV/AIDS Spectrum Project 2016
- Change the way we talk about HIV: https://www.dhs.wisconsin.gov/publications/p01858.pdf
CONTACT INFORMATION:

Emma Nelson
Linkage to Care Specialist
Froedtert & The Medical College of Wisconsin

Froedtert Infectious Disease Clinic
840 N 87th Street
Milwaukee, WI 53226
Office: (414) 805-9956
Work Cell: (414) 530-7854

Email: emnelson@mcw.edu