



**SAMHSA-HRSA  
Center for Integrated  
Health Solutions**

**Client Recruitment and Retention**

**Tuesday, April 21, 2015**

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**Slides for today's webinar are available on the CIHS website at:**

<http://www.integration.samhsa.gov/mai-coc-grantees-online-community/webinars>

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**How to ask a question during the webinar**



If you dialed in to this webinar on your phone please use the "raise your hand" button and we will open up your lines for you to ask your question to the group. **(left)**



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**Recruitment and  
Retention in HIV Care and  
Behavioral Health  
Services**

**Erin Nortrup, M.S.W.**  
Senior Program Manager, Access to Care  
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**Retention in HIV Care  
& Behavioral Health  
Services**

Erin Nortrup, MSW  
Senior Program Manager  
AIDS United

aidsunited.org

**AIDS  
United**  
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**Access to Care (A2C) Initiative**

- Twelve innovative, public-private partnerships around the country focused on improving individual health outcomes and strengthening local service systems.
- Emphasis on hard-to-reach populations, particularly those living in poverty and those who know their HIV status but are not in care.
- Innovative approaches driven by local epidemic and gaps in linkage and retention.
- Funded by the Corporation for National and Community Service's Social Innovation Fund and numerous foundations.




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### Retention in Care (RiC) Initiative

- Cohort of seven organizations across the country.
- Identify, document and evaluate innovative, emerging or promising program models for improving retention in care.
- National evaluation monitoring improvement in individual health, systems change and cost effectiveness.
- Funded by the M-A-C AIDS Fund.




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### Evaluation Data Collection

- All A2C and RiC sites collect data at enrollment, six, twelve and eighteen months.
- Data collected:
  - Demographic information
  - Health outcomes
  - Needs and barriers
  - Self-reported health status
  - Timeframe for engagement in care




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### Barriers to Care

- Transportation.
- Lack of money.
- Lack of stable housing.
- Didn't want to think about HIV/denial.
- Forgot to go/missed appointment.
- Multiple competing priorities.




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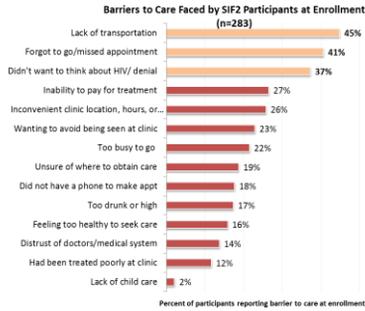
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## Impact of HIV-Related Stigma

- At baseline assessment for A2C participants, almost 1 in 5 participants reported they “sometimes” or “always” avoided treatment because someone might find out about their HIV status.\*

\*Preliminary data from national evaluation of A2C initiative.



## Recruitment Strategies

- Referral Relationships:
  - HIV counseling and testing providers
  - Medical providers
  - Local hospital systems
  - Disease Intervention Specialists (DIS)



## Recruitment Strategies

- Partnership with local jail/prison system.
- Collaboration with state/county health departments to identify individuals who are out of care.
- Collaboration with local hospital systems.
- Social media.




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## Strategies for Retention

- Peer navigation services.
- Trauma-Informed Care.
- Address barriers to retention in care.
- Coordination of care.




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## Peer Navigation

As a client turned employee I believe the value of a Peer Navigator is incomparable. The overwhelming support and information I received from my Peer helped me to overcome the anxiety and fear of being newly diagnosed HIV positive. The positive impact she made on me and my life is what led me to my passion to become a Peer Navigator. I only hope to be as supportive, loving, and helpful for my clients as she was for me.

-Peer Navigator




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## Peer Navigation

- Most of the A2C and RiC sites include a peer navigation component.
- AIDS United publication on Best Practices on Integrating Peers into HIV Care.
- Uniquely suited to address some of the major barrier to HIV care.
- Out of Retention in Care participants who had an HIV medical visit in the past six months, 75% found peer navigation services to be “very helpful” or “extremely helpful” in helping them to attend HIV medical appointments.




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## Benefits of Peer Navigation

- Trust & rapport-building.
- Typically have greater flexibility than traditional case management.
- Insights into the impact of cultural background on engagement.
- Provide valuable insight to the medical team.
- HOPE.




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## Need for Trauma-Informed Care

- Disproportionate trauma history amongst women living with HIV.
  - The rate of Intimate Partner Violence among HIV-positive women (55%) is double the national rate.
  - Rates of childhood sexual abuse (39%) and physical abuse (42%) were more than double the national rate.
  - Associated with poorer health outcomes.




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### Barriers to Retention: Transportation

- Potential solutions:
  - Co-location of services
  - Use of technology (telemedicine)
  - Assistance with transportation




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### Barriers to Retention

- HIV-related stigma.
- Multiple competing priorities:
  - Lack of stable housing
  - Lack of money
- Client goal plans need to include comprehensive support/stabilization.
- Coordination of care across all providers.




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### Thank You!

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**PATH (Promoting Access to  
Health) Project**

**Freddie Smith, M.P.H.**  
Program Services Coordinator  
Alameda County Behavioral Health Care  
Services  
Oakland, CA



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**PATH Project (Promoting Access to Health)**



**Alameda County, Behavioral Health Care  
Services (BHCS)**  
Freddie Smith, Program Manager  
Manuel Jimenez, Director

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BHCS is the County's Safety Net mental health provider serving over 31,770 individuals each year.

36% Black; 34% White; 11% Latino; 15% Asian/Pacific Islander; 3% Other.

3,770 individuals with **Serious Mental Illness (SMI)** are assigned to Community Support Centers' Service Teams.

Service Team staff expected to provide mental health services, assistance with legal issues, housing, health concerns, benefits, and money management.

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### Psychiatric Profile Overview

Fiscal Year 13-14

#### Adult Clients (18-65 years old) assigned to Service Teams

Diagnosis Breakdown	# Clients Served	Percentage
Schizophrenia Disorders	1824	65%
Bipolar Disorders	372	13%
Depressive Disorders	289	10%
Psychotic Disorders	243	9%
Other Disorders	68	3%

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### Sample of Health Characteristics of Service Team Clients

In 2006, research started linking increased morbidity and mortality among people **with SMI**.

1. **228%** more likely to be diagnosed with **diabetes**.
2. **62%** more likely to be diagnosed with **hypertension**.
3. **61%** more likely to be diagnosed with **asthma**.
4. **53%** more likely to be diagnosed with **heart disease**.

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## PATH Project Goals

In September, 2010, SAMHSA funded Alameda County's, Primary Behavioral Health Care Integration (PBHCI) application to provide primary care services in two adult community support centers.

Under the PATH Project, the Oakland Community Service Team was to serve 390 SMI Consumers by:

1. Improving their **Access** to primary care services.
2. Creating a **"Medical Home"** for the consumers that aimed to improve their key health indicators.

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## PATH PROJECT IMPACT OVERALL

To address gaps in care as many do not seeking primary care in the traditional medical care setting on account of barriers (stigma of mental illness, lack of transportation, wait time require to see primary care providers).

- **Average number of visits** with Primary Care:
  - Before SAMHSA Grant: 0.5 per year
  - One Year after Integration Services: 5 visits per year
- **Improved** blood pressure levels, blood glucose levels, and Body Mass index (BMI).

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## Impact on Service Team Process

Site has 3 teams, meet weekly to discuss client mental health treatment concerns and recommended follow-up actions.

Due to SAMHSA PBHCI Grant, team meetings now include a Nurse Care Coordinator, Peer Counselor, and the primary care partner's Clinic Coordinator.

- **Nurse discusses referrals to specialty services; Peer Counselors let mental staff know about appointments for care and health and wellness activities. Data Collection includes both behavioral and health measures.**

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### Health and Wellness Activities

Led by peers or student interns, provide socialization, education, engagement, inclusion; a colorful calendar is posted monthly on the bulletin board

**Community Connections**, field trips to farmer's markets, bowling, movies.

**Cooking Class**, teaching nutrition, self sufficiency, healthy eating (free lunch!).

**Living Well Class**, participants set health goals based on Whole Health Action Management plan (WHAM) developed by SAMHSA-HRSA Center for Integrated Health Solutions.

**Tobacco Cessation**, group and one-on-one coaching ("Bye Bye Butts").

**Meditation/ Movement**, yoga, walking, for exercise, stress reduction ("Fun and Games" and "Feel Good Fridays").

**Lunch and Learns**, medical staff present a topic and answer questions.

**The PATH Café** for socialization and relaxation for clients to primary care or wellness services.



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### Client Retention Strategies

- Establish an Advisory Board (clients, family members, staff) that meets monthly.
- Schedule a periodic team "de-brief" to share information and problem solve (improves care coordination *and* helps build relationships).
- Convene "Lunch and Learns" so providers (primary care and psychiatrist) can introduce themselves to consumers, present different health topics, and encourage discussion (consumers feel less isolated).
- Orient consumers on "how to be an effective consumer in the program".
- Get Peer Counselors and volunteers involved early on, to help design service delivery, communication, and educational materials that makes sense to your consumers, designing the program brochure, "naming" the classes, etc.

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### Annual Visioning Retreats Ask Stakeholders "IS IT WORKING?"

TOPIC: "Strategies for improvement"

- Health Education/Wellness Activities
- Recruitment/Enrollment/Outreach
- Clinic Operations and Communication
- Information Sharing and Data Utilization



Consumers,  
PATH Staff &  
Family Members



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Program Brochure  
Designed by Advisory Board Consumer



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### Collaborative Leadership Skills

- All Staff have to take ownership of program's measures of success (break-even, revenues and expenses, billable patient visits).
- Build trusting, dependable, reliable working relationships with all project staff (MH, AOD, and Primary Care).
- Always be willing to listen and to help solve issues that might impact the collaboration and program effectiveness.
- Be willing to lead – even without direct lines of authority.
- When you hit barriers (i.e. the bureaucratic process) use patience and persistence.
- Think "outside the box" -- because we are changing and improving not only health outcomes, but also our organizations!

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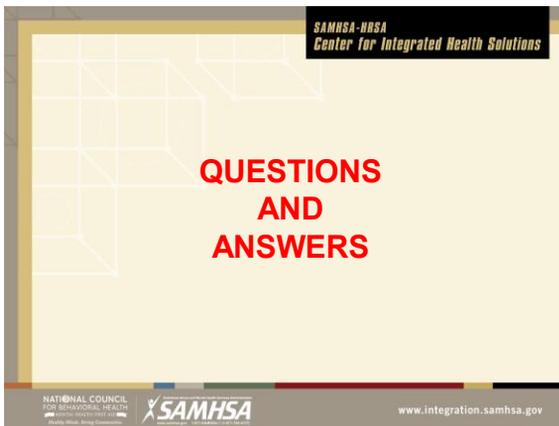
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### Additional Resources

- WHAM – Whole Health Action Management Training (SAMHSA-HRSA Center for Integrated Health Solutions)  
<http://www.integration.samhsa.gov/health-wellness/wham>
- Case Management to Care Management Training (National Council for Behavioral Health)  
<https://www.thenationalcouncil.org/training-courses/moving-case-management-to-care-management/>

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Additional Questions?  
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### For More Information & Resources

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