Improving Health Outcomes

Moving Patients Along the HIV Care Continuum

INTERVENTION GUIDE

SPNS Demonstration Model on Women Empowered to Connect and Remain Engaged in Care (WE CARE)

SEPTEMBER 2018

HRSA Health Resources & Services Administration

U.S. Department of Health and Human Services
Health Resources and Services Administration
HIV/AIDS Bureau

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Improving Health Outcomes

Moving Patients Along the HIV Care Continuum

INTERVENTION OVERVIEW & REPLICATION TIPS

Project Women Empowered to Connect and Remain Engaged in Care (WE CARE)

Ruth M. Rothstein CORE Center, Chicago, IL

- Diagnosing HIV
- Linkage to Care
- ▶ Retention in Care
- Prescription of ART & Medication Access

This intervention guide examines an intervention focused on retention in care and provides information on key components of the intervention and the capacity required by organizations/clinics to conduct this work.

This intervention guide is part of a training series entitled, "Improving Health Outcomes: Moving Patients Along the HIV Care Continuum," and is published by the Special Projects of National Significance (SPNS), under the HIV/AIDS Bureau (HAB) of the Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (HHS). The purpose of this intervention guide and others featured as part of the *Translation of SPNS Findings and Technical Assistance Support to Implement New Models of Care* project is to highlight interventions along the HIV care continuum and support replication of these evidence-informed innovative models of care. The HIV care continuum refers to the fluid nature of HIV health care delivery and client experiences, and research has demonstrated the importance of moving clients along the continuum with the goals of being fully linked, engaged, retained, and virally suppressed. This framework has received attention as research has demonstrated the importance of these activities. Therefore, finding programs that help clients move along the stages of the continuum are particularly important.

About SPNS

The Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services, is the primary federal agency for improving health care to people who are geographically isolated, economically, or medically vulnerable. The Special Projects of National Significance (SPNS) Program is a part of the HRSA HIV/AIDS Bureau (HAB). The SPNS Program supports the development of innovative models of HIV care and treatment in order to quickly respond to emerging needs of clients served by HAB. SPNS advances knowledge and skills in the delivery of healthcare and support services to underserved populations living with HIV. Through its demonstration projects, SPNS evaluates the design, implementation, utilization, cost, and health-related outcomes of treatment models while promoting the dissemination and replication of successful interventions.

About the Enhancing Access to Retention in Quality HIV Care for Women of Color Initiative

The featured evidence-informed intervention was part of the SPNS "Enhancing Access to and Retention in Quality HIV Care for Women of Color Initiative." For this initiative, SPNS supported 10 demonstration sites (five urban sites and five rural sites) for five years to design, implement, and evaluate innovative methods for enhancing access to and retaining women of color living with HIV in primary medical care and support services. Interventions included community-based outreach, patient education, intensive case management, and patient navigation strategies. Populations of interest included HIV-positive women of color who are not retained in care or who may benefit from additional supportive services. The demonstration sites also participated in a robust multi-site evaluation. The study evaluation design assessed the effectiveness of the selected models in enhancing access to and retention in HIV care for women of color. To learn more about this initiative, visit: **https://hab.hrsa.gov/about-ryan-white-hivaids-program/spns-women-color**.

Project Women Empowered to Connect and Remain Engaged in Care (WE CARE)

Ruth M. Rothstein CORE Center, Chicago, IL

Why This Intervention?

The Ruth M. Rothstein CORE Center's Women Empowered to Connect and Remain Engaged in Care (WE CARE project) advances hard-to-reach African American/Black women along the HIV care continuum. Results included 91.4 percent of WE CARE graduates linked to care versus 63 percent of comparable clients; 89.2 percent of WE CARE graduates retained in care versus 77.9 percent of comparable clients; and 81.4 percent of WE CARE graduates had viral load suppression compared to 35 percent of comparable clients.

At-a-Glance

The table below provides a general overview of the Ruth M. Rothstein CORE Center's Healthy Relationships intervention so readers can assess the necessary steps required for replication.

Model at-a-Glance	
Step 1	**Review Healthy Relationships Intervention** Review Healthy Relationships intervention for appropriateness and necessary capacity and resources. The CORE Center's Healthy Relationship intervention focuses expressly on African-American/Black women. Complete a logic model to support the development of a preliminary implementation plan.
Step 2	**Identify and Train Staff** Identify case management staff who will support clients participating in the Healthy Relationships intervention and associated Patient Navigation services. Train staff on this intervention as well as in group facilitation skills. Identify a mental health counselor who will be available to support women after Healthy Relationship sessions, as sessions may have triggers for some women.
Step 3	**Select Facilitators** Select a Peer (from the pool of Peer Patient Navigators) and a seasoned Health Educator to co-facilitate group sessions. Because of the past experiences of violence experienced by group members, it is strongly recommended that both facilitators be women.

Model at-a-Glance

Step 4 	**Identify Advisory Board** This group will inform the marketing, recruitment, materials, and staffing for the intervention. These are women of color who share cultural characteristics of the population receiving the intervention.
Step 5 	**Identify Location for Sessions** Select a location to host Healthy Relationships session, ideally somewhere centrally located that provides a secure and private environment for discussing sensitive topics.
Step 6 	**Identify Materials and Any Necessary Incentives** Identify and secure materials necessary for the intervention, such as a television, video clips, poster board, colored paper for personal feedback reports, and any food, refreshments, or other incentives that may be provided at sessions.
Step 7 	**Recruit Clients and Arrange Logistics** Peer Patient Navigators will actively recruit clients for the Healthy Relationship groups. The Project Leader will arrange all logistics, identifying a quiet dedicated closed space for the five weeks of sessions, and confirming the scheduling. During this time the Advisory Board will be creating the resource materials.
Step 8 	**Run a Pilot Group Session** Run one session with staff and volunteers as the participants. This should be done to ensure that any kinks are worked out and that the facilitators are comfortable leading discussions.
Step 9 	**Host the First Session** This session is a brief one hour overview of expectations, explanation of the intervention and the role play videos, meet and greet, and a chance to go over the resource packet. This is also a time for the clients to become comfortable in the environment in which sessions will be taking place.
Step 10 	**Remaining Skills Building Sessions** These four sessions are each three and one-half hours. During these sessions, the participants will be able to practice the skills of disclosure, self-efficacy, risk reduction, and safer sex practices. These skills are all taught through modeling, personal feedback reporting, role playing, and the sharing of their own experiences.
Step 11 	**Alumni Group** This is an opportunity for the participants who have graduated from the Healthy Relationships intervention to come back and support the new cohort as well as receive additional support.

Resource Assessment Checklist

Prior to implementing the CORE Center's Healthy Relationships intervention, organizations should walk through a Resource Assessment (or Readiness) Checklist to assess their ability to conduct this work. If organizations do not have these components in place, they are encouraged to develop their capacity so that they can successfully conduct this intervention. Questions to consider include:

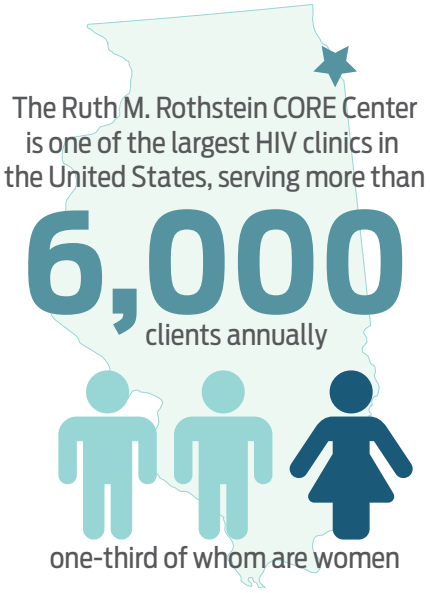
- ☐ Does your organization have ready access to the target population, or do you partner with another organization that does?
- ☐ Is your organization a clinic or other healthcare setting that offers at least two HIV services on the premises?
- ☐ Does your organization currently have Peer educators, Peer Patient Navigators or some kind of pre-trained staff or volunteers who work with clients on a peer level? If not, is there capacity to hire such individuals or tap into those at a partnering agency?
- ☐ Can staff dedicate at least 40–60 hours to intervention training and development prior to client group sessions? (Note: time may be less if utilizing existing video clips and resource packets but there will still be a training period before the participant group sessions begin.)
- ☐ Are you able to secure or purchase snacks or meals as an incentive at least for the first group meeting? (While this is not required, it will likely make a difference. Other incentives that are popular include gift cards to local grocery, convenience, and cosmetics stores.) A graduation ceremony with framed certificates of completion and gift bags were appreciated and motivated the participants.
- ☐ If you plan to develop your own video clips (i.e., versus using existing ones), do you have access to video editing equipment or know a partner agency that does?
- ☐ Do you have access to a DVD player or computer with DVD capabilities to play video clips for use during the group sessions?
- ☐ Do you have or can you procure a flipchart pre-printed with Healthy Relationships scenarios as well as blank flipchart pages and markers? Or have access to PowerPoint to create a digital version?
- ☐ Does your organization have a quiet, centrally located, closed space with chairs to be arranged in a circle for five to 12 clients? Can this space be used for the duration of the intervention so that clients can become comfortable and familiar with the space? If not, can a partner agency provide this?

Setting the Stage

People of color in Chicago, Illinois have some of the highest HIV diagnosis rates in the country.[1] This is largely due to *social determinants of health*, which refers to overlapping social structures and economic systems that can lead to health inequities (e.g., social environment, physical environment, structural, and societal factors).[2]

Among HIV-positive women of color, barriers to accessing and retaining HIV primary care include poverty, unmet basic sustenance needs, lack of childcare, low levels of education and health literacy, and lack of insurance or underinsurance. Common psychosocial barriers include gender inequality in relationships, including financial dependence on men; intimate partner violence; mental health disorders; substance use disorders; distrust of the health care system; lack of social support; and stigma (both real and perceived). Systemic barriers include lack of transportation, lack of cultural competency, and inadequate care coordination.[3]

PLWH can internalize stigma, leading to intense feelings of shame and fear. In fact, research shows that HIV-associated stigma is often the main reason why people are reluctant to be tested or disclose their HIV status.[4] PLWH who encounter high levels of stigma are also more likely to report inadequate access to care and poorer medication adherence.[5] The result is a vicious cycle of increased infectiousness and poorer health outcomes because people who do not know their status are more likely to transmit the virus, and those who do know, but are fearful about disclosure, are more likely to avoid treatment.[6]



The Ruth M. Rothstein CORE Center conducts HIV and other infectious disease research and provides "one-stop shop" care services. This clinic was established in 1998 as a partnership between the Cook County Health and Hospitals System (CCHHS) and Rush University Medical Center. Today, it is one of the largest HIV clinics in the United States, serving more than 6,000 clients annually—one-third of which are women.[7]

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[1] Centers for Disease Control and Prevention (CDC). Social determinants of health among adults with diagnosed HIV in 11 states, the District of Columbia and Puerto Rico, 2014. HIV Surveillance Supplemental Report 2016; 21. (No. 6). **http://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-supplemental-report-vol-21-6.pdf**. Accessed January 17, 2017.

[2] CDC. Social determinants of health among adults with diagnosed HIV in 11 states, the District of Columbia and Puerto Rico, 2014. HIV Surveillance Supplemental Report 2016; 21. (No. 6). **http://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-supplemental-report-vol-21-6.pdf**. Accessed January 17, 2017.

[3] Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB). *Enhancing access to quality HIV care for women of color: final report*. 2008. Accessed at: **http://careacttarget.org/library/HIVcare/WOCFinalReport.pdf**.

[4] HRSA, HAB. *Enhancing access to quality HIV care for women of color: final report*. 2008. Accessed at: **http://careacttarget.org/library/HIVcare/WOCFinalReport.pdf**.

[5] University of Texas Southwestern Medical Center at Dallas. *Healthy Relationships: a small group-level intervention with people living with HIV*. [Starter kit.] Available at: **https://effectiveinterventions.cdc.gov/docs/default-source/healthy-relationships-docs/hr_starter_kit1d1154a912356cddb4c6ff0000a6e6a7.pdf?sfvrsn=0**. Accessed February 4, 2017.

[6] Verdacios, N. et al. *Enhancing Access to and Retention in Quality HIV Care for Women of Color Initiative: An Intervention Monograph*.78-87. https://careacttarget.org/library/women-color-enhancing-access.

[7] Verdacios, N. et al. *Enhancing Access to and Retention in Quality HIV Care for Women of Color Initiative: An Intervention Monograph*.78-87. https://careacttarget.org/library/women-color-enhancing-access.

The CORE Center applied for and received SPNS funding to participate in the Enhancing Engagement and Retention in Quality HIV Care for Women of Color Initiative. Through this initiative, the CORE Center developed the Project Women Empowered to Connect and Remain Engaged in Care (WE CARE) program. This was developed to link and support women newly diagnosed with HIV, or new to care, as well as existing female clients struggling with retention in care.

The CORE Center has a long-standing history of incorporating well-trained and culturally competent Peer Educators to support new client orientations and other programs with other consumer-provider collaboration. The CORE Center leveraged this experience to adapt the CDC's Diffusion of Effective Behavioral Interventions (DEBI) Healthy Relationships intervention. This intervention is specifically focused on addressing retention barriers among their women of color through skills building and self-efficacy training.

The CORE Center has a long-standing history of incorporating well-trained and culturally competent Peer Educators to support new client orientations and other programs with other consumer-provider collaboration.

Running concurrently with the Healthy Relationships intervention was a Peer-led Patient Navigator Program. The Peer Patient Navigators served as some of the main recruiters for the Healthy Relationships intervention.

Description of Intervention Model

CHALLENGE ACCEPTED

THE CHALLENGE: Addressing individual-level barriers, particularly stigma, that women of color face in engaging in and remaining in care.

Intervention Model: Healthy Relationships

WE CARE includes an adaptation of the CDC DEBI *Healthy Relationships*. This intervention is focused on reducing stigma, building self-efficacy skills around safer sex practices, disclosure, and risk reduction, and establishing positive expectations around new behaviors through modeling behaviors and practicing new skills.

The intervention is based on the Health Belief Model and Social Cognitive Theory. The Health Belief Model stipulates that a person's health-related behavior depends on the perceived risk of the following areas: the severity of their illness, benefits of taking a preventive action, and barriers to taking that action.[8] Social Cognitive Theory[9] is defined as a triadic, dynamic, and reciprocal interaction of personal factors, behavior, and the environment. This means that expectations, beliefs, and understanding of the world are

[8] Rosenstock IM, Strecher VJ, Becker MH. The Health Belief Model and HIV Risk Behavior Change. Preventing AIDS Prevention and Mental Health. 1994:5–24.
[9] Nurius PS. Cognition and Social Cognitive Theory. Encyclopedia of Social Work. November 2013.

developed and changed by social and environmental influences. Through processes such as observing behaviors being modeled and modeling those new behaviors, receiving clear instructive feedback, seeing outcomes of people's behavior, and receipt of social support, translate into self-efficacy skills.[10]

Healthy Relationships also uses Motivational Enhancement strategies,[11] such as fostering a collaborative atmosphere, affirming strengths and self-efficacy, and feedback based on participant-identified reasons for change and self-motivating statements.[12]

WE CARE Healthy Relationships is a five-session, small-group intervention targeting HIV-positive women of color. Because clients are most likely to model behavior patterned after those most like themselves, women of color facilitate sessions.

At the CORE Center, Peers and Peer Patient Navigators recruited participants into the WE CARE program (which consisted of using patient navigation services and engaging in the Healthy Relationships support group). When it came time for the Healthy Relationships intervention to occur, Peer Patient Navigators posted flyers throughout the clinic and the front desk to help direct women to the group location, as the CORE Center is a large facility. After completion of the first cohort, **these flyers were updated with testimonials about the intervention**. (**See Marketing Sheet in Appendix.**) Additionally, the Peer Patient Navigators conducted in-reach to inform women they were working with about the Healthy Relationships intervention.

Food was served to help entice women to attend the first meeting. The CORE Center provided food throughout meetings, but participants mentioned that once they started, they wanted to attend regardless of incentives or food. Thus, replicating sites may only need this incentive for the first session though should manage expectations if that's what they plan to do.

The CORE Center's adaptations of the CDC Healthy Relationships intervention included:

- Engagement of only HIV-positive women of color (compared to multiple population types);
- Extension of sessions from the traditional 120 minutes to 210 minutes, at the request of participants who wanted to keep sharing and further practice their skills; and
- Development of new movie clips (not provided in the CDC DEBI) which included *Precious* and *For Colored Girls.* These movies were selected by the Advisory Board as being more current and relevant for the CORE Center's specific target population.

[10] Seth C. Kalichman. *Preventing AIDS: A Sourcebook for Behavioral Interventions*. Mahwah, NJ: Lawrence Erlbaum Associates, 1998.
[11] WR Miller, A Zweben, C. DiClemente, R Rychtarik. Motivational Enhancement therapy Manual. Washington, DC: US Government Printing Office, 1992.
[12] University of Texas Southwestern Medical Center at Dallas. *Healthy Relationships: a small group-level intervention with people living with HIV*. [Starter kit.] Available at: **https://effectiveinterventions.cdc.gov/docs/default-source/healthy-relationships-docs/hr_starter_kit1d1154a912356cddb4c6ff0000a6e6a7.pdf?sfvrsn=0**. Accessed February 4, 2017.

At the beginning of the intervention, an initial baseline assessment survey and personal feedback report were administered to help identify client barriers to care and areas for self-improvement. These can be used at the end of the five weeks to identify areas of growth and autonomy.

At the onset of each meeting, facilitators outline the activities and information to be covered. The women sit in a circle to support a sense of engagement. Video clips (of just a couple minutes each) are used to highlight a particular challenge or event and are used as a jumping off point for conversation and to encourage the women to open up about their own experiences. Facilitators need to introduce clips prior to playing them, helping to set the tone for the clip and informing the women of what to look for. Afterwards, a flipchart or easel chart guide will be used to write questions the group will explore. Thereafter, group members will re-enact the scene, identifying ways in which the main characters could have improved, and finally, participants discuss how these themes and events relate to their lives.

As the CDC Healthy Relationships Starter Kit explains:

> "Set up the context for the movie clips along these lines:
>
> 'You may have seen this movie (tell them the title) but now forget anything you know about it. For our purposes, the (add description, like 'main female') character is living with HIV/AIDS and is thinking about disclosing . . .'
>
> When creating the easel chart guides, you can choose to insert a 'title' for the clip.
>
> Questions for many of the movie clips are the same, as they tie back to the skills being taught in the group. Frame your 'set the scene' so you can talk about 'What would you have said or done?' or 'What could be done to make this situation safer?'
>
> Arrange clips in order from the easiest to role-play to the most difficult. Generally, the more discussion there is in the scene, the easier the situation is to deal with; the more passion and less talk, the harder. The easier situations are dealt with in the earlier sessions, the harder/hardest ones in the last session."[13]

The CORE Center ensures that a mental health specialist is onsite after each group session as discussions and themes can be triggers for both participants as well as facilitators. At the end of the five weeks, graduates receive a **Certificate of Completion** acknowledging and celebrating their success. (**See sample certificate in Appendix.**)

Healthy Relationships graduates at the CORE Center didn't want the sharing and connection to end. In response, the CORE Center made a final adaptation to the CDC model and created an Alumni Group. This

[13] University of Texas Southwestern Medical Center at Dallas. *Healthy Relationships: a small group-level intervention with people living with HIV*. [Starter kit.] Available at: **https://effectiveinterventions.cdc.gov/docs/default-source/healthy-relationships-docs/hr_starter_kit1d1154a912356cddb4c6ff0000a6e6a7.pdf?sfvrsn=0**. Accessed February 4, 2017.

enables alumni to come back and visit a new cohort, share their experiences, and continue the feeling of connection with the clinic and reinforce the importance of engagement in care.

Participants cited the feeling of being the only ones going through particular scenarios or hardships and that the Healthy Relationships group helped show them that there are others with similar experiences—like the alumni—who have successfully completed the program, are healthy, and engaged in care. As the CORE Center explains, addressing stigma and fostering a sense of community can have everything to do with linking and retaining clients in care.

Staffing Requirements & Considerations

Staff/Organizational Capacity

Based on The CORE Center's work, here are the types of staff capacity and characteristics necessary to replicate this intervention.

Project Director or Coordinator

This is the leader of all aspects for reporting, planning, logistics, and protocols. This will be the go-to person who will synchronize and synergize efforts across the intervention. This person should be familiar with the policies and procedures of the setting, as well as have the trust and respect of staff and clients alike.

Facilitators/Group Staff

Two to four part- or full-time staff during the actual group session are suggested for facilitation. If replicating on a smaller scale, this can be done with two part-time staff, particularly if using existing staff. (Note: There is some intensive upfront work for planning and recruitment that staff must do before group sessions begin.)

Advisory Board Capacity

An Advisory Board is needed to help select staff, movie clips, and provide feedback on the length and day of the group session. This should be a group of diverse staff, board members, and other stakeholders who can offer a variety of viewpoints. This is the group that in conjunction with the other staff will edit the clips should it be done in-house.

Mental Health Counselor

It is recommended that the women have easy access to a mental health counselor after group sessions as there may be triggering conversations. This person could be in-house, available through a partner agency, or available during visiting hours immediately after the group, so long as they are easily accessible.

Staffing Requirements & Considerations

Staff Characteristics

At least one of the staff should be a PLWH. Staff characteristics include:

- Trustworthy
- Flexible
- Active listener
- Follows up on identified needs
- Empathetic
- Not judgmental
- Understanding
- Ability to manage/control problems
- Solution seeker
- Uses humor appropriately/effectively
- Ability to make suitable referrals
- Maintains eye contact
- Understands group dynamics
- Ability to adapt to changing dynamics of a group
- Creates a warm and welcoming environment
- Effective time manager
- Interested in working with groups
- Respectful of others and their opinions
- Ability to easily make connections
- Willingness to learn from others

Disqualifying Characteristics

- Anxious in a group
- Feels superior to participants
- Dominates discussion
- Withdraws physically or emotionally
- Lacks sensitivity to the needs of others
- Inflexible or non-adaptive
- Places own personal needs first
- Needs to be center of attention
- Pushes personal agenda

Additional disqualifying characteristics include:
a history of coercion or violence against partners or peers, mental illness in an acute stage, jeopardized or delayed health or social needs due to participating in the intervention.
CDC-Healthy Relationships Implementation Guide

Sources: Ruth M. Rothstein CORE Center, *CORE Center Final Report*. November 2016; and University of Texas Southwestern Medical Center at Dallas. *Healthy Relationships: a small group-level intervention with people living with HIV*. [Starter kit.] Available at: **https://effectiveinterventions.cdc.gov/docs/default-source/healthy-relationships-docs/hr_starter_kit1d1154a912356cddb4c6ff0000a6e6a7.pdf?sfvrsn=0**. Accessed February 4, 2017.

Replication Tips for Intervention Procedures and Client Engagement

This section provides tips for readers interested in replicating the intervention and, where applicable, includes grantee examples for further context.

Recommendations for getting started:

- *Ensure easy access to the target population.* Whether through outreach, Peer Education training, internal recruitment, or case management, it's imperative that an organization can readily recruit women of color for this intervention.
- *Appoint a Project Director or Coordinator.* This person leads the team and will become the go-to person for any challenges and will serve as the main contact for the intervention. This person should also serve as a "champion" for the intervention and help secure buy-in from stakeholders.
- *Advanced preparation is imperative.* Planning, organization, and preparation ahead of time will enable more productive and engaging sessions. This includes the following activities.
  - *A Plan-Do-Study-Act (PDSA) cycle* of the intervention will provide useful feedback and enable any modifications before formal rollout.
  - *Train agency staff and volunteers.* This will alleviate some pressure if there are scheduling conflicts or turnover in the future as additional staff will have been trained on the intervention.
  - *Gather your Advisory Board.* This is a group of stakeholders in your community who understand the intervention and have cultural competency working with the target population.
  - *Familiarize yourselves with Fair Use Doctrine.* This is the part of Copyright Law that allows films and other materials to be used for educational purposes. The CORE Center worked with a local university's Electronic Media Department to help them edit clips, although provider sites familiar with film editing could do this in-house.
- *Build comprehensive strategies for planning.* Be inclusive of others in the organization and community.
  - *Focus or planning groups* can assist in filtering information.
  - *Develop a Resource Kit.* Have staff alongside the Advisory Board develop a kit inclusive of an overview of the intervention program, expectations, guidelines, anticipated participant outcomes, worksheets—including feedback forms—and the selected movie clips.
  - *Facilitator selection* should be a team discussion and the Advisory Board should have the opportunity to make suggestions and offer feedback on proposed Healthy Relationships group facilitators. Facilitators should be women of color, reflective of the client population, HIV-positive or comfortable working with HIV-positive clients, and have either a background in peer education or health education with skills in group facilitation. Skills building sessions should include two facilitators for the group with a third observer/helper for logistics.

- *Cross-purpose planning activities.* The Advisory Board should work with group facilitators to create the Healthy Relationships curriculum, resources, and assist in marketing materials creation.
- *Create clear protocols* for communication, job descriptions, and processes for all involved. Should any issues arise there will now be protocols in place.
- *Incorporate specific intervention activities into job descriptions* when recruiting new staff who might be recruited to deliver Healthy Relationships.

- *Nurture existing partnerships* with other local organizations, universities, and vendors that can provide support.
- *Create new partnerships* with organizations, as necessary, who can help support the intervention.
- *Create and distribute dynamic marketing* materials that will reach the target population and get them interested in joining the Healthy Relationships intervention.
- *Have Peer Educators/Peer Patient Navigators do the recruiting.* This can put clients at ease, as well as to maintain the communication across service offerings.
- *Hold a staff-only pilot run through* prior to the first group session with clients. This session also allows group facilitators to become more comfortable.
- *Launch Healthy Relationships group.* After the pilot session, launch the skills building sessions.
  - Four skills building sessions—each at three and one-half hours—will leverage the pre-selected movie clips to showcase scenarios about disclosing to family and friends, disclosing to sexual partners, risk reduction, protective behaviors, building healthier and safer relationships. Modeling, role playing, and facilitated discussions assist participants in feeling more comfortable to explore health beliefs and discuss their own experiences. At the end of each session, participants will fill out personal feedback forms, helping identify areas where they can make improvements and motivations that will help them reduce risky behaviors.
  - As clients graduate from the Health Relationships intervention, identify and schedule opportunities for them to come back and offer support to new cohorts. The Alumni Group encourages clients still in training while enabling graduates to feel continuously connected to the clinic and encouraged in their self care.

Logic Model

Healthy Relationships Intervention				
Resources	Activities	Outputs	Outcomes	Impact
• Clinic Staff • Advisory Board • Peer Educators • Case Managers • Resource Packets • Funding • Prior research experience/ expertise	• Assess client barriers to care • Retain clients (including newly diagnosed, sporadically-in-care, lost-to-follow-up, and lost to care clients) • Peer Patient Navigators support women of color for six–12 months, depending on need • Through Social Cognitive Theory, Health Belief Model, and Motivational Enhancement, increase client self-efficacy, reduce risk taking, and increase client belief in long-term survival • Provide support and encouragement to reduce stigma • Empower clients through modeling, roleplaying, and providing personal feedback	• Client linked to Peer Patient Navigator within 2 weeks of a missed appointment • Client linked to Peer Patient Navigator within 60 days of new diagnosis • Clients are actively recruited to participate in the Healthy Relationships intervention/WE CARE program by Peer Patient Navigators • Groups meet for five sessions over five weeks • Contact is maintained for 12–24 months, depending on client needs	• Decreased perceived stigma • Higher rates of viral suppression • Improved health outcomes • Decreased risk of transmitting HIV to others	• Improved client engagement in care • Increased number of clients engaged at each point along the HIV Care Continuum • More “whole person” care • Improved long-term survival

Securing Buy-in

Ensuring transparency and communication throughout the planning and implementation process will help elicit and maintain buy-in. For this intervention, buy-in starts with staff and volunteers who will be working on or engaging with the intervention. Staff need to understand why the Healthy Relationships intervention was selected, what it seeks to do, and how it will potentially improve the stability and outlook for female clients. Clearly delineated staff roles and responsibilities will help ensure intervention fidelity and manage expectations. Community stakeholders and partnering sites should be engaged early and often while the intervention is being developed and tested. Lastly, it is important to be clear with all administrators about what is needed for the intervention and any requisite space and resource needs.

Staff need to understand why the Healthy Relationships intervention was selected, what it seeks to do, and how it will potentially improve the stability and outlook for female clients.

Overcoming Implementation Challenges

This intervention requires the most resources and labor upfront, from securing buy-in, preparing recruitment flyers, preparing movie clips (if developing new ones or at minimum reviewing existing clips), identifying and securing permission for a consistent space, identifying a day and time to hold meetings, and providing staff training.

To help identify a day and time to hold the intervention, first review when other support meetings and events are taking place. Solicit input from staff and the Advisory Board as well as potential participants. Review any existing marketing collateral such as recruitment flyers for other programs and see if they can be modified for this intervention (rather than "reinventing the wheel"). Identify whether partner agencies or any existing staff have familiarity with the Healthy Relationships intervention and discuss how that experience can be leveraged up front. Be sure to consider the optimal time for the participants, many of whom have jobs and/or child care needs.

Identify centralized areas large enough to hold the group sessions, review any associated booking calendar with the space, and discuss with management and other stakeholders early on.

Because the CORE Center adaption supports linkage and engagement in care, assess whether non-medical case management or other similar reimbursable non-medical social support services funding may help cover some of the costs.

Incorporate specific intervention activities into job descriptions when recruiting new staff, who might be recruited to be a facilitator.

Promoting Sustainability

The CORE Center continues to use the Healthy Relationships modeling and personal feedback reporting both in small group work and in some one-on-one case management work with clients. They have also rolled components of and lessons learned from Healthy Relationships into their newer Latino(a)-funded initiative through SPNS. Setting up any evaluation data or feedback loop from participants can also be used to demonstrate to potential funders about the importance of this work.

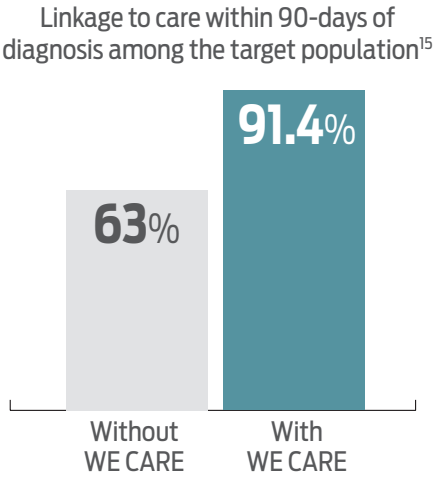
Conclusion

The primary lessons learned from this adapted Healthy Relationships intervention at the CORE Center can be broken down into the following:

> *Much of this intervention revolves around working with the Peer Patient Navigator and Peer Educator who also functions as a Healthy Relationships Facilitator. The most significant lesson learned by the CORE Center was to narrow recruitment efforts to peers who are already public about their HIV status. That said, organizations conducting this work need to balance hiring "peers" while observing employment and confidentiality laws and HR processes as there may be potential barriers to openly recruiting HIV-positive peers (e.g., mentioning HIV status in job ads).[14] This intervention relies heavily on teaching skills of disclosure. Organizations, however, will also need to work with recruited Peers around reimbursements (e.g., part-time, full-time, or stipend) to ensure Peers are adequately reimbursed for their time and efforts, maintain a work/life balance that allows them to continue their care management, while maintaining necessary benefits coverage.*

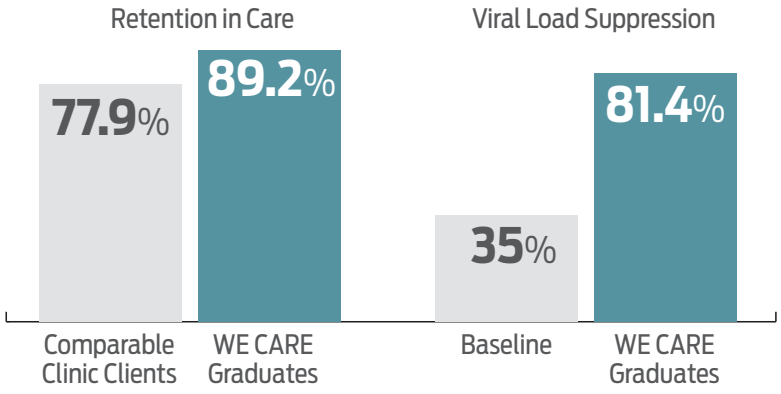
Peers may require a lot of training and additional supervision. Provide clear and engaging training on the personnel policies and professional conduct required. Set up additional support to help Peers navigate boundaries between themselves and clients and how to identify and deal with triggers. This is particularly important when it comes to separating medical and social issues of their own from their clients. Set up additional supervised time to debrief with Peers regarding client cases and progress.

Newly diagnosed clients referred to the CORE Center were the primary group recruited for this intervention. At the onset of the WE CARE Program (including Peer Patient Navigation support and Healthy Relationships) linkage to care within 90-days of diagnosis among the target population was 63 percent.[15] With the WE CARE Program, linkage rose to 91.4 percent.[16]



When comparing, WE CARE Program graduates to CORE Center counterparts, participants reported:

- greater health outcomes
- higher retention rates (from 67 percent among comparable clinic clients to 75 percent of intervention participants; 89.2 percent of participants who completed the WE CARE Program were retained in care after one year—underscoring the importance of this work and its associated completion)
- lower viral loads
- improved HIV medication knowledge
- lower levels of provider mistrust



Sources: Ruth M. Rothstein CORE Center, CORE Center Final Report. November 2016. The Ruth M. Rothstein CORE Center. "Project Women Empowered to Connect and Remain Engaged in Care (WE CARE)." In *Enhancing Access to and Retention in Quality HIV Care for Women of Color Initiative: An Intervention Monograph*. 2014.

[14] Ryerson Espino S, Precht A, Gonzalez M, et al. Implementing peer-based HIV interventions in linkage and retention programs: successes and challenges. *Journal of HIV/AIDS & Social Services*. 2015; 14 (4): 417–31.
[15] Ruth M. Rothstein CORE Center, *CORE Center Final Report*. November 2016.
[16] Ruth M. Rothstein CORE Center, *CORE Center Final Report*. November 2016.

Tested and Proven HIV Strategies

The Integrating HIV Innovative Practices (IHIP) project is an outgrowth of SPNS. HAB created IHIP to share knowledge gained from SPNS interventions, and to promote their replication. IHIP takes tested innovations and turns them into practice. IHIP is where training meets implementation, with the intended results being more informed providers, better care delivery and, ultimately, healthier clients and communities.

This intervention guide is part of a larger series of resources and capacity building assistance activities including webinars about the interventions, a dedicated IHIP listserv, and a help desk.

Tell Us Your Replication Story!

Are you planning to implement this intervention? Have you already started or know someone who has? We want to hear from you. Please reach out to **SPNS@hrsa.gov** and let us know about your replication story.

Other Resources

- Enhancing Engagement and Retention in Quality HIV Care for Women of Color SPNS Initiative: **https://hab.hrsa.gov/about-ryan-white-hivaids-program/spns-women-color**.
- Blank, AE, Ryerson Espino S, Eastwood B, et al. The HIV/AIDS Women of Color Initiative: Improving Access to and Quality of Care for Women of Color. *Journal of Health Care for the Poor and Underserved*. 2013; 24:15–26.
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Appendix: SWOT Analysis

SWOT is an acronym for Strengths, Weaknesses, Opportunities, and Threats. A SWOT analysis is a structured planning method that can be used to assess the viability of a project or intervention. By conducting a SWOT analysis in advance of an intervention, organizations can proactively identify challenges before they occur and think through how best to leverage their organizational strengths and opportunities to improve future performance.

Healthy Relationships Intervention
Strengths: • Funding to dedicate four full time staff as Advisory Board allowing for fidelity • Had Interns as well as internal Peer Education staff to assist with implementation • Development of self-advocates/role models • Fostered plans for community action • Clear results of better health outcomes
Weaknesses: • Recruitment plan lacks outreach • Resource intensive in beginning of project • Retention was difficult—women have complex lives • The sessions build on each other, as a result, less graduates
Opportunities: • Disclosure of Violence-Debriefing/Vicarious Trauma • Additional Alumni meetings/support • Consistency and designation of outreach work • Third person as observer or logistical helper
Threats: • Long lag time between consent and start of groups • Burden on the overall prevention budget • Challenging to secure space for enough people for five consecutive weeks • Extremely resource intensive—both cost and staff-wise

Appendix: CORE Center Intervention Tools

Return to Care Survey

Ruth M. Rothstein CORE Center
Confidential Return to Care Survey 2013

We are trying to learn more about why patients leave and then return to care. By sharing your story with us through this survey, you will help us keep our patients in care and healthy. Your answers will be kept confidential. Choose the answers that best match how you feel. When you're done with both sides of the survey, place it into the locked box labeled "Feedback and Survey Data." Thank you!

1. When was the last time you saw a CORE Center primary care medical provider?
   within the last year over a year ago

2. What kept you from coming *to the CORE Center* for HIV care? PLEASE SELECT ALL THAT APPLY.

   Change of address/Living Situation

   1. moved 2. became homeless 3. moved into shelter 4. incarcerated/in jail

   Transportation

   5. transportation cost too much 6. takes too long to get here 7. transportation not convenient
   8. I had no way to get here

   Provider

   9. I got insurance/changed provider 12. my doctor left 15. wait time in clinic too long
   10. seeing a non-CORE provider 13. was treated poorly at CORE 16. appointment wait time too long
   11. not same provider all the time 14. I go to the ER when I'm sick 17. clinic schedule not convenient

   Disclosure Concerns

   18. wasn't ready to accept diagnosis 19. didn't want to be seen coming here
   20. didn't want people to know I'm HIV positive (avoided all HIV care)

   Health

   21. I felt too sick to come in 25. felt healthy/didn't need to come in
   22. worried about side effects of meds 26. too sad/down to come in
   23. I could get my meds without an appointment 27. no energy to come in
   24. drugs/alcohol stopped me from coming in

   Employment/Family & Community

   28. cultural barriers 32. neighborhood violence 36. loss of job
   29. too many family responsibilities 33. no childcare/no babysitter 37. new job
   30. experience with domestic violence 34. family/relationship problems 38. can't get off work
   31. experience with sexual assault 35. death of a loved one

3. Of the items you chose above, pick the *three* biggest things that kept you from coming to care. Use the numbers that go with the above items.

   1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18
   19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36

4. If prescribed, are you currently taking HIV meds?
   yes no sometimes NA

5. What are your reasons for returning to the CORE Center now? (select all that apply)
   lost insurance started feeling sick I'm ready to accept I'm HIV positive
   I ran out of meds returned to this area CORE Center staff
   needed paperwork other

6. If your answer to #5 was "other," please specify here:

Ruth M. Rothstein CORE Center
Confidential Return to Care Survey 2013

General Questions:

7. Has anyone at CORE ever asked you the above questions before (either in person or on the phone)?
   yes no not sure

8. When you were coming to the CORE Center before, how would you rate your overall service?
   excellent good fair poor

9. Gender
   female male transgender male to female transgender female to male other

10. If your answer to #9 was "other," please specify:_____

11. Race/Ethnicity (select all that apply)
    African American Latino White Native American/Alaskan Asian/ Pacific Islander

12. What is today's date?

Month	*Day*	*Year*

13. What is your age? _____ 14. What is your medical record number _____

15. What is your ZIP code? _____
    If you did not enter your zipcode please explain: homeless don't know my zipcode

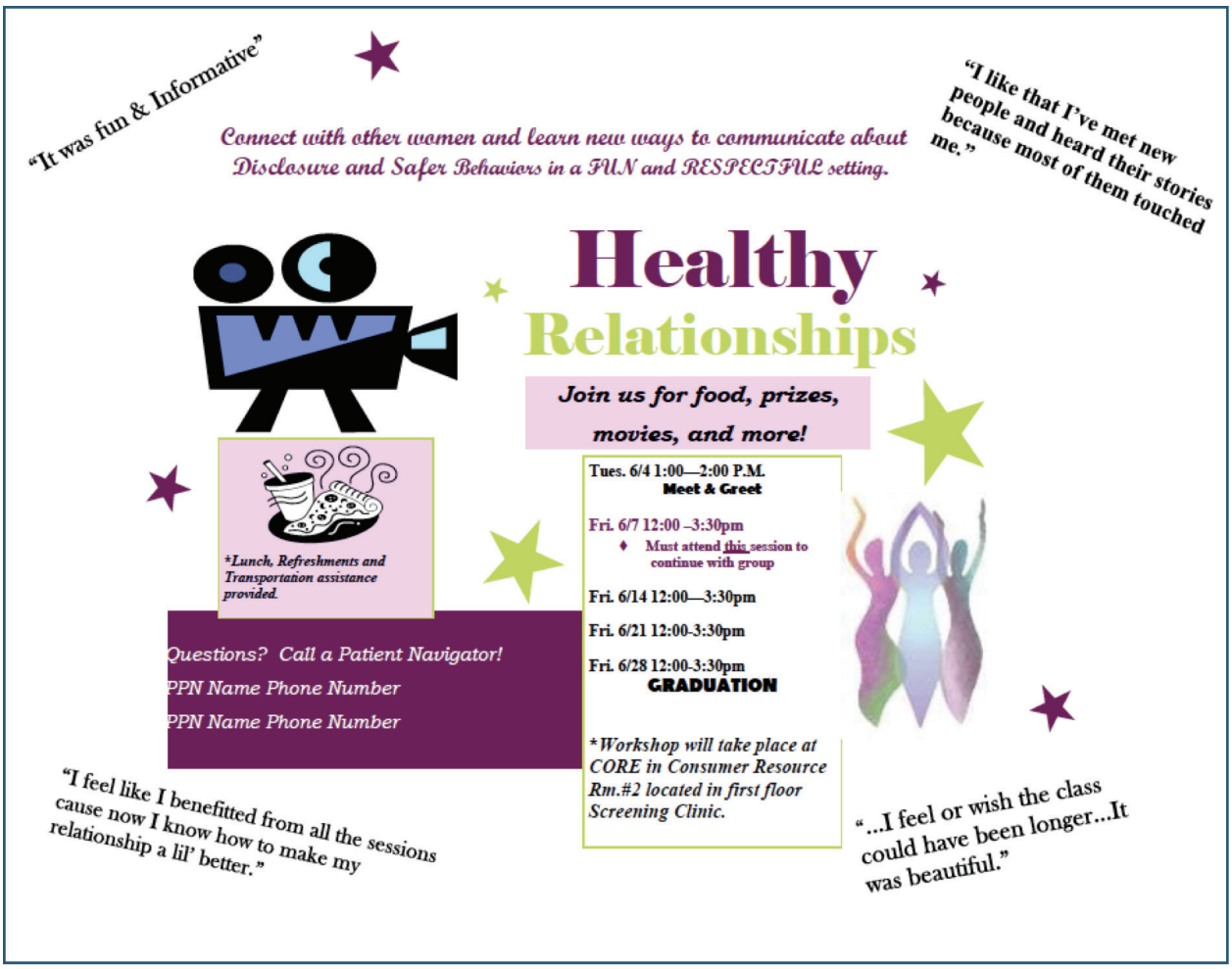
Office Use Only:

Clinic Day: Mon Tues Weds Thurs Fri

Telephone Survey? _____ If yes please fill in circle

Clinic lime: morning afternoon evening Clinic Side: 3 East 3 West

Marketing One Sheet (Recruitment Flyer)



Healthy Relationships Observation Log

Healthy Relationships Observation protocol

Observer Name: _____ Date: _____/_____/ _____

Start Time: _____End Time: _____ Session #:_____

Facilitator(s): _____ Number of Participants: _____

Overall Impressions:

Highlights(s):

Things to think about for next time:

Healthy Relationships Certificate of Completion

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