HIV Counseling, Testing and Referral among Urban Indian Health Programs:

A Review

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I. Executive Summary

This report provides findings from an evaluation of HIV Counseling Testing and Referral (CTR) Programs funded by the Minority AIDS Initiative (MAI) and Indian Health Service (IHS) at Urban Indian Health Programs (UIHP) across the country. Researchers conducted primary data collection at all funded sites and reviewed secondary documents to compile the findings.

Overview

The resources provided by IHS to support HIV CTR has expanded access to HIV testing and counseling for American Indian/Alaskan Natives (AI/AN) utilizing UIHP across the country. Most sites have engaged in outreach activities to reach high risk individuals while many sites have also taken steps to increase the routine administration of HIV tests in the clinical setting. Without IHS support for these activities, HIV testing activity would likely decrease and fewer AI/AN would become aware of their status, be linked to services, or receive counseling to help reduce their risk of becoming HIV infected.

Highlights of the findings

Service Provision

- IHS HIV prevention funding for CTR programing provides valuable resources for the expansion of HIV testing among AI/AN.
- Most CTR funded UIHPs have met target goals related to the provision of HIV testing. While the target number of HIV tests per grant cycle for a particular clinic depended both upon grant size as well as the number of AI/AN in their catchment area (smaller sites, for example, might have smaller target numbers), a relatively commonly referenced target was 300 administered tests per grant cycle.[1]
- HIV CTR programs increased the early identification of individuals with HIV/AIDS. While the number of newly identified HIV infections varied by program, at least 19 new infections had been identified collectively since 2009.

Programmatic Strengths

- Funded sites have demonstrated promising practices for the reduction of HIV stigma in the AI/AN community that include consistent participation in community events, relationship building, facilitation of discussions around sexuality, educating elders and providing a voice for community members living with HIV.
- Routinization of HIV testing has been effective in increasing number of tests. HIV testing has been routinized in a variety of ways ranging from distribution of promotional flyers to administering panels of HIV/STD/Hepatitis tests to providing opt-out HIV testing.
- Where available, diversified funding streams geared towards HIV prevention (usually from the CDC or state health departments) resulted in a substantial increase in operational capacity while at the same time improving programmatic sustainability.
- Cultural competency training appeared a vital aspect of clinical programming.
- Collaboration among providers across IHS is a key factor towards targeting largely transient populations. Among other areas, individual sites expressed interest in learning how HIV CTR programs are conducted within other clinics, with particular interest in successful, targeted outreach methodologies.

[1] For data surrounding the proportion of tests administered with respect to grant size and client load, please see Table 3 in the Findings section of this report.

Programmatic Opportunities

- Outreach activities have proven challenging and uneven across programs. However, promising practices for conducting effective outreach were identified.
- There is a need for technical assistance surrounding how to balance increased routinization of HIV testing while continuing to target high-risk individuals through outreach and other screening mechanisms.
- Staffing is a challenge for many sites. This includes finding appropriate staff to conduct HIV testing, as well as training and retaining staff once they have become a part of the organization. However, several sites have successfully retained staff through a clinic-wide approach to staff development that includes support for ongoing training/professional improvement and adequate collaboration and supervision.
- Clinic capacity to provide Hepatitis C testing in conjunction with HIV testing is a major gap for a number of sites and represents an opportunity to bolster the manner in which STD prevention is approached in several urban areas.
- While the use of incentives has clearly been an effective mechanism by which to increase the volume of HIV tests completed, it obfuscates a site's ability to determine if the individuals who receive the test are truly at high risk for infection.
- Few sites had protocols in place to track HIV-related risk by geographic distribution.

Recommendations and strategies moving forward

1) Build and strengthen communication channels across funded sites to encourage collaboration and enhance the utilization of best practices. The following suggested methodologies could provide opportunities for sites to learn from the challenges, successes and initiatives of their peers while relaying consistent messages from IHS along with information pertinent to HIV CTR programming:
    - An annual conference with clear objectives
    - An online message board
    - A series of moderated webinars
    - A technical IHS HIV-related newsletter disseminated across funded programs on a monthly or bi-monthly basis
2) Provide a consistent and predictable flow of IHS resources to support ongoing planning at the clinic level. This includes, but is not limited to:
    - Relaying ongoing and consistent messages surrounding grant funding and the future direction of the IHS HIV CTR program.
    - Providing training and technical assistance around topics as diverse as data systems; phlebotomy; HIV 101; and effective outreach methodologies, such as the CDC Social Networking Strategy to reach high risk individuals.
    - Providing operational assistance, such as guidance around the efficient use of RPMS software and clinic flow.
    - Training in new/social media to enhance client/provider communications.
3) Brainstorm means by which to efficiently move away from incentivized testing while at the same time enhancing systems to target high risk individuals who may be in need of more routine or frequent/repeat testing.
4) Develop and utilize a performance indicator based on positivity rates relative to known HIV prevalence rates in the program's surrounding area. This would provide help to determine funding efficiency by describing clinical ability to target high risk populations.
5) Identify resources to help sites address community need through identification of high risk areas. This could include enhancing relationships with local/county health departments to share geographical risk assessments involving sexual or drug-related behavior.

II. Introduction

A report issued in 2007 by the Urban Indian Health Commission, with support from the Robert Wood Johnson Foundation, titled, "Invisible Tribes: Urban Indians and Their Health in a Changing World," provided an in-depth perspective as to the multiple challenges Urban Indians face in accessing quality health care services. The report quantifies health-related disparities facing AI/AN when compared to the general population, including an infant mortality rate 33 percent higher than the general population, a death rate due to diabetes 54 percent higher, and an alcohol-related death rate 178 percent higher. In addition, the report cites outside studies indicating that up to 30 percent of AI/AN adults suffer from depression and that cardiovascular disease among AI/AN has grown to become the population's leading cause of death. Also pertinent, the report goes on to state that more than 1 million AI/AN have moved to urban areas over the last 30 years and that "Urban Indians are much more likely to seek health care from urban Indian health organizations (UIHOs) than from non-Indian clinics."[2]

In addition to the challenges cited above, the AI/AN population in the United States has been disproportionately impacted by the HIV epidemic. In one CDC surveillance report, the AI/AN population ranked third among racial/ethnic groups in terms of its incidence of HIV infection.[3] From the beginning of the epidemic through 2005, AIDS was diagnosed for an estimated 3,238 AI/AN.[4] Women accounted for 29% of the HIV/AIDS diagnoses among AI/AN.[5]

Developing and delivering effective HIV/AIDS programs to the AI/AN population is challenging. The AI/AN population is comprised of 562 federally recognized tribes plus at least 50 state-recognized tribes.[6] Differences in culture, beliefs and traditions require sensitivity to diverse groups within the AI/AN community.

Given this diversity within the AI/AN community, this report summarizes findings from a number of programs that have developed and utilized varying approaches in their efforts to reach out to the AI/AN community, expand HIV testing, reduce stigma, and provide linkages to care for HIV-positive community members. Building upon these findings, the IHS can continue to expand HIV testing, and help prevent further infections among the AI/AN population.

Goals

Since 2007, the IHS has funded UIHPs to provide HIV CTR to the AI/AN population they serve. In 2010, the IHS contracted with JSI to conduct an evaluation of these programs to learn the following:

1. To what extent have UIHP increased access to HIV CTR services generally; and, in particular, to what extent have they succeeded in identifying new cases of HIV infection?

[2] Urban Indian Health Commission. 2007. "Invisible Tribes: Urban Indians and Their Health in a Changing World." Available at http://www.uihi.org/wp-content/uploads/2009/09/UIHC_Report_FINAL.pdf
[3] CDC. HIV/AIDS Surveillance Report, 2005. Vol. 17. Rev ed. Atlanta: US Department of Health and Human Services, CDC: 2007:1–46.
[4] CDC. HIV/AIDS Surveillance Report, 2005. Vol. 17. Rev ed. Atlanta: US Department of Health and Human Services, CDC: 2007:1–46.
[5] CDC. HIV/AIDS Surveillance Report, 2005. Vol. 17. Rev ed. Atlanta: US Department of Health and Human Services, CDC: 2007:1–46.
[6] US Department of the Interior, Bureau of Indian Affairs. Indian entities recognized and eligible to receive services from the United States Bureau of Indian Affairs. Federal Register 2003 (December 5); 68(234):68179–68184.

2. What promising practices can be learned about that are occurring at sites in areas such as, but not limited to:
   - Outreach to the AI/AN population?
   - Change in the number of AI/AN receiving and/or requesting CTR services over time?
   - Linkage to care mechanisms for HIV positive individuals?
3. Are there challenges that sites have encountered in providing HIV CTR services that can be useful in adapting the program or for which technical assistance may be provided?

Through site visits and a review of secondary documents, JSI compiled this report to provide information on how expanded HIV testing has fared at the UIHPs and to identify successes, challenges and opportunities to provide additional support to help each program achieve its goals.

Indian Health Service Strategic Plan

The IHS Strategic Plan for 2006-2011 puts forward three strategic goals. They are to: 1) build and sustain healthy communities; 2) provide accessible, quality health care; and 3) foster collaboration and innovation across the Indian Health System. The HIV CTR program was evaluated in the context of the other services provided at UIHPs, i.e. the linkage and integration of HIV CTR services with other existing services and programs. In addition, systems to measure and assure quality of HIV CTR services were assessed. The study documented partnerships with outside programs, including other agencies within the Indian Health System.

National HIV/AIDS Strategy

The IHS has worked in close collaboration with other federal agencies in the development of the National HIV/AIDS Strategy (NHAS). Among the major goals of this strategy are to Reduce New HIV Infections, and the NHAS recognizes that multiple strategies are needed to accomplish this. Prominent among such strategies is enhancing access to routinized screening for HIV and other infectious diseases.[7] In a recent webinar entitled, “The State and Future of AIDS” sponsored by the White House Office of National AIDS Policy, Director Jeff Crowley noted that it is necessary to “couple routine testing with targeted testing of people at higher risk.” This message represents a key point in assessing strategies employed by HIV CTR programs for the AI/AN population.

Overview of Report

This report summarizes findings from site visits to thirteen currently funded UIHPs receiving funding to support HIV Counseling Testing and Referral (CTR) Programs. The write-ups of the site visit reports are being submitted separately to document the findings at individual sites. Information from each site visit was organized according to the following categories: Vision of HIV CTR Services; Services Provided; Outreach and In-reach; CTR Protocols and Processes; Intervention Effectiveness and Program and Clinic Staffing. Following the findings in each area is a section on Ideas for the Future that provides ideas for supporting the HIV CTR programs across sites.

[7] National HIV/AIDS Strategy For The United States, p. 24 accessed online on June 9, 2011 at http://www.whitehouse.gov/sites/default/files/uploads/NHAS.pdf

III. Methods

Thirteen sites currently receive grants to conduct HIV CTR. The most recent round of grant applications for each funded program was reviewed and a matrix developed to identify key aspects of programs as delineated in the applications. The study team developed a site visit protocol to allow for in-depth discussions with UIHP leadership and HIV CTR managers and staff about successes, challenges and what might be needed going forward. Staff pilot-tested the site visit protocol at one of the sites and made adjustments to the protocol as needed. IHS staff was included in development and review of the site visit protocol, the pilot test and revisions.

With the revised site visit protocol completed, the study team scheduled and conducted site visits at the remaining twelve programs between late February and May, 2011. Site visits took one day and generally lasted 5-8 hours (see Appendix A). The site visit protocol was used to conduct interviews (see Appendix B). Site visit reports were prepared and programs were given the opportunity to review for accuracy and provide feedback. The study team made any necessary changes and prepared final site visit reports. Information was extracted from the individual site visit reports to compile the findings of this study.

IV. Findings

Vision of HIV CTR Services

Programs are committed to HIV testing. Staff at all of the UIHPs are dedicated and committed to the provision of high quality HIV CTR services. Most, though not all, UIHPs indicated that they would continue to provide HIV testing services regardless of whether or not funding from IHS remained available. These statements demonstrate a commitment to the provision of HIV CTR services and involvement with the HIV/AIDS epidemic in the local area.

Resources from IHS are used to expand outreach and ability to test high risk individuals. While many of the UIHPs would continue to provide HIV testing in some form, the IHS HIV CTR program is responsible for generating substantial numbers of HIV tests, identifying HIV positive individual who did not know their status and linking those individuals to care. While many individuals would not be tested without these resources, even fewer programs would be able to conduct outreach activities and identify high risk individuals for testing. As one site put it, "While we could continue to offer HIV CTR through our clinical program, we could not conduct outreach to bring additional, high risk individuals in specifically for HIV CTR." Other sites indicated that offsite HIV CTR at powwows, college campuses, and HIV testing awareness days would be diminished or eliminated by an absence of funding.

Sites need greater access to training for HIV testers/counselors. Several states require that CTR services be provided by certified testers, yet opportunities for training are often limited to trainings provided by health departments or their vendors. Due to numerous fiscal constraints, opportunities for training are decreasing. Programs in these states have done well to either hire testers who are already state certified, utilize in-house personnel to provide training (if acceptable within the specific state) or capitalize on any and all opportunities to obtain the required certification. The Health Resources and Services Administration (HRSA) provides training and technical assistance in this area. The IHS could potentially work with HRSA to ensure that these UIHP grantees get the training and assistance needed to provide uninterrupted, high quality services across all funded sites.

Database development is needed across multiple sites. A challenge for many sites surrounds database development and/or staff training to better utilize the RPMS system. Specific challenges surrounding the RPMS system include unlocking the HIV field, freezing HIV specific information when sending information out and training staff to use the system efficiently. Further work should be done to make sure that UIHP staff has sufficient resources and trainings available in order to efficiently input data, generate necessary reports and customize information in order to target outreach and service provision to their catchment area. Where RPMS is unavailable, challenges include database development and/or tracking of specific indicators, which may be unavailable due to the nature of anonymous testing, clients' unwillingness to provide identifying information, lack of training or lack of resources. In these cases, IHS should work with clinics to develop systems capable of both collecting and analyzing necessary data.

Activity is increasing at several sites in Hepatitis C screening and treatment. High numbers of AI/AN with Hepatitis C are being identified and treated. Most sites, however, lack the resources to provide Hepatitis C testing and feel that their at-risk clients would benefit from this test. Individual sites in which this is an identified must develop relationships with organizations capable of filling this key gap pertaining to Hepatitis C diagnosis and treatment. In such cases, IHS could provide overarching guidance and networking support.

CTR Services, Processes and Protocols

Prevention Education: All sites offered some form of HIV prevention education, which usually occurred during the pre- or post-test counseling session. Education styles varied, but all included information surrounding transmission methods, risk behavior and risk reduction practices. Some sites offered pre-and post-test 'quizzes' to determine how much a client learned about given topics during their testing appointment. These 'quizzes' were always succinct and included questions such as, "What are the bodily fluids through which an individual can contract HIV?" Conversely, risk reduction counseling usually entailed the counselor trying to get the client to agree to at least one change to reduce risky behavior before they left the clinic. Some clinics utilized motivational interviewing as a risk-reduction strategy.

Safe-sex supplies: Most sites offered safe-sex supplies in conjunction with educational materials. These supplies were usually provided at the end of the counseling session and included things like condoms (both male and female), lubricant and dental dams. Provision of these supplies affords additional opportunities for counselors to explain how to use such supplies and how proper usage relates to decreased risk of contracting or spreading HIV.

Incentives: Many of the sites relied on an incentivized testing structure in which clients receive a nominal incentive, such as a five dollar gift card to Wal-Mart, in exchange for receiving an HIV test. One site used T-shirts as an incentive. The T-shirt included a culturally appropriate message supporting HIV awareness. Thus the T-shirt was both an incentive to test and increased community awareness (when worn) around the issue.

Clinics used both rapid tests and blood tests: Rapid tests were available at almost all of the funded programs. All sites were able to demonstrate how rapid tests were stored and how proper temperature levels were maintained and checked on a routine basis. Blood tests were commonly used by health centers for a variety of reasons. Blood tests were sometimes less expensive to administer from the clinic perspective because insurance would reimburse for the test. Other times, blood tests were utilized because the HIV test was part of a panel of tests that included screening for Hepatitis B and C and/or other STDs. One site reported that many people did not want to add another 20 minutes to their visit to wait for the test to be processed, preferring to return on another day for their results.

Funded programs utilized both confidential and anonymous testing: The provision of confidential testing is important when reaching out to tribal areas, as many individuals in such areas would rather be tested in an urban setting with clear confidentiality protocols in place. Anonymous testing creates clear challenges in terms of data tracking. Most clients seemed to find confidential testing to be sufficient, and did not feel the need for anonymous testing.

Cost issues are a factor in selection of type of tests: Some programs were able to bill for tests utilizing their laboratory for blood draws for the standard test. When they utilized rapid testing, they were required to use grant resources to cover costs of the test and quality assurance testing. Therefore, there is a financial incentive to the blood test. Sites that saw the blood test as a cost-saving mechanism and indicated that by doing so, they are able to utilize HIV CTR funds for outreach, training, and other such endeavors.

Confirmatory testing: Capacity to provide confirmatory testing varied across sites. In instances where confirmatory testing was available, the ability to provide the service in-house was a significant strength in that a client testing reactive did not have to leave the clinic, travel to another clinic, hospital or health department, and make another appointment with a different provider in order to receive a confirmatory test. Where confirmatory testing was unavailable, sites generally relied upon strong relationships with local health department Disease Intervention Specialist (DIS) staff to either come to the clinic to conduct the blood draw or to follow up with the client at a later date.

Training on proper testing methodologies is needed: Some sites may benefit from information or technical assistance regarding selection of HIV tests. Some programs needed more information regarding the tests that are available, test cost, purchasing with discounts, and how tests can impact clinic flow with their readability time.

Transience remains an issue for providing care, including HIV CTR: Transience among urban Indians is another challenge faced by many sites. Many programs adopt a strategy of, “working up” new clients with as many screenings and brief interventions as possible because the health center knows that there is a very real possibility that the client may never return to the health center. Sites also try to coordinate care between programs, but this has proved to be challenging.

Referrals: In all cases, clinics had comprehensive referral procedures in place by which to refer individuals testing reactive into HIV specialty care. While the specific mechanisms of those procedures varied slightly across clinics, all agencies relied upon either (a) the direct and immediate involvement of local health department DIS staff, or (b) the direct and immediate referral into a specialty care facility with which the agency had either contractual MOUs or informal understandings in place, in which case DIS staff are usually included in such a process as well.

Variations in such procedures were due either to the nature of the HIV test (i.e. rapid vs. standard), the nature of the partnerships involved (i.e. having in place an MOU or an informal understanding) or to the degree of involvement of health department DIS staff. All such variations impact the time line by which an individual is effectively referred into care. While these types of variations are unavoidable based on clinic resources, the implementation of best practices where possible can enhance the efficiency in which clients are referred to the appropriate care. Routine rapid testing, for example, can maximize a clinic’s ability to retrieve same-day results and make a same day referral. Having a formalized MOU in place with an appropriate HIV specialty care facility can also provide opportunities to reduce wait-times for appointments. In the event that an extended wait time is unavoidable, efforts could be made to ensure that initial, primary care related services are provided internally as soon as possible. Finally, clinic staff should follow-up with both health department DIS staff as well as the HIV specialty care clinic for all reactive test results on both an immediate (i.e. directly after the initial appointment) and annual basis in order to ensure that appointments are being both made and kept. Follow-up services should be formally documented in the patient chart and an ongoing relationship should be developed with the client whenever possible.

Outreach and In-Reach

Many strategies are being used to encourage testing: Sites utilize a wide variety of strategies both outside the walls of their UIHP and within its programs to encourage greater access to HIV testing. Several sites spoke of the need to build trust over time within the AI/AN community as a cornerstone of stigma reduction and increasing the willingness of individuals to have discussions about HIV transmission and its associated risk behaviors. All of the sites discussed utilization of culturally appropriate methods to conduct outreach beyond the walls of the UIHP.

One innovative form of outreach was a Wii bowling tournament (held at Grantee 2). The tournament was done with limited resources, funded by donations and appeared to be successful at getting people involved. This site also conducted outreach through local radio stations, which appeared to be a relatively effective and inexpensive means by which to disseminate information.

Many sites have used incentives to support efforts to increase testing. In some cases, incentivized testing may have increased numbers of people being tested, but have not necessarily attracted individuals with behavior that put them at risk for HIV infection.

Stigma reduction is a critical part of increasing HIV testing: Dedicated staff and strong community relationships are important in terms of reducing stigma. At one site, stigma reduction includes honoring and giving voice to people living with HIV. Reaching out to community elders seems to have had an impact in a number of areas. Most sites reported that the provision of continuous and sustainable programming has been integral to reducing stigma and building community trust.

There are a variety of locations where UIHPs conduct outreach: Outreach to the Powwow circuit appeared to be the most common outreach technique, although the number of newly reactive individuals identified through those efforts is difficult to determine. Outreach through local college student bodies also appeared to be relatively successful at finding individuals who engage in high risk behaviors or might be in the future.

Programs need access to “ready-to-go” outreach materials: A challenge identified across almost all sites has surrounded outreach and outreach materials. While some sites had relatively good outreach materials others had very limited material. Few clinics were either aware of or utilized outreach materials provided by the IHS. One site noted that it is difficult to find sustainable funding for prevention materials such as condoms, female condoms, and lubricant.

Routinization of HIV testing is effective: Integrating and “normalizing” HIV CTR into routine health care visits has been a successful strategy to increase the number of tests performed. At one site, any patient with any identified risk for any sexually transmitted disease, or expressing a concern about STDs, receives a panel of tests including HIV, STDs (gonorrhea, syphilis, chlamydia) and Hepatitis B and C.

Tracking of outreach activities demonstrates success. Some sites kept track of how many individuals they reached with specific community outreach events. Among other programs, Grantee 6 kept detailed logs of both current and future outreach activities, including the number of individuals attending specific events.

Intervention Effectiveness

Overall, the program has proven effective at testing significant numbers of AI/AN: As seen in Table 2, below, the sites have reported offering a total of 3113 HIV tests in CY 2010. Accounting for 586 encounters in which the test was declined, a total of 2527 test were administered, many to individuals who had never been tested before or found out their HIV status for the first time. In fact, 900 individuals learned their status for the first time in 2010 through these efforts.

Table 2 – Site Reports for Calendar Year 2010

IHS - MAI HIV/AIDS Grantee Evaluation of HIV Screening Activities - 2010 Progress Report														
	Grantee 1	Grantee 2	Grantee 3	Grantee 4	Grantee 5	Grantee 6	Grantee 7	Grantee 8	Grantee 9	Grantee 10	Grantee 11	Grantee 12	Grantee 13	TOTALS
Number of HIV tests offered*	33	285	546	107	170	422	339	84	149	90	408	34	446	3113
Number of refusals to HIV tests offered	1	0	271	0	4	143	0	0	0	0	64	0	103	586
Number of persons learning of their status for the first time via this test	31	0	80	0	68	106	82	23	149	17	254	15	75	900
Number of clients who refused due to prior knowledge of HIV status	0	0	15	0	0	33	0	0	0	0	26	0	49	123
Number of individuals tested with rapid testing technology	32	0	208	12	170	231	339	84	111	0	59	0	322	1568
Number of individuals tested via standard HIV antibody	1	0	15	95	0	48	0	0	38	0	285	0	22	504
Number of reactive tests	1	3	0	0	1	1	0	0	0	0	4		14	24
Number of reactive tests confirmed seropositive	1	3	0	0	0	1	0	0	0	0	3	0	14	22
Number of false positives after confirmatory testing	0	0	0	0	0	0	0	0	0	0	1	0	0	1
Number of negative results	31	282	237	0	169	278	339	84	149	0	404	27	330	2330
Number of individuals receiving their confirmatory test results	1	0	12	0	1	1	2	84	0	0	358	0	14	473
Number of clients linked to care/treatment (ex. If test is reactive or other reasons)	1	285	0	0	1	49	5	0	0	0	2	0	14	357
Number of referrals for prevention counseling	1	84	0	0	25	48	0	0	149	0	59	0	322	688
Number of post-test counseling sessions	1	84	237	107	170	279	339	31	149	0	0	0	322	1719
Number of pre-test counseling sessions (brief)	32	84	237	107	170	422	339	31	149	0	322	0	322	2215
Number of prevention counseling sessions due to higher risk populations (less brief)	1	0	0	12	33	48	0	84	0	0	0	0	322	500
Number of missed follow up after rapid test is reactive	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cost Per Test	$242	$17	$0	$13	$123	$19	$71	$15	$80	$15	$26	$11	$87	**$55**
Measures in place to protect confidentiality	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	

* Fields shaded in light blue indicate required reportable variables.

In order to quantify the catchment areas for specific clinics, Table 3, below, provides an overview of how many unduplicated clients each clinic served in CY 2010, including the number of AI/AN served as well as the number of HIV tests offered, refused and administered.

Table 3. Total Clients Served and HIV Tests Offered per UIHP in CY, 2010[1,2]

		Grantee 1	Grantee 2	Grantee 3	Grantee 4	Grantee 5	Grantee 6	Grantee 7	Grantee 8	Grantee 9	Grantee 10	Grantee 11	Grantee 12	Grantee 13	TOTALS
Testing Information															
1	Number of HIV tests offered	33	285	546	107	170	422	339	84	149	90	408	34	446	**3113**
2	Number of refusals to HIV tests offered	1	0	271	0	4	143	0	0	0	0	64	0	103	**586**
3	Number of HIV tests administered (*row 1 minus row 2*)	32	285	275	107	166	279	339	84	149	90	344	34	343	**2527**
4	Number of reactive tests	1	3	0	0	1	1	0	0	0	0	4		14	24
Client Base Information															
4	Total Unduplicated Patients	2303	6460	3532	3751	4262	28453	10019	1358	11835	1684	3816	1135	1879	**80487**
5	Total Unduplicated AI/AN Patients	2036	2042	2386	2583	2838	3187	2617	1191	6230	1667	1243	1105	1224	**30349**
Ratios															
6	HIV Tests *Offered* per Unduplicated AI/AN Patient (*row 1 divided by row 5*)	2%	14%	23%	4%	6%	13%	13%	7%	2%	5%	33%	3%	36%	**10%**
7	HIV Tests *Administered* per Unduplicated AI/AN Patient (*row 3 divided by row 5*)	2%	14%	12%	4%	6%	9%	13%	7%	2%	5%	28%	3%	28%	**8%**
8	Positivity Rate (*row 4 divided by row 3*)	3.1%	1.1%	0%	0%	0.6%	0.4%	0%	0%	0%	0%	1.2%	0%	4.1%	0.9%

1. The number of HIV tests offered is derived from the "IHS - MAI HIV/AIDS Grantee Evaluation of HIV Screening Activities - 2010 Progress Report"
2. The number of clients served, both duplicated and unduplicated, is derived from Calendar Year 2010 Uniform Data Systems (UDS) reporting.

Many AI/AN have learned of their HIV positive status and been linked to care: The program has identified at least 24 HIV positive individuals in CY 2010 and has successfully linked those individuals to care. Again, see Table 1, above.

There is a need to ensure data reporting quality and consistency: Currently, UIHPs are only required to report a limited range of variables to IHS surrounding HIV CTR services. The number of HIV tests actually administered in a given grant cycle is not one such variable. This variable could be deduced - as in Table 3 - by subtracting the "number of tests refused" from the "number of tests offered," but this opens substantial room for error as clinics could interpret how they are supposed to report these variables differently. The number of HIV tests administered is an integral variable to determining a clinic's positivity rate, derived by dividing the number of reactive tests by the number of tests physically administered. A clinic's positivity rate is an excellent indicator of clinical ability to target high risk individuals for testing services. High positivity rates (usually ≥ 1%) indicate that high risk individuals are consistently being tested and that funds are being utilized efficiently.

Targeting high risk individuals has proven successful, yet challenging: As noted above, individual clinics have and continue to utilize a combination of approaches to reach out to their target communities. Clinics have struggled, however, to find a balance between the routinization of HIV testing amongst a wide client base in order to increase testing rates and targeting specifically high risk individuals in order to ensure the most efficient use of grant funding. Grantee 13, however, seems to have developed a particularly effective manner in which to find such a balance. As can be seen in Table 3, above, Grantee 13 has among the highest HIV testing positivity rates of all funded UIHPs. The clinic also administered the highest number of HIV tests in CY 2010. While much of this success is due to their location amongst a particularly high risk community, the clinic maximizes their testing efficiency through the use of a routine questionnaire: The Green Sheet. This questionnaire, found in Appendix C, is offered to every AI/AN client who walks into the clinic. However, the questionnaire is not forced upon any one and judgment is utilized to ensure that routine clients are not offered the questionnaire too often. The questionnaire asks brief, simple questions designed to make the client aware that free, confidential HIV testing services are available. In doing so, clinic staff have the opportunity talk to clients about why they may or may not want to be tested. This process is minimally invasive, allows the client to refuse the test at any time, and also allows potentially high risk individuals to receive more information without having to identify themselves as “high risk.” Used effectively, this tool provides an opportunity to promote routine HIV testing while still targeting high risk individuals.

Program and Clinic Staffing

Staffing patterns influence how HIV CTR is delivered to clients: All-staff meetings appeared to be very effective in terms of making other health center programs aware of the availability of HIV testing services. At clinics in which all-staff meetings were held infrequently or not at all, services tended to silo themselves such that the HIV CTR staff felt as though other staff did not even know that they provided HIV CTR services. Conversely, all-staff meetings at other clinics provide a forum for other staff members to learn about the HIV program and the services provided, which seemed to expedite internal referral mechanisms.

Ongoing reporting: HIV CTR Program Administrators reported to the clinical Executive Director (ED) on a monthly basis at a number of programs. Regular reporting seems to allow the ED to remain well-informed of HIV CTR programming while not being intricately involved. Importantly, many monthly reports capture outreach efforts and outline upcoming events.

Use of multiple trained staff increases access to testing: Having multiple staff trained in HIV CTR, even if some are not primary testers, allows for a great deal of flexibility when conducting outreach. It was important for one clinic, for example, to provide HIV testing services at all times when the clinic was open. However, because only trained HIV CTR staff is allowed to conduct outreach, the clinic’s ability to maintain HIV testing during clinic hours was limited when outreach was prioritized. Training multiple staff to provide high quality HIV CTR services would mitigate these scenarios, providing consistent and sustained services.

Cultural competency among program staff is high: Cultural competency of staff was high across sites. In eleven of thirteen sites all or part of the staff conducting CTR services was AI/AN. All sites had some form of cultural competency training provided on either a routine basis or available through attending training opportunities outside the UIHP. Individuals who test positive are generally referred to a clinic that has a track record of providing care to many individuals with HIV. UIHPs have built relationships with these programs over multiple years, working together jointly, training together or building direct referral relationships.

Additional Services

Comprehensive medical services: Most of the sites offer medical services and some sites offer more comprehensive health care including behavioral health, dental, reproductive health, as well as an array of community services. It was not always clear how often health center staff integrated HIV CTR with the activities of the larger health center.

Nutritional counseling: Nutritional counseling service was more limited in terms of the number of sites able to offer it, but some clinics do provide a relatively extensive nutritional counseling program. In some instances, nutritional counseling entailed volunteers coming into the clinic to teach interested clients how to cook nutritious meals.

Fitness counseling/fitness resources: Similarly, this service was limited in terms of the number of sites able to offer it, but some clinics had relatively extensive fitness centers in-house that usually included cardio machines such as treadmills, elliptical machines, or stationary bikes, as well as limited free weights. In all cases in which a fitness center was available, clients were trained as to how to use the equipment and were sometimes directly supervised if additional assistance was needed.

Spiritual counseling: Many sites also offered clients access to either spiritual healers (who would attend the clinic on a monthly or similar basis) or to spiritual grounds, such as a communal garden, where clients could reflect for a given period of time.

V. Ideas for the Future

1. Technical assistance surrounding data collection and tracking could facilitate the manner in which services are targeted. Specifically, sites need guidance on how to ensure that HIV tests are included in the medical record in a way that protects confidentiality by excluding HIV testing information when records are shared but this information is not needed – this is primarily a concern specific to the RPMS system. As noted earlier, in cases in which RPMS software is not available, IHS should work with clinics to develop systems capable of both collecting and analyzing necessary data

2. The need for phlebotomy training was pointed out in a number of sites. Such training could help HIV CTR staff conduct HIV confirmatory and/or Hepatitis C testing. Again, this is an area in which HRSA can provide trainings through collaboration with IHS.

3. Cross training for agency staff around HIV 101, Education, Referral and Rapid Test training are to be considered. Vendor agencies or state/local government can provide the above training. Cross training allows sites to better meet the needs of the clients, their agencies, contributes to more effective clinic flow and efficiency and enhances staff job satisfaction. This is another area in which HRSA has the resources to provide training.

4. Targeting more “at risk” individuals and those that are unaware of their HIV (and Hepatitis C) status will help to achieve the over-arching goal of risk reduction and prevention. An estimated 55,000 persons become infected with HIV in the United States annually and of the 1,000,000 persons living with HIV, 21% are not aware of their infection, which increases the risk of HIV transmission. People who are not diagnosed or diagnosed late in their infections miss valuable opportunities to begin to receive HIV care.

5. The CDC strategy for reaching people with undiagnosed infection and those at most risk is called Social Networking Strategy (SNS) for HIV CTR. The primary goal for a program using SNS is to identify persons with undiagnosed HIV infection within various networks and link them to medical care and prevention services. Across nine CDC funded sites that implemented SNS, approximately 6% of people tested were newly diagnosed with HIV. This prevalence rate is six times higher than the average CTR testing program, which highlights the effectiveness of SNS.

   There are four major phases to this social network program:
   - Recruiter Enlistment
   - Engagement (Orientation, Interview, and Coaching)
   - Recruitment of Network Associates
   - Counseling, Testing and Referral (CTR)

   Enlisting HIV positive or high risk HIV negative people (recruiters) to encourage people in their network (network associates) to be tested for HIV provides an effective route accessing individuals who are infected or at risk. The SNS provides viable recruitment opportunities for reaching people beyond current partners and clients. JSI can provide training and TA to sites that would like to explore the model.

6. Clinic Flow and Efficiency interventions provide sites with the opportunity and skills to effectively integrate new programs while continuing to maintain the highest quality of patient-centered care. JSI has successfully implemented the clinic efficiency process and evaluated its success with over 60 health care sites. JSI begins the TA intervention by on-site tracking of patient visits, followed by data computation and all staff training.

   The Clinic Efficiency Methodology uses these principles for enhanced clinic flow:
   - Move around the patient, instead of moving the patient
   - Identify the clinicians role and cross train all staff
   - Do not beat around the bush; communicate directly
   - Identify capacity and match it to demand
   - Come prepared with all the tools needed
   - Techniques to improve no shows, reschedules and patient cancellations

   Some of the goals of the clinic efficiency intervention include:
   - Increased clinic capacity
   - Increased financial viability
   - Increased patient and staff satisfaction
   - Increased number of users of integrated services
   - Identification of clinic capacity and demand
   - Interventions for improved scheduling

7. Other training that sites may want to consider would include:
   - Social Media training - designed to demonstrate successful uses of new media, including developing patient satisfaction survey approaches. Grantee 13, for example, seemed interested in sending out 'e-mail blasts,' and Grantee 3 seemed interested in social marketing techniques. This could be an efficient manner in which to reach out to the target community for UIHPs with limited resources.
   - Marketing and Building Community Partnerships – This is a training curricula used to enhance or develop marketing plans and increase community collaboration.
   - Peer to Peer training or committees – To engage community/patients in development and strategic plans.
   - HIV 101 training- To all staff within the UIHP, including HIV CTR staff, to increase general knowledge regarding HIV
   - HIV C/T training- Insuring that staff have the CDC recommended HIV Rapid Testing training in a timely manner will allow for the continuation of testing and education.

VI. Conclusion

IHS funded HIV CTR programing has been successful with respect to increasing access to HIV testing among AI/AN who have never tested before, identifying HIV infected individuals who were previously unaware of their status, and linking newly diagnosed individuals to clinical care. The move over time to routine testing has been a major factor in expanding the number of HIV tests administered. Routine testing has also helped to reduce stigma and make it easier for medical staff to provide services to a range of individuals.

In addition, outreach efforts into the AI/AN community continue at almost all of the funded sites and help to normalize discussions around HIV and methods of transmission. In so doing, significant progress has been made to reach high risk individuals and link them to CTR services. Building community trust over time and utilizing culturally appropriate messages have been integral to these efforts.

Against that backdrop of success, however, some programs struggle with maintaining qualified staff, developing broad yet efficient outreach strategies, and utilizing data for programmatic quality improvement. Strained resources at the state level have created yet another challenge by reducing the availability of HIV CTR-related trainings for clinic staff. In order to address such challenges, the following recommendations are posed:

1) Build and strengthen communication channels across funded sites to encourage collaboration and enhance the utilization of best practices. The following suggested methodologies could provide opportunities for sites to learn from the challenges, successes and initiatives of their peers while relating consistent messages from IHS along with information pertinent to HIV CTR programming:
    - An annual conference with clear objectives
    - An online message board
    - A series of moderated webinars
    - A technical IHS HIV-related newsletter disseminated across funded programs on a monthly or bi-monthly basis
2) Provide a consistent and predictable flow of IHS resources to support ongoing planning at the clinic level. This includes, but is not limited to:
    - Relating ongoing and consistent messages surrounding grant funding and the future direction of the IHS HIV CTR program.
    - Providing training and technical assistance around topics as diverse as data systems; phlebotomy; HIV 101; and effective outreach methodologies, such as the CDC Social Networking Strategy to reach high risk individuals.
    - Providing operational assistance, such as guidance around the efficient use of RPMS software and clinic flow.
    - Training in new/social media to enhance client/provider communications.
3) Brainstorm means by which to efficiently move away from incentivized testing while at the same time enhancing systems to target high risk individuals who may be in need of more routine or frequent/repeat testing.
4) Develop and utilize a performance indicator based on positivity rates relative to known HIV prevalence rates in the program's surrounding area. This would provide help to determine funding efficiency by describing clinical ability to target high risk populations.
5) Identify resources to help sites address community need through identification of high risk areas. This could include enhancing relationships with local/county health departments to share geographical risk assessments involving sexual or drug-related behavior.

VII. Appendix A: Site Visit Overview

Overview of Site Visit

Thank you sincerely for your involvement with this evaluation. The efforts of your organization and your staff are truly appreciated. This evaluation is designed to assess the impact of Indian Health Services (IHS) HIV/AIDS Counseling, Testing and Referral (CTR) program funding using a combination of qualitative and quantitative measures. Specifically, we hope to provide detailed descriptions to IHS as to the following key areas of your CTR program:

- Outreach to the American Indian population
- Change in the number of American Indians receiving and/or requesting CTR services over time
- Linkage to care mechanisms for HIV positive individuals

In order to make this process as efficient and effective as possible, we are asking individual clinics to review in advance certain documentation which will aid us throughout this evaluation. The following table provides a brief overview of what to expect throughout the course of our visit. Thank you and we truly look forward to speaking with your CTR project staff!

Site Visit Schedule Overview			
Event	**Estimated Time**	**Overview**	**Suggested Documentation**
Interview with Executive Director	1.5 hours	• goals/vision of the project • organizational structure • funding • program sustainability	none
Interview with Program Director/Coordinator	3 hours	• goals/objectives of the project	• most recent comprehensive plan, if available
		• overview of services provided	none
		• overview of target population	• client surveys
			• demographic data collection tools
		• outreach and enrollment strategies	• promotional materials
		• overview of counseling, testing and referral services	• counseling, testing, and referral protocols and tools
		• staff overview	• CTR training documents
		• community impact/ partner participation	• listing of community partners
		• monitoring and evaluation	• monitoring and evaluation guidelines/protocols • most recent assessment reports
		• quality assurance	• quality assurance guidelines/protocols • most recent quality assurance reports
		• programmatic challenges	• needs assessment tools
CTR Staff Interviews	2 hours (20-30 minutes with each staff member)	• overview of position and responsibilities • position challenges • position strengths	none
Wrap Up (all invited)	1 hour	• technical assistance needs • review of site visit • THANK YOU!	none

VIII. Appendix B: Site Visit Protocol

HIV Targeted Capacity Project
Site Visit Guide – Urban Indian Health Programs

Before site visit, ask for the following materials to be ready at the clinic:

- Screening/assessment tools used
- Site brochures/other background materials (describing population served, funding, target area)
- Quality improvement/evaluation reports
- Patient surveys (if used)
- Summary operational/utilization data
- Let director know that questions will be asked related to staffing, quality assurance, fiscal policy, outreach for the target population, sustainability and effectiveness, and governance

Setting up the on-site visit:
JSI will work with grantees prior to the visit to organize the activities and interviews and confirm who we should interview, including any community partners. The site visit will occur over two days (one day, if possible)

Activities:

1) Site visit Welcome/Introduction/Overview Meeting
2) Interviews with site staff and patients including:

    - Project Director
    - Organizational or department director, if not project director
    - Project advisory committee
    - Clinical staff
        - medical
        - behavioral
        - Care coordinator
    - Clients/patients

3) Visit to partner sites and/ or other clinic locations as necessary
4) Site Visit Review with Project Director reviewing the SSA tool to guide discussion of evaluators' impressions of site.

Grantee/Project:
Grantee #: _____
Location: _____
Date of Visit: _____
Signature: _____

I. QUESTIONS FOR EXECUTIVE DIRECTOR/HIGHER LEVEL ADMINISTRATOR

ED NAME: _____

Assessment of the Larger Organization's View of the Project

1. Please describe the vision of your CTR program.

2. How does the vision/mission of your CTR program fit with/reflect the larger organizational mission?

3. Describe where the program sits within the structure of the organization. How was this decided? (prompt: connection to behavioral health services?)

4. How are you kept informed about the status/progress of this program?

5. What contact does CTR program staff have with other programs within the organization? How are other programs/staff kept informed of this initiative?

   (i.e. meetings attended by project staff outside of their own program meetings.)

6. To what extent do other programs refer potential clients to the CTR program?

6a. Are systems in place to implement internal (in-reach) activities?

7. What plans has the organization made to secure funds for the future of the program?

8. How would you describe the most pressing challenges facing your CTR program?

II. QUESTIONS FOR THE PROGRAM DIRECTOR AND/OR PROGRAM COORDINATOR

PROGRAM DIRECTOR NAME: _____

PROGRAM COORDINATOR NAME: _____

A. OVERVIEW OF PROGRAM GOALS AND OBJECTIVES

Program Vision and Goals

1) What are the goals of your CTR program?

2) What are the program objectives?
   a. How are they outlined?
   b. Are they associated with specific indicators?
   c. If so, how are they tracked?

B. DESCRIPTION OF CLINIC SERVICES

Services Provided

1) Please describe the services provided here (at the clinic in general – not necessarily just CTR programming?

   (Probe for depth and/or description. This is intended to get a sense of the setting in which CTR programming takes place)
   Prompt: again, ties to behavioral health

2) Are there additional services you would like to provide? If so, what are the barriers in doing so and what, in your opinion, is required to overcome those barriers?

C. DESCRIPTION OF CLINIC SERVICES

Demographic Characteristics

1) To what extent do you capture information about your target population and tailor your programming accordingly?
   a. Can you provide an example of an instance in which you have tailored your program to suite a specific population based need?

2) What systems are in place to capture target population demographics?
   a. How is this information utilized?
   b. Is there staff dedicated to collecting, analyzing and reporting this data?
   c. How is this data incorporated into programmatic policy?

3) Describe community characteristics that may have an impact on the success/effectiveness of the program.
   a. Demographic characteristics
   b. Substance abuse/Mental Health issues
   c. MSM
   d. Youth
   e. Cultural issues
   Etc…

D. Outreach and Enrollment Strategies

Please note here that if service delivery has not begun, ask what are the plans for outreach and engagement of the target population.

1) How are participants recruited to the program? (includes internal & external outreach)

2) What outreach and recruitment materials do you use? (get copies)
   a. Do you feel as though these materials have been effective in generating interest in the CTR program?
   b. Why or why not?

3) What messages do you try to put out there and how do you evaluate how the community receives your messages?

4) What have been some success and challenges in reaching out to the community? (lessons learned).
   a. What notable barriers have you encountered in reaching out to the community?

5) What have been your most successful strategies in reaching out the community?
   a. What outreach strategies seem to have generated the most interest among the community?

6) What strategies do you use to facilitate/ promote your CTR services? (Indicate all that apply)
   a. Transportation provided
   b. Child care provided
   c. Food or refreshments are made available
   d. Reminder calls or correspondence
   e. Monetary incentives (e.g., raffles)
   f. Other _____

7) What are some of the most common barriers people face in accessing your intervention (Indicate all that apply)
   a. Lack of transportation
   b. Lack of child care
   c. Conflicting schedules with school or work
   d. Lack of enough available staff
   e. Other_____

Notes:
_____

E. POLICY

1) What are the most pressing policies issues at the state or local level which have a routine impact on your programming?
   a. Have you had to alter your programming on account of specific policy changes on a state or local level?
   b. Can you provide examples?

2) Does your program utilize opt-out testing policies?
   a. If yes, please describe. Further, do you feel as though this policy is effective and/or cost efficient?
   b. If no, why not?

3) What have been some of the more significant programmatic changes you have implemented (if any) over the past 2 years?
   a. What was the rationale for those changes? (e.g. increased persons seeking services, increased awareness of services, increasing HIV testing rates)

4) How would you characterize some of your program's more notable successes? These could be monumental successes or day to day achievements

5) How would you characterize some of your program's more notable challenges? Either monumental challenges, or routine challenges

F. STATUS OF COUNSELING, TESTING, AND REFERRAL SERVICES (CTR)

CTR Overview

1) Does the CTR Program have a standard written protocol for counseling, testing and referral?
   a. If yes or no, please describe the overarching process and the main steps involved (specific steps for each process will be discussed in more depth later)
   b. If yes, obtain copy

2) How is cost evaluated for each step in the CTR process?
   a. Do you have a system in place to determine which steps (from outreach and advertising to referrals) add value and which do not?
   b. If so, can you describe this system?

3) How often is CTR conducted? (How many clients per week, approximately)

4) How are patients tracked from initial screening/testing to final referrals? To what extent do you use EHR? How do you ensure that the tracking system maintains patient confidentiality?
   a. How do you follow-up with positive, negative or indeterminate tests?
      i. Follow-up for positive tests
      ii. Follow-up for negative tests
      iii. Follow-up for indeterminate tests

5) Are the program activities appropriate to the target population with regards to culture, gender, and development?
How is this evaluated?

6) How, if at all, has the intervention been designed or modified to reflect the culture(s) of the participants?

7) Who delivers the services (nurses, behavioral health workers)?
a. Does this change throughout the CTR process? (for example, a nurse for testing and a behavioral health worker for counseling, etc…)

(*For JSI to determine - Is there any pattern between the programs that are the most successful?)*

8) Is there a doctor(s) on site?
a. How many are on site?
b. How often are they on site?
c. How often does he/she perform CTR functions?
d. What is his/hers caseload like?
e. How long would it take an average newly diagnosed patient to make an appointment with him/her
f. Does he/she have a specific expertise in HIV or infectious diseases?
g. If yes, please describe

Counseling

1) Does the CTR Program have a standard written protocol for HIV prevention counseling? If so, please indicate if the following elements are present and if yes, please provide descriptions:
a. Information on HIV testing including benefits and consequences
b. Assurances of confidentiality
c. Information on anonymous testing (if applicable)
d. Information on legal obligations if found to be HIV positive
e. Individualized risk assessment
f. Development of a personalized risk reduction plan
g. Provision of referrals and support
h. Information and discussion of partner counseling and referral services options
i. Obtain written informed consent for HIV testing (if client consents to testing)
j. Provide educational materials and risk reduction tools
k. Document risk reduction plan
l. Document referrals
m. Provision of test results (if client has been tested)

4) How often is counseling offered (on a daily/weekly/monthly basis – whichever is more appropriate)
b. Is pre and post test counseling offered for every HIV test?

5) Does the counseling protocol address special situations? If yes, which situations does it address?
(e.g. presenting co-morbidities, if their partner is HIV+ and they are not, if they have diabetes, etc…)

Testing

1) How many HIV tests were administered in CY 2010?

2) How many people sought testing over the most recent 3-6 month period?

3) Has the volume of people seeking an HIV test changed over time?
   a. How do you track this information?
   b. How do you determine how this [volume of persons seeking/getting an HIV test] has changed since before implementation of your CTR program

4) Which HIV test is used at your facility?
   a. Are multiple testing technologies available?

5) What informed your choice of the HIV test provided by the program? Financial? Patient time constraints?

6) Describe the testing process: from pre-test counseling to administration of the test to post-test counseling.
   a. Do clients need to make an appointment? Or is it done on a walk-in basis?
   b. How many tests do you perform on a daily basis? On average…

7) What proportion of people tested for HIV learn their serostatus?
   a. What is the strategy used to reach people who do not return for their test results?
   b. What is the most common reason for not learning serostatus?

8) How many persons were newly diagnosed at your clinic in CY 2010?
   a. How is the information collected?
   b. How is this information utilized?

9) Do you track your HIV testing positivity rates?

10) Is there a protocol in place for persons who test HIV+? If so, please describe…
   a. Is a referral immediately made? (in house or out of house?)
   b. Are they screened for additional services?
   c. Are they screened for eligibility in public programs, such as an AIDS Drug Assistance Program?

G. COMMUNITY PARTNERS AND REFERRAL POLICIES

Community Partners

1) Who are the key partners/collaborators on this project? List names or agencies.

2) What is the goal/rationale for the linkages with these specific community partners?

3) Are there MOUs, subcontracts, or verbal agreements in place with community partners? (get copies – also, this will be discussed in more depth later, so this should serve as an overview for now)

4) Do you meet with community partners? If so, when was your most recent meeting? If not, how do you generally communicate?

Referral Management

1) How are referrals managed? Describe the degree to which those relationships are formalized through written agreements? Please expand upon the partnerships.

2) Do you maintain a current community resource guide that includes necessary information for effective referrals (i.e. description of program, contact information, cost, etc…)
   a. If so, is this guide available to community members?

3) Do you maintain a referral protocol?

If yes, does it address the following elements?

   a. Assessment of client referral needs
   b. Prioritization of client referral needs
   c. Development of a referral plan
   d. Assistance in accessing referral services
   e. Consent for release of medical/client records to facilitate referral
   f. Follow-up of referrals (i.e. completion of referral)

4) Are referrals made to service providers in the patients' communities in order to ensure speedy and convenient service provision?

5) How are referrals tracked?
   a. How many clients (generally speaking) accept or deny referrals? Does this rate change depending on the type of referral? If so, which referrals see the most follow through and which see the least?
   b. What follow-up is given for referrals? For example, do you follow up to make sure appointments are made and/or kept?

H. COMMUNITY IMPACT/PARTICIPATION

Description of Community/Locale

1) What kinds of mechanisms are in place to inform the community as to the successes, purpose and/or values of this project, if any? – Aside from general outreach, this is intended to get more to community participation / feedback mechanisms.
   a. What mechanism are used/or will be used to accomplish this? (e.g. community meetings – get appropriate documentation of this)
   b. Who was/will be responsible for sharing the information?
   c. Are there mechanisms in place for the community to provide feedback? What are those mechanisms?

2) What tools have been used to assess community perceptions and what have been the results of those tools?
   a. Who performs such assessments?
   b. How are those results analyzed and incorporated into future programming?

3) How is the following information collected, organized, analyzed and utilized? – all refer to the clinic's "target population" (again, this information could be captured through community or participant surveys/ participant service evaluations, etc…)
   - Knowledge of HIV transmission methods
   - Knowledge of safe sex practices
   - Knowledge of resources available
   - Attitudes towards safe sex
   - Attitudes towards the HIV positive
   - Beliefs concerning efficacy of desired behavior
   - Belief in one's ability to perform desired behavior
   - Changes in engagement in risky behavior
   - Changes in engagement in protective behaviors

4) How are the service needs and service area gaps of the target population assessed? (For example, through a Needs Assessment evaluation, independent studies, community feedback mechanisms, Etc…)

I. STAFFING CHARACTERISTICS

Description of Project Staff/Function

1) Please identify the project staff funded by this project: (check all that apply)
   ____ Project Director: # of FTE_____
   ____ Program Coordinator; # of FTE_____
   ____ Principal Investigator (how many____); # of FTE_____
   ____ Staff who provide direct services:
   ____ Outreach Workers (how many___); # of FTE_____
   ____ Peer Educator (how many____); # of FTE_____
   ____ Counselors (how many____); # of FTE_____
   ____ Mentors (how many_____); # of FTE_____
   ____ Case Managers (how many_____); # of FTE_____
   ____ Other_____ (how many___); # of FTE____
   ____ Evaluator ; # of FTE_____
   ____ Other _____; # of FTE_____

2) How many staff funded by this grant are members of the target population/community or constituency?
   a. How many staff are not?
   b. Have staff demographics impeded in any fashion your ability to reach out to the Native American population?

3) Is Cultural Competency training provided?
   a. If so, what does it entail?
   b. How often is it provided?

5) How many staff funded by this grant speak a language other than English that is used on the job? Please list the staff and the language.

6) How are CTR staff recruited? (Indicate all that apply)
   a. Through community organizations and groups (such as churches, universities)
   b. Through flyers, media
   c. By word of mouth
   d. Other:_____

7) Are there specific staff dedicated to Quality Assurance (QA) or Monitoring and Evaluation (M&E)? If so, how does the clinic outline specific roles and responsibilities related to each? (This is an introduction to the next section and should be considered an overview of such roles, to be explored in more depth later

Notes:
_____

J. EVALUATION PROTOCOLS

Description of Program Evaluation Protocols

1) Please describe your CTR monitoring and evaluation plan.
   a. Is there a written, formal M&E plan?
   b. If yes, may be obtain a copy?
   c. When was the last time it was updated?
   d. Did it go through an approval process?
   e. If yes, with who and when?

2) Do you have specific staff responsible for M&E? If yes, who is it?

3) Do you have a mechanism by which to apply the findings of evaluation reports to the improvement of the program?

4) Capacity around evaluation (JSI to identify)

Evaluator

1) How frequently does the evaluator have contact with the Program Director?
   a. Daily
   b. Several times a week
   c. Weekly
   d. Several times a month
   e. Monthly
   f. Less than monthly

2) How frequently does the evaluator have contact with the Program Coordinator?
   a. Daily
   b. Several times a week
   c. Weekly
   d. Several times a month
   e. Monthly
   f. Less than monthly

3) How frequently does the evaluator have contact with the supervisor of service delivery staff?
   a. Daily
   b. Several times a week
   c. Weekly
   d. Several times a month
   e. Monthly
   f. Less than monthly

4) Approximately how many hours per month (on average) does the evaluator spend with service delivery staff or observing program activities?
   a. Often, once a month
   b. Regularly, at least once a quarter
   c. A few times a year
   d. Annually or less

e. Not at all

5) Does the evaluator provide written or verbal input on any of the following? (circle all that apply)
   a. Programs goals and objectives
   b. Recruitment and retention issues
   c. Curriculum or program activities
   d. Areas of program improvement
   e. Other_____

K. QUALITY IMPROVEMENT/MANAGEMENT(QI)

Description of Quality Improvement/Management Plan

1) Does the clinic have a Quality Improvement/Management Plan (Y/N)?
   a. If Yes, please describe

2) If Yes, how was it developed and how is it informed and/or updated?

3) Do you receive guidance from IHS?

4) Do you have systems in place to ensure high quality CTR data? (Y/N) If Yes, please describe the types of data you collect

5) What systems are in place to ensure data security and client confidentiality?

6) Has the plan been reviewed by an external review committee (Y/N)? If Yes, when?

7) Do you have staff specifically responsible for the plan? (updating, monitoring, adherence, etc…)
   a. If Yes, who is it?
   b. Please describe his/her resources
   c. Please describe his/her time dedicated to QI
   d. Please describe his/her training process

8. What resources (aside from staff time) are dedicated to QI?

9. Do you have a mechanism by which to routinely apply the QI plan to the improvement of the program?

10. Are there systems in place to monitor performance and improvement (Y/N) in the following:
    Client Satisfaction – (Y/N)
    Quality of Care (Y/N)
    Quality of work environment (Y/N)
    Programmatic and client Data – (Y/N)
    Staff Productivity – (Y/N)
    Client follow up/referral status – (Y/N)

11. If Yes was answered to any of the questions above (in question 11), please provide a description.

QI Staff

1) How frequently does the QI staff member have contact with the Program Director?
   a. Daily
   b. Several times a week
   c. Weekly
   d. Several times a month
   e. Monthly
   f. Less than monthly

2) How frequently does the QI staff member have contact with the Program Coordinator?
   a. Daily
   b. Several times a week
   c. Weekly
   d. Several times a month
   e. Monthly
   f. Less than monthly

3) How frequently does the QI staff member have contact with the supervisor of service delivery staff?
   a. Daily
   b. Several times a week
   c. Weekly
   d. Several times a month
   e. Monthly
   f. Less than monthly

4. Approximately how many hours per month (on average) does the QI staff member spend with service delivery staff or observing program activities?
   a. Often, once a month
   b. Regularly, at least once a quarter
   c. A few times a year
   d. Annually or less
   e. Not at all

5) Does the QI staff member provide written or verbal input on any of the following? (circle all that apply)
   a. Programs goals and objectives
   b. Recruitment and retention issues
   c. Curriculum or program activities
   d. Areas of program improvement
   e. Other_____

III. STAFF INTERVIEWS

1) Is there a written job description for your position?

2) Does your job description adequately reflect your actual job responsibilities/duties?

3) What is your position? What are your job responsibilities on this project?

4) How did you become a member of this project staff?

5) What related work experience did you have prior to accepting this position? Have you worked with this population before?

6) Are you a member of the community being served? If no, are you familiar with the community and its needs?

7a) Who supervises you?

7b) How often do you meet with your supervisor?

8a) How much training did you receive from the program before you begin to provide services?
# of hours_____

8b) Are ongoing training/educational opportunities available for staff members? If yes, what are they and how often do they occur?

9) How well do you feel staff is able to record all services clients receive on the service/encounter forms? What services may be undercounted?

10) Do you coordinate/work with staff outside of the program about specific clients? If so, how? Please comment on the effectiveness of these coordination strategies.

11) What do you do if a client needs additional services that your program does not provide?

12) What are the main challenges you encounter in your job?

NOTES:_____

IV. WRAP UP

1) How can JSI continue to support the project through technical assistance? Identify specific TA needs/content areas.

2) Are there additional resources the project needs in order to implement the proposed initiative? Identify specific unmet resource needs.

Sustainability

1) Has the program begun to address the issue of future funding and sustainability?
   a. Are supplemental funds received? If yes, where from?
   b. Is your program currently billing for services? If no, are plans in place for billing to begin soon?

Feedback on Site Visit

1) Review of Site Visit:
   Grantee feedback on site visit protocol

2) Review of Site Visit:
   PCC feedback.

V. OVERALL ASSESSMENT OF PROGRAMMATIC AREAS

Summarize your overall assessment of the grantee's programmatic areas. Consider the effectiveness of programmatic issues at the following levels: Design of Intervention; Community Involvement; Organizational/project expertise; and Linkages/collaborations.

Strengths:

_____

_____

Weaknesses:

_____

_____