From Outreach to Retention in Care for HIV+ Youth:

Maximizing Intra- and Inter-organizational Collaborations

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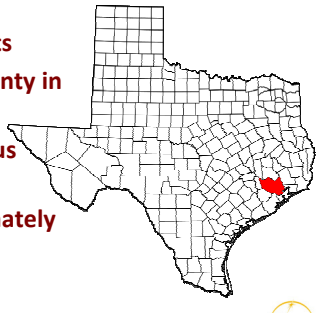
Special Projects of National Significance – Young Men of Color Who Have Sex with Men (YCMSM)

Houston/Harris County, Texas

About Harris County

- 3.7 million residents
- Most populous county in Texas
- Third most populous county in the US
- Spanning approximately 1,700 square miles



About Houston

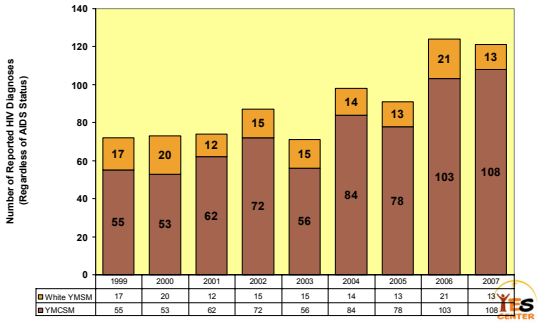
- Approximately 2 million residents
- Fourth most populous city in the US
- Spanning more than 600 square miles

Project Partners

- Harris County Public Health and Environmental Services (Charles Henley)
  - County Health Department
  - Administrative Agent for Part A and SPNS
- Harris County Hospital District (Nancy Miertschin)
  - County Public Healthcare System
  - Home of Thomas Street Health Center – HIV/AIDS Clinic
- Houston Department of Health and Human Services
  - City Health Department
- Baylor College of Medicine
  - Evaluator (Jessica A. Davila, PhD)
  - Principal Investigator (Thomas Giordano, MD)

YMSM HIV Cases Diagnosed (Regardless of AIDS Status)

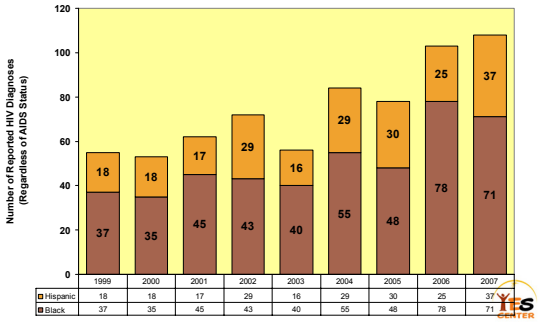
By Year of Diagnosis and Categorized by Race/Ethnicity (Age at Diagnosis = 13 - 24)
Houston/Harris County, Texas as of July 31, 2008 (N = 811)



	1999	2000	2001	2002	2003	2004	2005	2006	2007
White YMSM	17	20	12	15	15	14	13	21	13
YMCSM	55	53	62	72	56	84	78	103	108

YCMSM HIV Cases Diagnosed (Regardless of AIDS Status)

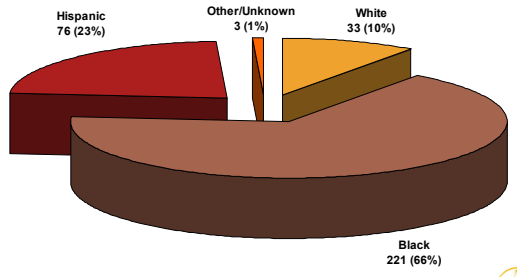
By Year of Diagnosis and Race/Ethnicity (Age at Diagnosis = 13 - 24)
Houston/Harris County, Texas as of July 31, 2008 (N = 671)



	1999	2000	2001	2002	2003	2004	2005	2006	2007
Hispanic	18	18	17	29	16	29	30	25	37
Black	37	35	45	43	40	55	48	78	71

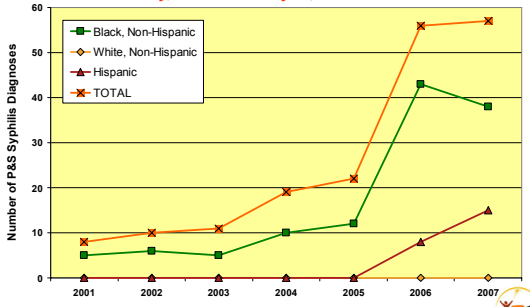
YMSM Presumed Living with HIV (Regardless of AIDS Status)

By Race/Ethnicity (Current Age = 13 - 24)
Houston/Harris County, Texas as of July 31, 2008 (N = 333)

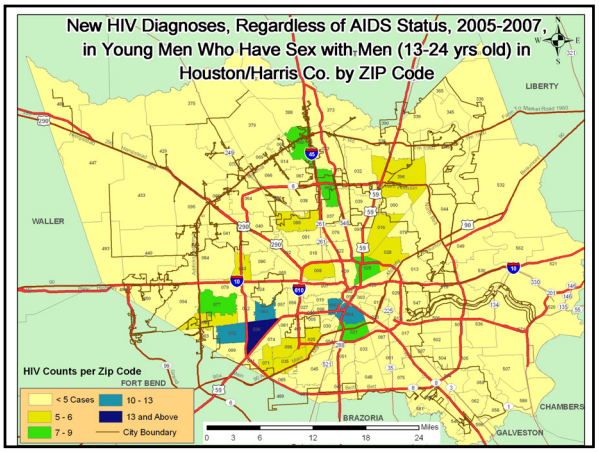


Primary and Secondary Syphilis Cases in YMSM

Age at Diagnosis 15 – 24
By Year of Diagnosis and Race/Ethnicity
Houston/Harris County, Texas as of July 31, 2008

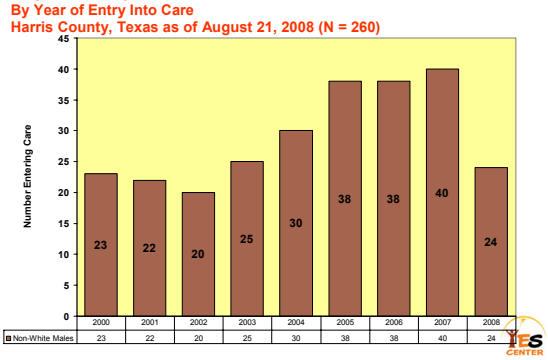


NOTE: Data points less than or equal to 5 are suppressed in order to protect confidentiality.



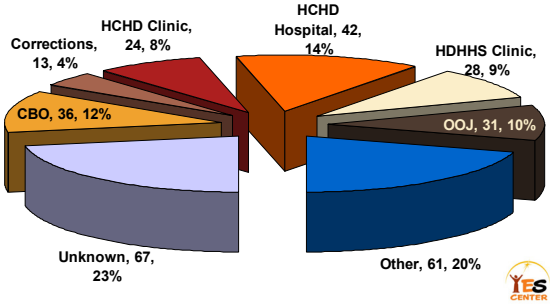
Non-White Male HIV Clients Entering Care at HCHD (Age at Entry 13 – 24)

By Year of Entry Into Care
Harris County, Texas as of August 21, 2008 (N = 260)



Non-White Male HIV Clients Entering Care at HCHD (Age at Entry 13 – 24)

By Place of Diagnosis (Entering Care from 1999 to 2008)
Harris County, Texas as of August 21, 2008 (N = 302)



Client Identification

- HCHD (26 Clients Engaged)
  - Inreach within HCHD facilities
    - Rapid HIV testing by request
    - Routine HIV screening in Emergency Centers
    - Physician ordered HIV tests
  - Linkage to HCHD laboratory

- HDHHS (31 Clients Engaged)
  - Outreach workers trained as Disease Intervention Specialists (DIS)
  - Linkage to HIV/STD Surveillance (HARS)
    - Sources of diagnoses range from private medical providers to HDHHS clinics
    - Receives weekly line list of newly diagnosed YMCSM
  - HIV/STD Mobile Clinic
    - Targets YMSM hangouts at least twice a month

Client Identification

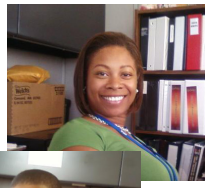
- Newly initiated routine, opt-out HIV screening project
  - HCHD
    - Ben Taub General Hospital ED (Level I Trauma)
    - LBJ General Hospital ED (Level III Trauma)
    - Eleven community health centers
  - Memorial-Hermann Hospital ED (Level I Trauma)
  - Legacy Community Health Services
    - Two Federally Qualified Health Centers (FQHC)
  - Approximately 100,000 conventional HIV tests annually
  - Estimated 600 new HIV diagnoses due to project

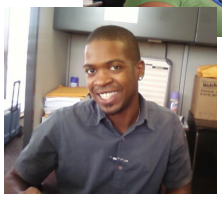
Linkage to Primary Care

- HCHD
  - Inreach worker
    - Contacts clients and schedules initial screening appointment at TSHC
    - Addresses other barriers to care including transportation, documentation, etc.
  - Internal hand off from Inreach worker to Social Work Case Manager at TSHC

Linkage to Primary Care

- HDHHS
  - Engages client with collaboration from DIS
  - Meets client where they feel comfortable
  - Average of 4 contacts before client agrees to enter care
  - Collaborative hand off from Outreach worker to HCHD Social Work Case Manager





Entering Primary Care

- Both HDHHS and HCHD staff assist with eligibility documentation
  - Address unmet needs
    - Transportation
      - HDHHS staff will transport client to appointments at HCHD
    - Housing
  - Accompany client to first appointment(s)
- HDHHS and HCHD staff remain in contact with each other and the client to meet client needs
  - Providing education
  - Motivating client to engage and return to care

Case Study

- Client A Is a 21 year old African-American male who self-identifies as "Gay". He was diagnosed HIV positive in 2007. He was testing because he was identified as partner of a person recently diagnosed with HIV through contact tracing. At the time, Client A had no transportation, was unemployed, and had unstable housing.
- After being diagnosed, Client A decided to enter care at the Thomas Street Health Center. The outreach worked arranged to meet Client A at his residence to transport him to Thomas Street to complete his eligibility application. Client A was introduced to the social work case manager (SWCM) assigned to the SPNS project, who welcomed him into care at the clinic and answered question and concerns that Client A had about receiving care at the clinic.
- On the day of the first primary care visit, the outreach worker again picked Client A up to transport him to the clinic, where they were joined by the SWCM. Using a team approach, Client A was escorted through his visit by both the outreach worker and SWCM.
- To date Client A reports adherence to his meds, his HIV viral load is undetectable (<400), and his CD4 count is 423. Client A keeps regular contact with all of the staff on the SPNS team. Client A was even instrumental in helping another SPNS client engage in care.

Challenges

- Other providers targeting same population
  - Two other CDC directly-funded projects in Houston
  - Perceived "competition" for clients
  - Solution: Work closely with these providers from the beginning of project
    - HDHHS Outreach worker is on CAB for one of these other projects

Challenges

- Barriers to this population entering primary care
  - Denial of HIV status
  - Fear of disclosure
- Keeping up with clients
  - Very mobile population
  - Reaching/engaging clients
  - Solution: Don't give up! Consistent contact is key with this population and texting works

Keys to Success

- Utilize existing infrastructure and resources
- Create and maintain relationships with key partners
- Develop institutional buy-in
  - Funding
- Conduct joint meetings
- Assign joint responsibilities
- Providing transportation and/or finding reliable transportation
- Frequent, coordinated, continuous contact by both outreach worker and case manager (tag-team effort)

Other Youth Initiatives

- YMSM Summit
  - May 1, 2008
  - Approximately 160 attendees from all provider types
- Hip Hop for HIV Concert
  - Collaboration with radio station
  - 2007 – tested 7,500 youth
  - 2008 – tested 2,500 youth

Other Acknowledgements

- Diana Parkinson-Windross, LMSW – HCHD
- Randall Ard – HCHD
- F. Sonny Ballard – HDHHS
- Sheronda Allen – HDHHS

Contact Information

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