HARLEM UNITED

2013 Annual Evaluation Report

Dear Reader,

Our community is larger and more diverse than ever before. This growth reflects a community with evolving needs and has ushered in the need for expanded services. While our organizing principles remain firm—we were part of the original, community-based movement to care for people living with HIV and AIDS--we are expanding to continually meet the needs of the people we serve.

We know that members of our community face not only HIV and AIDS, but other chronic illnesses, as well as many challenging issues like homelessness, mental illness, substance and alcohol use, and/or poverty. Our services and programming aim to address these issues head-on. For example, our NY/NY III housing program provides permanent scatter site housing to chronically homeless single adults living with HIV/AIDS and a mental illness or substance use disorder. Furthermore, we are in the process of opening a state-of-the-art healthcare facility at 169 West 133rd Street that will integrate a multidisciplinary team of physicians, dentists, and mental health professionals so clients can receive quality care all in one place.

In 2013, Harlem United was selected by the Medicaid Redesign Team to provide housing placement assistance, supportive services, and a rental subsidy with a goal of permanent housing placement for 50 HIV positive, but non-HASA eligible adults. We crafted a unique program that provides rental subsidies and on-site services for homeless or unstably housed Health Home members that encourages self-sufficiency. We were also awarded a three-year SAMHSA-funded program to expand access to substance abuse treatment and HIV prevention services for minority women. Harlem United also was among the 10 organizations awarded funding to implement culturally-appropriate service delivery models focused on improving health outcomes among Latinos/as living with HIV.

These accomplishments not only reflect our great work, but also highlight our commitment to providing high-quality care. The enclosed report highlights a few our successes, demonstrating that with community health, supportive housing and responsive human service, our communities can thrive.

Thank you for your continued support of our work.

Jacquelyn Kilmer
CEO, Harlem United

Latraviette D. Smith
Board Chair, Harlem United

HARLEM UNITED'S HERITAGE

When the AIDS crisis was exploding in New York City and agencies were turning away those with the most need, Harlem United was founded by a group of people who believed we are in this together. Harlem United is a nationally-recognized nonprofit organization with a 26-year history of providing life-saving services to some of the most underserved and hard-to-reach communities in New York City, with particular focus on Upper Manhattan and the South Bronx. Our mission is to provide full access to integrated health care and social services for clients experiencing multiple and complex issues—HIV/AIDS, social stigma related to sexuality and gender identity, mental illness, chronic substance and alcohol use, homelessness, and extreme poverty—regardless of race/ethnicity, socioeconomic status, or sexual orientation. Our clients are often deemed too difficult to serve by other providers.

We now operate as a fully-integrated patient centered medical home for underserved communities, including people living with HIV/AIDS (PLWHA), the Lesbian, Gay, Bisexual, Transgender and Queer/Questioning (LGBTQ) community, communities of color, and many other groups at highest risk for HIV/AIDS and other sexually transmitted infections. These groups are also often coping with chronic homelessness, mental illness, substance and alcohol use, and/or extreme poverty. Many also face compounding barriers to care due to HIV status, sexual orientation, gender identity, and/or race.

In 2013, we served over 15,000 individuals agency-wide through our prevention, housing, primary and dental care programs and other support services.

The agency's highly recognized "one-stop shop" allows our staff to work together with clients at each stage of care: HIV testing; treatment and education; primary medical care; substance use counseling; mental health services; pastoral counseling; housing placement; and an array of other expressive therapies. We offer a unique continuum of care that integrates socially and economically disenfranchised people into a healthy and healing community. Today, Harlem United provides the following services using an integrated and non-judgmental approach: primary care including PrEP, behavioral health care and dental services, supportive housing, Adult Day Health Care for PLWHA, HIV/Hepatitis C/sexually transmitted infection testing and prevention services; Health Home care coordination and patient navigation services for Medicaid-eligible people with multiple chronic conditions; integrated harm reduction; and food and nutrition services, among various other support services.

FUND DEVELOPMENT

In 2013, Harlem United further diversifeid our revenue streams through individual fund development

In order to diversify the revenue streams and continue to provide a strong foundation for our the work that we do every day, we produced a staff-led fundraising event, in addition to the running fundraisers that have been in existence for the last four years.

Harlem United Staff Make It Happen

Our first fundraising effort was successful. Staff and board members were empowered and encouraged to reach out to their personal and professional networks to increase awareness about the work that Harlem United does, as well as, to generate supporters. These supporters gave money, but more importantly were introduced to the important work that is done every day throughout our programs. This campaign was created to be the springboard from which we could then create a more formal giving program in 2014.

In 2013, 81 staff raised over $48,000 from more than 467 individual donors, most of whom were first time donors!

New York City Marathon

As an official charity partner of New York Road Runners, Harlem United is able to offer guranteed entry to the New York City marathon for runners who raise funds for our cause.

At Harlem United, we are proud that our runners represent diverse backgrounds: not only are some first time marathoners and others seasoned runners. Our team is a mix of staff, board members, long-time supporters, and community members who are just discovering our work!

In 2013, eight runners raised $24,000 from 277 donors.

Since Harlem United's inception, funding from private foundations and individuals has been crucial to the agency's growth and success. Such funding has allowed Harlem United to offer new and innovative programs, while filling in funding gaps not covered by agency's various government contracts.

2013 FOUNDATION GRANTS

Below is a summary of foundation grants received in 2013.

The Paul Rapoport Foundation ($500,000)

This grant is used to expand educational assistance, job training and development, and support services to young men who have sex with men living in Northern Manhattan and the South Bronx.

Robin Hood ($800,000)

General operating support for Harlem United's housing, healthcare, case management, HIV testing and syringe exchange programs

van Ameringen Foundation ($50,000)

This grant supports mobile healthcare for the homeless. It provides primary care, dental care, and mental health services to homeless individuals and those suffering from HIV/AIDS in underserved communities of Brooklyn and the South Bronx.

Broadway Cares/Equity Fights AIDS ($35,000)

This grant funds activities related to communications, visibility, and mobilization through our advocacy network, Harlem United ACTS!

MAC AIDS Fund ($25,000)

This grant is used for pantry and snack bags, for clients in our harm reduction programs which support active injection drug users. These bags add to our efforts to provide basic nutritional needs and engagement in preventative and/or treatment services.

EVALUATION OVERVIEW

Evaluation is the systematic collection and scrutiny of information about the activities and outcomes of programs to make judgments about the program, improve program effectiveness, and inform decisions about future programming[1]. Harlem United routinely incorporates evaluation into program management and extracts the "lessons learned" from experiences in order to improve programming and to develop solutions to program and organizational problems. For many years, Harlem United has utilized internal and external resources to manage and improve the planning and development of its programs. Over time, it has become evident that by employing an internal evaluation staff, HU reduces expenses, ensures timeliness of data, and with accessibility and communication with program staff develops program-specific goals that take the needs of the program, contract requirements, and staff resources into consideration. Within the last year, increased focus has been given to ensuring evaluation quality. The evaluation and data units were dedicated to program evaluation, outcome monitoring, continuous quality improvement, quality assurance and research.

Harlem United program staff and administrators are truly invested in evaluation – collaborating with evaluators and data managers on project design, reviewing measurement tools and procedures, facilitating evaluation activities, and using data to make informed decisions about service provision. Across the agency we employ collaborative evaluation processes including the three types of evaluation: planning (before program design), formative (information for program improvement), and summative (measuring effects). We merge evaluation and continuous quality improvement (CQI) activities to ensure the agency is meeting service provision and client outcome goals. For evaluation and CQI to be successful, we have learned that they need to be parsimonious—they must be relatively limited in scope and must be integrated, as much as possible, with existing assessment tools and procedures. To ensure the greatest impact, HU's evaluation and CQI processes are "staff-owned and operated."

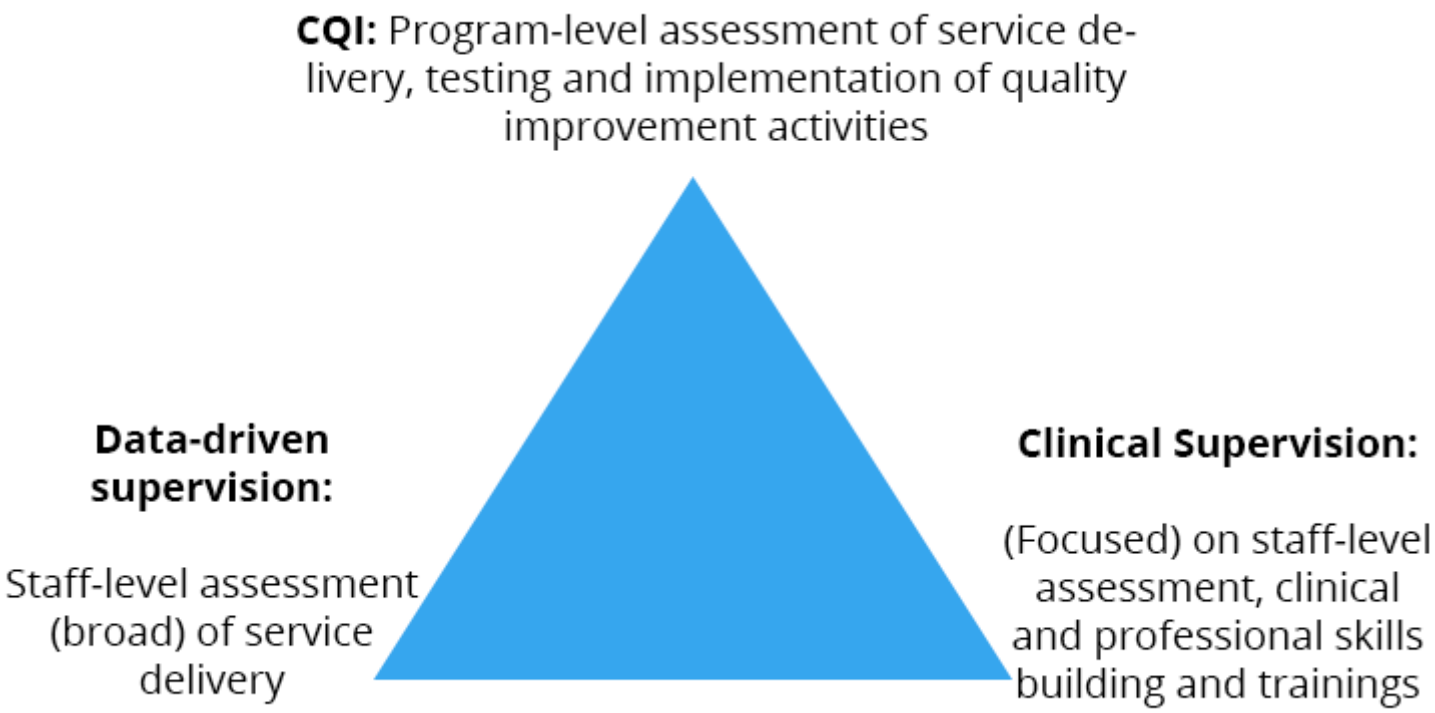
1 Marynowski, S., Denny, S., & Colverson, P. (2006). Best Practices Guide to Program Evaluation. Pandion Systems, Inc. Gainesville, FL.

EVALUATION ACTIVITIES

The evaluation activities at Harlem United consists of process and outcome monitoring, Continuous Quality Improvement (CQI), outcome evaluation, and participation in research projects

The Management Triad

The Triad is a tri-modal approach to organizing and focusing on the most critical information needed to ensure effective decision-making, problem solving, and program management. The Triad serves to motivate and stimulate a learning environment in a culture where data is crucial to the longevity of our programs and service to our clients. It consists of three evaluative processes: Continuous Quality Improvement (CQI), Data-driven Administrative Supervision (DDS), and Clinical Supervision.



While CQI focuses on assessing and improving services on the program level, DDS and Clinical Supervision focus on assessing and improving services on the individual staff level. DDS involves a relatively quick and broad review of program data and staff-level goals. Clinical supervision focuses on assessment, training, and development of professional and interpersonal skills.

Within this management paradigm, program managers are the nexus. Through routine (e.g., monthly) "Triad meetings" with the staff who are responsible for each of the three evaluative processes, program managers are able to synthesize data from various sources (e.g., DDS data, clinical data, CQI data, dashboard data, audit data, etc.), prioritize performance issues, and create cogent plans for addressing these issues. For example, if census for a particular program is down, a program manager may ask his administrative supervisor to analyze supervisory data to determine the extent to which each staff person is performing assigned tasks that might affect clients' connection to or retention in care. A clinical director might be charged with reviewing client records to ascertain whether each staff person is providing the quality of services that promotes retention in care. The program's evaluator might be asked to do any number of tasks including digging deeper into the data to see if a certain segment of the client population is no longer entering the program or has left the program, assessing the productivity of conventional outreach sites, or conducting formal focus groups or a survey with clients to get their perspective on the problem.

As one of the management tools within the Triad, CQI is the only process that incorporates collaboration between program staff and the evaluation and data management units in order to assess and improve service delivery systems and infrastructure. The primary purpose is to increase the quality of care and, ultimately, to improve outcomes for clients. CQI builds staff problem solving and teamwork capabilities through their active participation in all improvement processes from problem identification to solution implementation. The process includes:

- Identification of key progress indicators
- Data collection and interpretation
- Development and implementation of a workplan or Plan Do Study Act (PDSA) cycle[1]

Regularly scheduled CQI meetings provide the opportunity for all program

1 W. Edwards Deming presented an early version of the Plan Do Study Act cycle for a Japanese Union of Scientists and Engineers seminar in 1950 as a cycle for learning and improvement. Deming, W.E. 1993.The New Economics. MIT Press. Cambridge, MA. page 135.

staff to review progress toward program goals and key indicators. Any indicator that falls below program targets is carefully analyzed to determine the root causes. Root cause determination is done via various brainstorming techniques such as the fishbone diagram and flow diagrams. Workplans are developed with the goal of completing action steps within the quarter. PDSA cycles are implemented in a similar fashion, but cycles are rapid and could require action step (Do) completion in as little as one week or one month. Unlike workplans, PDSAs test out improvement plans and could include target improvement indicators and/or established measures (tools).

We have had dramatic success using CQI and have made efforts to disseminate our model to other HIV service providers. We have conducted workshops, presented at professional conferences, and have provided CQI training and technical assistance to sister organizations.

Outcome Monitoring

In addition to routine reporting of process evaluation data, many of our contracts require ongoing outcome monitoring, typically as part of national, multi-site evaluation projects supported by funders such as the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration (HRSA) and the Centers for Disease Control and Prevention (CDC).

SAMHSA

Pathways to Recovery

In 2013, The Foundation for Research on Sexually Transmitted Diseases (FROST'D) (a subsidiary of at Harlem United) was in its third year of implementing a SAMHSA-funded intervention named Pathways to Recovery, a substance use recovery support program that offers a holistic approach to helping clients define and achieve what recovery means for them. SAMHSA requires data reporting under the Government Performance and Results Act

(GPRA). Programs are required to set program-specific performance targets, to measure performance on a regular basis against those targets, and to report to SAMHSA at least bi-annually. The GPRA has multiple domains that capture recent history of substance use, mental health status, and risk behaviors among other factors. The reporting mechanism requires baseline and follow-up assessments, calling for programs to retain clients for up to six months.

Prevention, Education and Recovery Learning Strategy (PEARLS)

In 2013, Harlem United was awarded a three-year SAMHSA-funded program that is intended to expand access to substance abuse treatment and HIV prevention services for minority women. The PEARLS Project uses evidence-based practices and trauma-informed approaches to expand services and provide participants access to drug treatment, HIV/HCV/STI testing, case management, group/individual counseling, and the implementation of Evidence-Based Practices (EBP's) and Evidence-Based Interventions (EBI's), including Sisters Informing Sisters on Topics about AIDS (SISTA), Motivational Interviewing (MI), Seeking Safety, and Sister to Sister. The project targets African American, Hispanic/Latina, and other racial/ethnic minority women, including heterosexual, lesbian, bisexual, previously incarcerated women, and their significant others, who have substance use or co-occurring substance use and mental disorders, and are living with or at risk for HIV/AIDS. This program also contributes to the nation-wide outcome monitoring of recovery support services and requires data reporting under the GPRA.

CDC

Evidence-Based Intervention Multi-site Evaluation

2013 marked the third year that the Helping Our Members Evolve (HOME) program has been involved as one of four CDC grantees chosen to participate in the Community-based Organization (CBO) Monitoring and Evaluation Project (CMEP) of RESPECT (CMEP-RESPECT). The purpose of CMEP-RESPECT is to (a) assess the fidelity of the RESPECT intervention implementation, a

brief intensive intervention designed to support risk reduction behaviors by increasing the client's perception of his/her personal risks and by emphasizing incremental risk-reduction strategies; and (b) improve the intervention delivery by monitoring changes in clients' self-reported attitudes and beliefs regarding HIV/STD and transmission risk behaviors after participating in RESPECT.

HRSA Special Projects of National Significance

NY LINKS: HIV medical care engagement and retention

In 2011 Health Resources and Services Administration's HIV/AIDS Bureau (HRSA HAB) launched the Special Projects of National Significance (SPNS): Systems Linkages and Access to Care for Populations at High Risk of HIV Infection Initiative. New York is participating as one of seven states engaged in the process of addressing access and retention in HIV care through the development and dissemination of effective and sustainable linkage models. The aim of the New York State Systems Linkages Project is to bridge systemic gaps between HIV related services within New York State and achieve better outcomes for PLWHA through improving systems for monitoring, recording, and accessing information about HIV care in New York State. The first two years focused on implementing successive "Waves" of collaboratives composed of traditional and non-traditional healthcare and supportive services providers in specific high incidence communities and creating a learning environment in which systemic collaboration and linkage innovations can be tested and measured.

Since 2013, NY Links engaged in a statewide scale-up of strategies shown to have promise during the Collaborative phase. Subsequent evaluation of their effectiveness and sustainability will be conducted. Ultimately, the development and scale-up of these interventions will foster communication between service providers and encourage the mitigation of barriers that limit the effective use of data systems. This will facilitate the entry and continuation in HIV care by those who are unaware of their status, have not entered care or are no longer retained in care.

Harlem United is participating at the New York City level under the guidance of the Upper Manhattan Regional Group, one of the HIV Quality Management Regional Groups responsible for organizing and submitting data to the state. Our 2014 plans include piloting an evidence-based intervention that incorporates lessons learned from the data that was captured in the first few years of the initiative.

Hepatitis C Treatment Expansion Initiative for co-infected individuals

For many years the HRSA's HAB has endeavored to increase access to hepatitis C (HCV) treatment for HIV-infected patients in Ryan White-funded programs. In 2010, HRSA HAB provided grants to two cohorts of demonstration sites, each consisting of 15 Ryan White funded clinics, and one Evaluation/ Technical Assistance Center (ETAC) as part of the Hepatitis C Treatment Expansion Initiative. Each of the demonstration site was expected to adopt one of the following treatment models:

- Collocation of care with an HCV specialist who manages treatment at the Ryan White clinical site
- Primary care management with expert back up
- Integrated care with HCV management by providers without designated HCV clinic
- Integrated care with designated HCV clinic

As one of the agencies in the first cohort that received funding from HRSA, Harlem United adopted the integrated care model with designated HCV clinic. Some of the interventions that Harlem United offered within this model encompassed providing structured educational groups to help increase clients' general knowledge in HCV disease and treatment, peer-led support groups, and comprehensive HCV treatment evaluation which included mental health and psychiatric assessments, nutritional assessments, substance use assessments, and medical history assessments. Some of our indicators include:

- Refer at least 250 co-infected clients annually to HCV treatment services
- Provide supportive service assessments to at least 200 co-infected clients annually
- Provide behavioral health services to 90% clients indicating needs
- Provide group-level HCV support/treatment education sessions to at least 200 co-infected clients annually

In collaboration with HRSA and other demonstration sites, the University of South Florida, the ETAC for this initiative, spearheaded the efforts to assess the effectiveness, feasibility, and costs of the service delivery model for which each site is funded As the ETAC, they provided expert technical assistance to the demonstration sites provided a uniform system to collect patient level data, and performed detailed and exhaustive evaluation of the individual models. Based on these assessments, the project will determine which model(s) of client care best serves the HIV/HCV co-infected clients.

Cúrate: For HIV-positive Puerto Rican individuals with a history of substance use

In 2013, HRSA solicited applications for a SPNS multi-site initiative entitled "Culturally Appropriate Interventions of Outreach, Access and Retention among Latino(a) Populations – Demonstration Sites". The purpose of this initiative is to address the goals and objectives outlined in the National HIV/AIDS Strategy that identifies reducing HIV-related heath disparities as a priority area.

Harlem United was among the ten organizations/demonstration sites that were awarded the funding to design, implement and evaluate culturally appropriate service delivery models focused on improving health outcomes among Latinos/as living with HIV disease. With this funding, Harlem United has developed a peer-led program named the Uptown Health Link/ Cúrate, which consists of innovative targeted outreach and engagement activities, a social marketing campaign encouraging access to primary care, retention in

care activities, and the expansion of the agency's extensive referral network of culturally competent providers.

As part of this initiative, all demonstration sites participate in a comprehensive multi-site evaluation throughout the five year project period led by an Evaluation and Technical Assistance Center (ETAC). University of California at San Francisco (UCSF) serves as the ETAC for this initiative, hence, will provide leadership, technical assistance, training, support, and will evaluate the interventions implemented by demonstration sites to improve the timely entry, engagement, and retention in HIV care for Latino/as who self-identify as of Mexican and Puerto Rican origin living in the continental United States. In addition, the ETAC will identify and document successful models for dissemination and replication at the national level.


Nervous

THE 2013 EVALUATION REPORT

Providing Housing and Supporting the National HIV/AIDS Strategy with Linkage to Cazre and Health Care to Improve Client Outcomes

The following report presents evaluation results from our integrated services: Prevention, Education and Supportive Services, Healthcare, Helping Our Members Evolve (HOME) programs as well as New York/New York III supported housing program.

I. Following a rigorous PDSA cycle our New York/New York III housing program demonstrates how infusing motivational interviewing-specific clinical supervision of case managers can improve mental health functioning. Testing program change and incorporating a standardized mental health measure into routine assessments ensures that we achieve program goals and are doing our best to support our housing clients in reaching theirs.

II. We present accomplishments from our efforts to employ interventions targeting stages of Harlem United's version of the Treatment Cascade, which tracks progress across stages from HIV testing to viral load suppression, for clients who engage in care at Harlem United clinics. Interventions focused on linking young men of color who have sex with men (YMCSM) to care post-HIV diagnosis demonstrate significant increase in linkage to care rates over time. Workgroups and continuous quality improvement projects aimed at strengthening our processes at each stage of the cascade with all of our clients who test with us and access our health care clinics also showed significant improvement in retention in care and helped clients achieve viral load suppression.

Each study presents our approach to providing coordinated support and care for all of our clients regardless of housing, socioeconomic status, or race and ethnicity- and highlights our efforts to improve overall quality of life and stability, and ultimately health outcomes, for all clients who come through our doors.

Motivational Interviewing in Housing Case Management:
An experimental study in an enhanced case management approach to client mental health engagement

Background

Harlem United's breadth of experience providing emergency and non-emergency housing services is unmatched. Currently, we operate eleven programs totaling 582 units for homeless persons living with HIV or AIDS (PLWHA), people with HIV-related illness, and people who are seriously mentally ill and/or active substance users in the Bronx, Manhattan, and Brooklyn. Using a Housing First model, the agency offers several types of supportive housing: scatter-site, congregate, permanent and transitional and incorporates a Harm Reduction philosophy in each of its programs. Our programs work with clients to coordinate care and utilize clinical-based approaches, such as Motivational Interviewing (MI) which has been proven to elicit behavior change among clients. While housing indicators such as rent payment, retention in permanent housing, and activities of daily living are monitored consistently, Harlem United also values health and wellness outcomes including adherence to specialty care (e.g., gynecology) appointments and dental visits. In 2013, 84% of housing clients had at least one primary care visit every six months.

NAME OF HOUSING	NO. OF UNITS	PROGRAM DESCRIPTION
Foundation House East	28	Permanent congregate housing with on-site supportive services to homeless single adults living with HIV/AIDS
Foundation House West	25	Permanent congregate housing with on-site supportive services for homeless, medically frail single adults with HIV/AIDS and other chronic health conditions
Foundation House North	10	Emergency transitional, congregate housing to homeless adults with chronic health conditions including HIV/AIDS
Foundation House South	14	Emergency transitional congregate housing to homeless adults with chronic health conditions including HIV/AIDS

NAME OF HOUSING	NO. OF UNITS	PROGRAM DESCRIPTION
NY/NY III Scatter Site	50	Permanent housing and supportive scatter site housing to chronically homeless single adults living with HIV/AIDS with a co-occurring serious mental illness and/or substance use disorder
HRA Scatter Site	166	Permanent housing with supportive services to homeless individuals and families living with HIV/AIDS
Women's Housing Scatter Site	150	Permanent housing for women with HIV/AIDS and mental illness and for women with HIV/AIDS and with children
HUD Family Scatter Site	22	Permanent housing with supportive services to women living with HIV/AIDS and their families in the Bronx
Transitional Scatter Site	35	Scatter site housing for homeless single adults with HIV/AIDS, substance use and/or mental health issues
Brookyln HUD Scatter Site	32	Transitional housing and supportive services for homeless single adults living with HIV/AIDS in Brooklyn
MRT HIV Health Home Housing	50	MRT-funded, providing housing placement assistance and rental subsidies in NYC to 50 homeless, HIV-positive Health Home clients not eligible for HASA benefits including rental subsidies

NY/NY III

In November 2005, Mayor Michael Bloomberg and Governor George Pataki signed New York/New York III (NY/NY III), committing to create 9,000 units of supportive housing for homeless people living with disabilities in New York City over ten years. The Agreement marked the largest commitment to creating housing for homeless people in the nation's history. Harlem United was awarded a NY/NY III contract for 50 units in 2009. In 2013, Harlem United's NY/NY III program provided permanent scatter site housing to 82 unique chronically homeless single adults living with HIV/AIDS who were living with a co-occurring serious mental illness and/or substance use disorder. All of our NY/NY III clients have an Axis I diagnosis, while 76% have more than one Axis I diagnosis including depression, anxiety disorder, schizophrenia, post-traumatic stress disorder, and dependency on alcohol or drugs. Many of our NY/NY III clients are also triply- diagnosed with other co-morbid conditions. A clear majority (81%) are active substance users.

CQI Methods

Because of the characteristics and needs of our NY/NY III clients, monitoring mental health outcomes, in addition to physical health and wellness outcomes, is a necessary activity. In 2013 we identified that there was no formal model that case managers could rely on for supporting mental health. In order to address this gap, we engaged in quality improvement activities and decided on a three-month Plan Do Study Act (PDSA) cycle to test whether creating a formal and strengthened MI approach would affect clients' mental health outcomes. In doing so, we piloted a standardized measure to assess mental health functioning (distress), the Brief Symptoms Inventory's (BSI)[1] symptom dimension scores and Global Severity Index (GSI). The nine symptom dimensions of the BSI are Somatization, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, and Psychoticism. The BSI has long standing use as a self-report measure of psychological distress in nonpatient settings and has solid psychometric properties[2]. The items are rated on a 5-point Likert-type scale, with response options ranging from 1 = "not at all" to 5 = "extremely." It will be used to not only provide a picture of clients' current level of functioning, but also as an outcome measure to assess clients' distress over time. Dimension and GSI raw scores are converted to T scores for interpretation. The average T score for a non-inpatient population is 50 with a standard deviation of 10. Clients who score T greater than or equal to 63 on two or more dimensions and/or T = 63 or higher on the Global Severity Index (GSI) should be assessed further and may require referral to mental health care if not already engaged.

Enhanced Case Management: MI-focused Clinical Supervision

To test change, we engaged in a comparison approach to study different methods of effecting mental health outcomes with NY/NY III full-time case managers. Case manager A (CM-A) provided standard client support activities. Case manager B (CM-B) provided an enhanced model that included

1 See: http://www.pearsonclinical.com/education/products/100000450/brief-symptom-inventory-bsi.html for additional measure details and ordering information.

2 (Derogatis, 1993) Cronbach's alphas for the dimensions range from α = .69 to α = .85 and .94 for the GSI.

MI-focused client support and clinical supervision.

The Harlem United standard clinical supervision model includes biweekly group and individual supervisions with the purpose of assessing, training, and developing the interpersonal skills needed for working with clients around behavior change. Clinical supervisors help staff develop professional interventions and strengthen their clinical skills to ensure accountability, thoughtfulness, and increased capacity to reflect on their work with clients. Training and assessment are key elements of clinical supervision and involve regular and on-going skills development and monitoring of progress through systematic chart reviews, formal evaluation in individual and group supervision sessions, and field observation. Formal trainings include a number of core competencies that are offered at least annually (e.g., MI, harm reduction, and documentation).

Standard individual supervision is individualized and based on staff learning needs. Prior to meetings, clinical supervisors conduct chart reviews and may conduct clinical observations. During the meetings, general focus is on skills-building by discussion of chart review and observation results and engaging in discussion about staff identified difficulties they experience in their work with clients.

For the PDSA, enhanced individual supervision with CM-B included MI-focused chart review and feedback. Specifically, supervision included addressing the CM's concerns about administering the BSI tool and her approach to dealing with any ambivalence demonstrated while the clients completed the survey. The clinical supervisor consistently discussed MI strategies regarding clients managing stress, substance use recovery, and mental health. Strategies included use of open-ending questions, along with collaboration, evocation and autonomy, which are the basic tenets of MI.

Mental Health Distress

The second component of the study included monitoring mental health distress using the Brief Symptom Inventory (BSI). Both CMs' clients completed the BSI during their standard monthly home visit at the beginning of the study and again three months later. Scores were shared with both CMs

with guidance on interpretation. Both CMs had follow up conversations with clients whose scores reflected the need for further assessment[3] and need for mental health support. CM-A discussed the results with her clients and suggested specialized care if the scores indicated it. CM-B discussed mental health engagement with a MI lens and received MI-focused clinical supervision around client-identified problem areas.

Findings

Client Demographics

There were 36 clients who participated in the PDSA who were supported by one of two full-time CMs. Clients who were supported by the NY/NY III intern were excluded because the intern was slated to complete her internship before the PDSA cycle completed. The majority (74%) of the clients were male, 26% were female. The mean age was 52-years-old, most (79%) of whom were between the age of 45 and 65 years old. Sixty-four percent of the clients were Black/African American, 8% were Caucasian, and 25% reported Hispanic heritage. The majority (66%) of the clients used substances and/or alcohol. Every client saw their CM at least once a month for the duration of the three-month cycle.

Gender	Percent
Male	26%
Female	74%

Race/Ethnicity	Percent
Black / African-American	64%
Caucasian	8%
American Indian or Alaskan Native	6%
American Indian or Alaskan Native, Black or African-American	3%
Unknown	19%

Hispanic	Percent
Non-Hispanic	64%

3 Guidance from the BSI-Brief Symptom Inventory: Administration, Scoring and Procedures Manual (Derogatis, 1993) suggests follow up with clients who score of 63 or higher on two or more dimensions or 63 or higher on the Global Severity Index (GSI).

BSI Outcomes

Twenty-six of the 36 clients who were eligible for study participation completed both administrations of the BSI. There were no significant differences in client demographics between CMs, however, unexpectedly, clients who were supported by CM-B demonstrated higher baseline BSI dimension and GSI scores on average and therefore presented characteristics of a more high-need group to begin with. General analysis indicated that clients who were supported by the two CMs reported a statistically significant decrease on the Depression ($t(25) = 2.09$ $p = .05$) and Psychoticism ($t(25) = 3.89$, $p = .001$) dimensions.

Table X.

Baseline Dimension and GSI Scores by CM

SOM = Somatizaion, OC = Obsessive-Compulsive, IS = Interpersonal Sensitivity, DEP = Depression, ANX = Anxiety, HOS = Hostility, PHOB = Phobic Anxiety, PAR = Paranoid Ideation, PSY = Psychoticism, GSI = Global Severity Index

	CM	N	MEAN	STANDAR DEVIATION
SOM	A	17	53.47	10.31
	B	19	58.16	9.71
OC	A	17	5.29	10.02
	B	19	64.26	7.65
IS	A	17	47.41	6.64
	B	19	57.58	9.11
DEP	A	17	49.71	7.10
	B	19	57.00	9.43
ANX	A	17	47.59	7.34
	B	19	55.63	7.43
HOS	A	17	46.88	10.90
	B	19	55.26	11.35
PHOB	A	17	47.88	4.18
	B	19	57.74	8.84

	CM	N	MEAN	STANDAR DEVIATION
PAR	A	17	49.00	8.02
	B	19	67.06	7.21
PSY	A	17	49.29	6.36
	B	19	59.84	6.18
GSI	A	17	51.29	12.05
	B	19	62.95	5.46

Table X.

Paired Samples t-test for All Clients df = 25				
	Mean Difference	**SD**	**t**	**Sig.(2-tailed)**
DEP	4.46	11.04	2.061	.050
PSY	6.31	8.26	3.892	.001

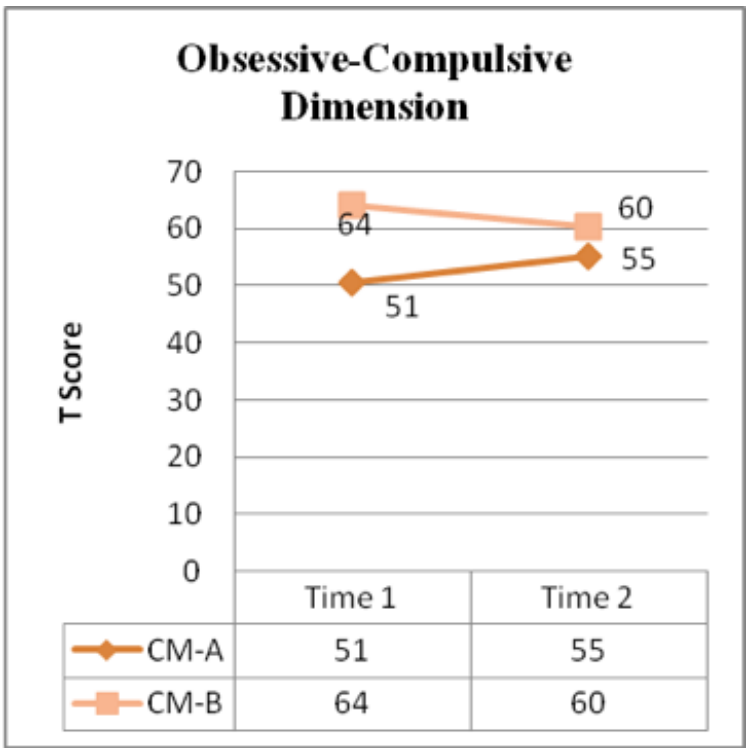
DEP = Depression, PSY = Psychoticism

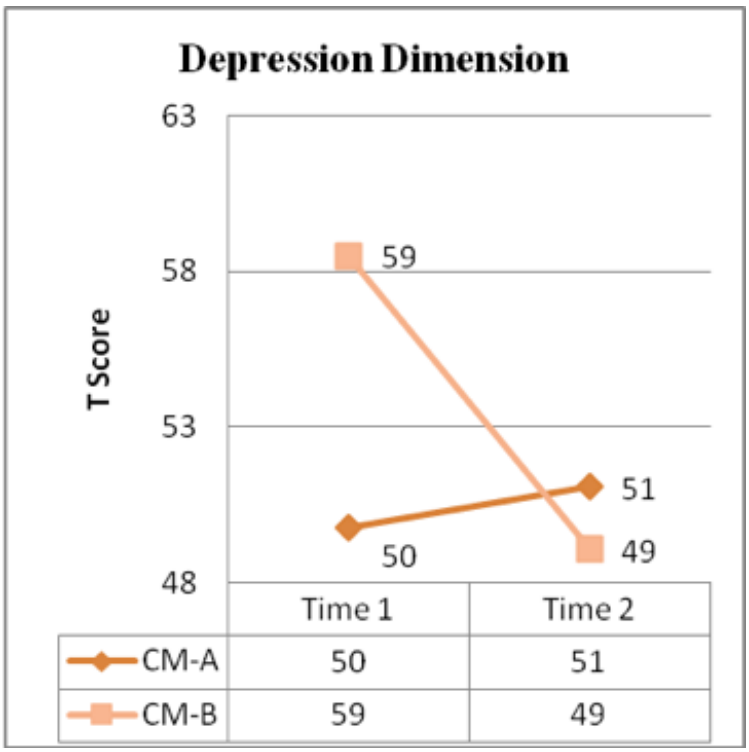
Table X.

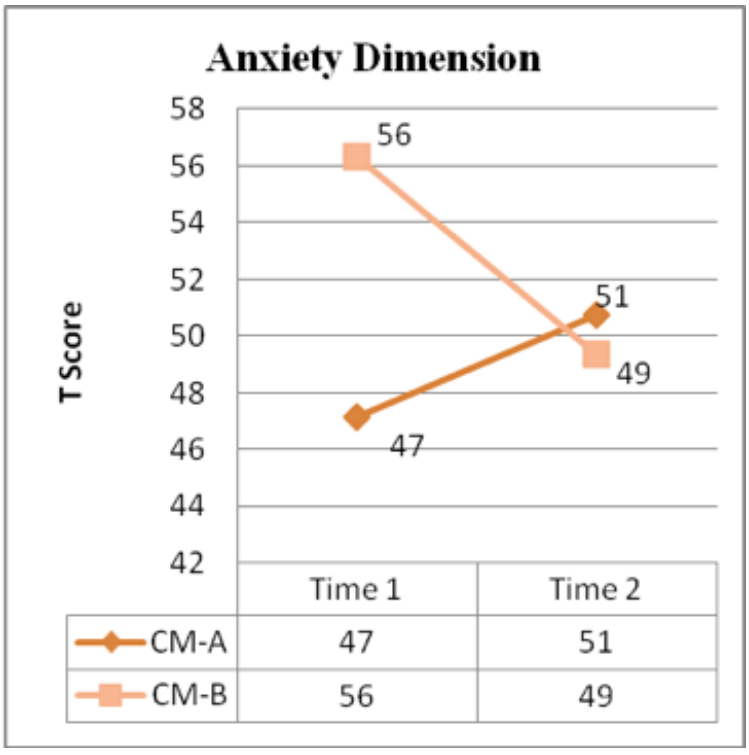
Paired t-test resulits for CM-B df = 25				
	Mean Difference	**SD**	**t**	**Sig.(2-tailed)**
OC	3.74	6.64	2.094	0.056
DEP	9.43	9.34	3.758	0.002
ANX	6.93	8.89	2.917	0.012
PSY	8.57	8.88	3.611	0.003

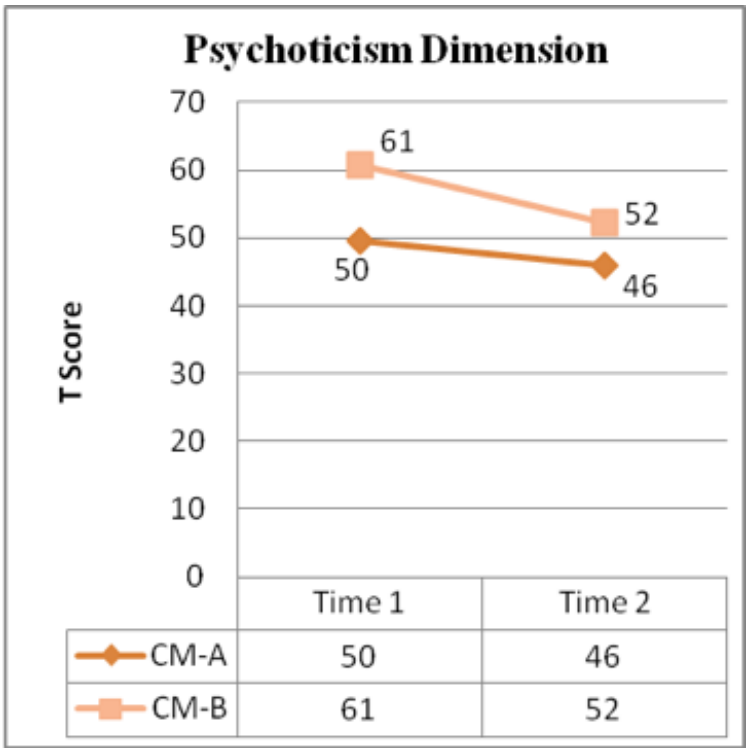
Figure X. Change over time by CM

When comparing outcomes over time, results indicated that CM-B's clients showed statistically significant improvement on Obsessive Compulsive, Depression, Anxiety, and Psychoticism dimensions. There were no significant changes in dimension scores for clients who were supported by CM-A. Repeated measures analysis showed a significant difference in the aforementioned dimensions between the two CMs' caseloads.


Obsessive-Compulsive Dimension
T Score
70
60
50
40
30
20
10
0
64
60
51
55
Time 1
Time 2
CM-A
51
55
CM-B
64
60


Depression Dimension
T Score
63
58
53
48
59
51
50
49
Time 1
Time 2
CM-A
50
51
CM-B
59
49


Anxiety Dimension
T Score
58
56
54
52
50
48
46
44
42
56
51
49
47
Time 1
Time 2
CM-A
47
51
CM-B
56
49


Psychoticism Dimension
T Score
70
60
50
40
30
20
10
0
61
52
50
46
Time 1
Time 2
CM-A
50
46
CM-B
61
52

Discussion

The brief PDSA cycle implemented by the NY/NY III housing program proves promising in affecting supervision methodology and clients' mental health outcomes. BSI results indicate that all clients who completed the BSI improved after three months on two dimensions: Depression and Psychoticism. In 2014, the program will continue to administer the measure at six-month intervals to allow for more time to support clients to assess improved mental health functioning.

Comparisons across case managers showed significant differences at baseline and three months later. It is difficult to draw causal conclusions after a brief amount of time; however, we will interpret the impact of MI-focused clinical supervision as positive. It should also be noted that CM-A's clients scored below the clinical line on all dimensions at baseline. It is not expected that significant change would occur because clients did not endorse "distress" and would not have received as much support to improve their functioning as clients who were supported by CM-B.

The BSI pilot provides insight into the feasibility and the appropriateness of administering a standardized mental health measure to NY/NY III clients, and possibly to other housing clients. Both CMs reported satisfaction with the process and the insight that the measures result provided. For example, some clients had not previously verbally expressed difficulty in some areas captured by the BSI. The tangible results allowed for discourse and for an easier time with broaching topics such as mental health functioning in the clinical areas and mental health care engagement. The unexpected results of CM-A's clients' baseline scores being lower than CM-B's on average is being reviewed for possible cause including issues with administration fidelity. When implementing new measurement processes, it often takes time to ensure fidelity across program staff. All program CMs will continue to receive clinical supervision regarding administration and interpretation.

As a follow-up to this pilot, Harlem United's Housing Department is considering utilizing the BSI in additional supportive housing programs, particularly those that serve a significant number of clients with mental illnesses. It will be informative to see whether the same changes occur among other

clients with depression and psychoticism, or among clients with different diagnoses. Expansion of the use of the BSI will also further inform our decisions regarding which programs to use the BSI across our organization, and most importantly, how to better tailor our services based on BSI results and the dimensions in which clients do and do not show improvement.

Harlem United's Efforts and Making a Difference in the National HIV/AIDS Strategy (NHAS): Outcomes from an agency-wide Treatment Cascade initiative

Background

The National HIV/AIDS Strategy

In July of 2010, the White House released its first ever National HIV/AIDS Strategy (NHAS) in order to increase uninterrupted access to high quality care, free of judgment and discrimination. As identified in Figure 1 below, the NHAS aims to reduce the number of new HIV infections, increase access to care and improve health outcomes for those living with HIV, as well as reduce any HIV related health disparities. This strategy comes after statistics showing that of the 1.2 million PLWHA in the US, an estimated 20.1% were unaware of their infection.[1] The NHAS was developed to create a platform of proven prevention strategies that can be implemented to reduce the risk of acquiring or transmitting HIV, not limited to: HIV testing, evidence based interventions, partner services, antiretroviral therapy, pre-exposure prophylaxis, substance abuse treatment access to condoms and syringes, as well as screening and treatment for other sexually transmitted diseases.[2] The NHAS employs high impact prevention; targeting the most at risk initially and scaling up accordingly. Although the NHAS notes that the use of these strategies differ across states and employing agencies, the main objective is identifying, linking and retaining in care. The NHAS goals include but are not limited to:

- 90% of infected persons know their status.
- 85% of newly diagnosed cases linked to care within 3 months
- 80% of PLWHA continue in care (>2 visits/yr; >3 months apart)
- Proportion of persons with undetectable viral load increase by 20%

1 White House Office of National AIDS Policy. The National HIV/AIDS Strategy for the United States, July 2010.

2 Vergidis, P.I., Falagas. M.E. (2009). Meta-analyses on behavioral interventions to reduce the risk of transmission of HIV. Infect Dis Clin North Am, 23:309–314.

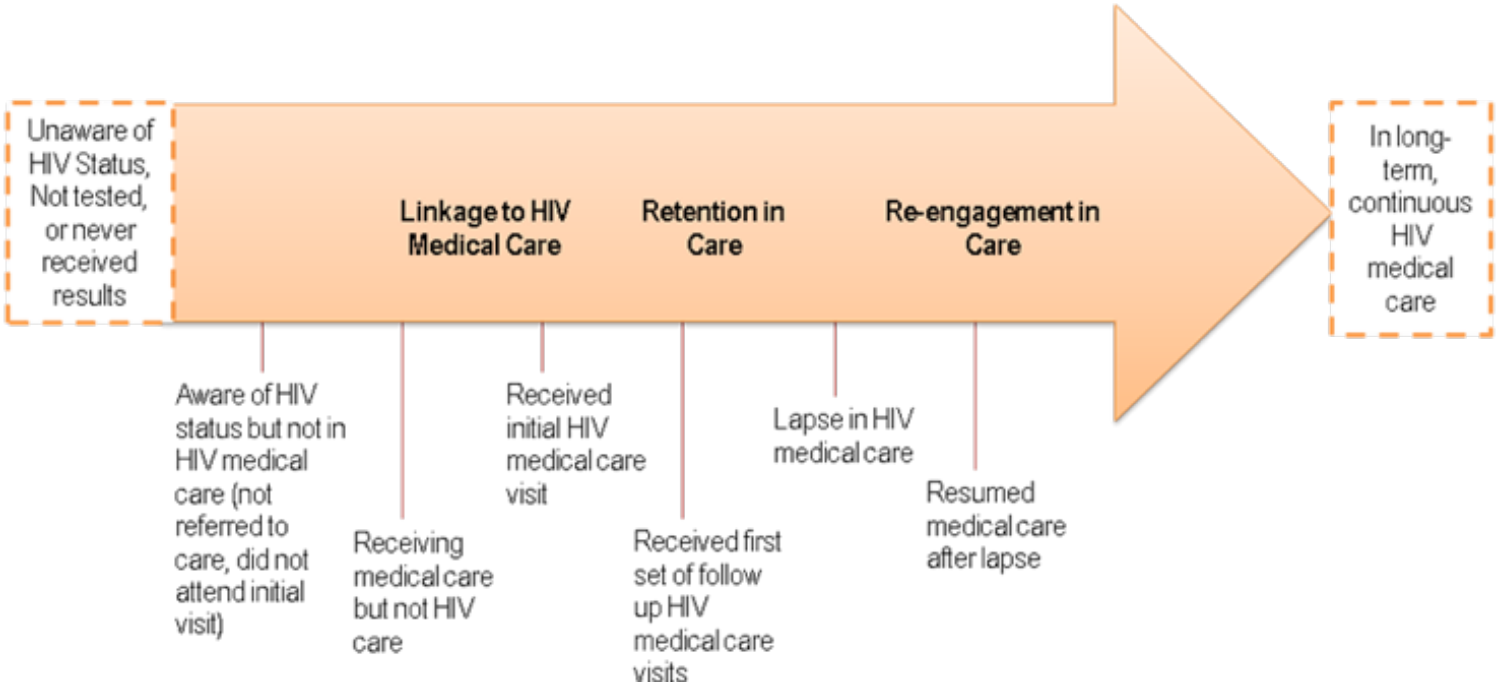


Figure 1. *Adapted from Health Resources and Services Administration, HIV/AIDS Bureau. Continuum of engagement in HIV care. Cheever LW. Engaging HIV-infected patients in care: their lives depend on it. Clin Infect Dis 2007;44(11):1500-02.*

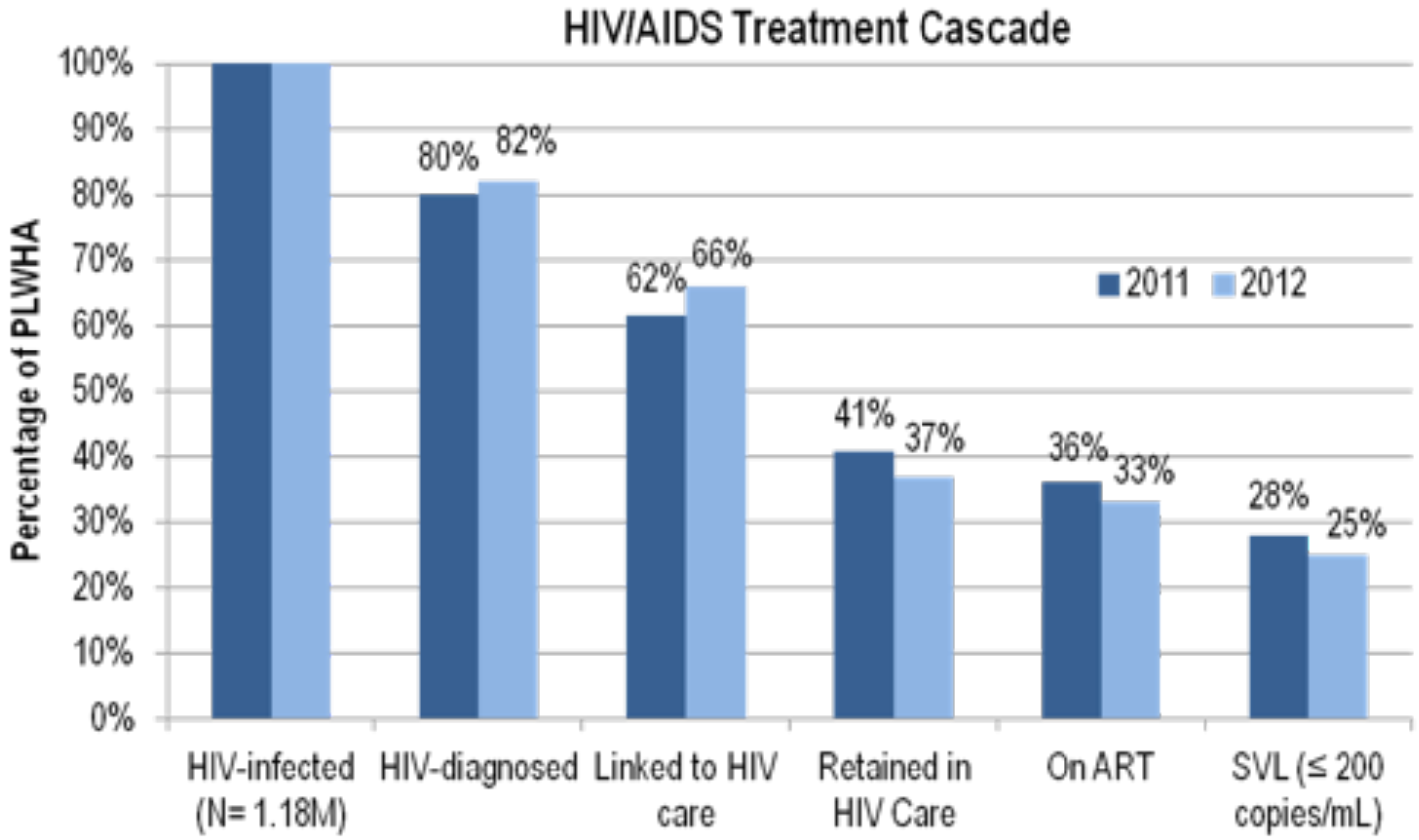


Figure 2. *HIV/AIDS Treatment Cascade Adapted from the Centers for Disease Control and Prevention - Morbidity and Mortality Weekly Report, December 2011, 2012.*

Each of these measures provides routine surveillance data, monitoring entry to care, retention in care, and success of continued care. These measures also yield comparable data points across varying geographic regions, populations and time. Since these changes were enacted, a recent inventory of state health department activities revealed a shift in resources toward HIV testing, linkage to care, and retention in care.

Although improvements were made, in 2013, President Obama signed into effect the HIV Continuum Initiative [Figure 1] that required a coordinated response on the part of health institutions to address the 70% or more PLWHA that had not achieved the goal of controlling the virus. It was realized that there is much more to coordinated HIV care than being diagnosed, initiating treatment, and suppressing the virus all together. The HIV Care Continuum illustrates that after identifying HIV positive individuals, they are to receive one of the two identified interventions within the first three months post diagnosis. Following this, PLWHA viral load is assessed at follow up visits along with their level of engagement, adherence to medications, and engagement in risky behaviors. If a lapse in care occurs, the client is to be re-engaged as soon as possible. As of 2012, about 66% of PLWHA in the US have been tested and completed their first medical visit. As shown in Figure 2, although linkage may be 66%, only 33% of those diagnosed continue in care. Following this, only 25% actually achieve a suppressed viral load by week 24 following initiation of treatment, down 3% from 2011.

These recent policies and paradigm shifts in HIV care are driven by findings from multiple studies that confirm that in order to get the full benefits of anti-retroviral therapy (ART), individuals with HIV need to first know that they are HIV infected, be engaged in regular HIV care, along with receiving and adhering to effective ART[3]. For a long time, due to the evidence supporting ART effectiveness in achieving viral suppression, the focus of HIV care has been on treatment related aspects, such as starting ART and testing the efficacy of various treatments.[4] Nevertheless, there are barriers in each stage of the cascade that need to be addressed in order to have effective management of HIV care.

New York City welcomed this transition in HIV care, and has continuously

3 Gardner, E.M., McLees M.P., Steiner, J.F., Del Rio, C., Burman, W.J.(2011). The spectrum of engagement in HIV Care and its relevance to test-and-treat strategies for prevention of HIV Infection. Clinical Infectious Disease, 52(6): 793-800

4 Mugavero, M.J. (2012). Getting HIV-Infected Patients Into Care: What Are the Barriers? Medscape Education Internal Medicine, Faculty and Disclosures, CME/CE Released 7/20/2012

scaled up its efforts to meet the goals set by the NHAS. In 2012, approximately seven out of 10 adults in NYC (age 18-24) reported having ever been tested for HIV. Among those newly diagnosed, those virally suppressed rose from 34.1% 12 months post diagnosis in 2007 to 57.7% in 2011 [Figure 3]. By the close of 2012, nearly 8 out of 10 persons with known positive status that continued in care, were virally suppressed.

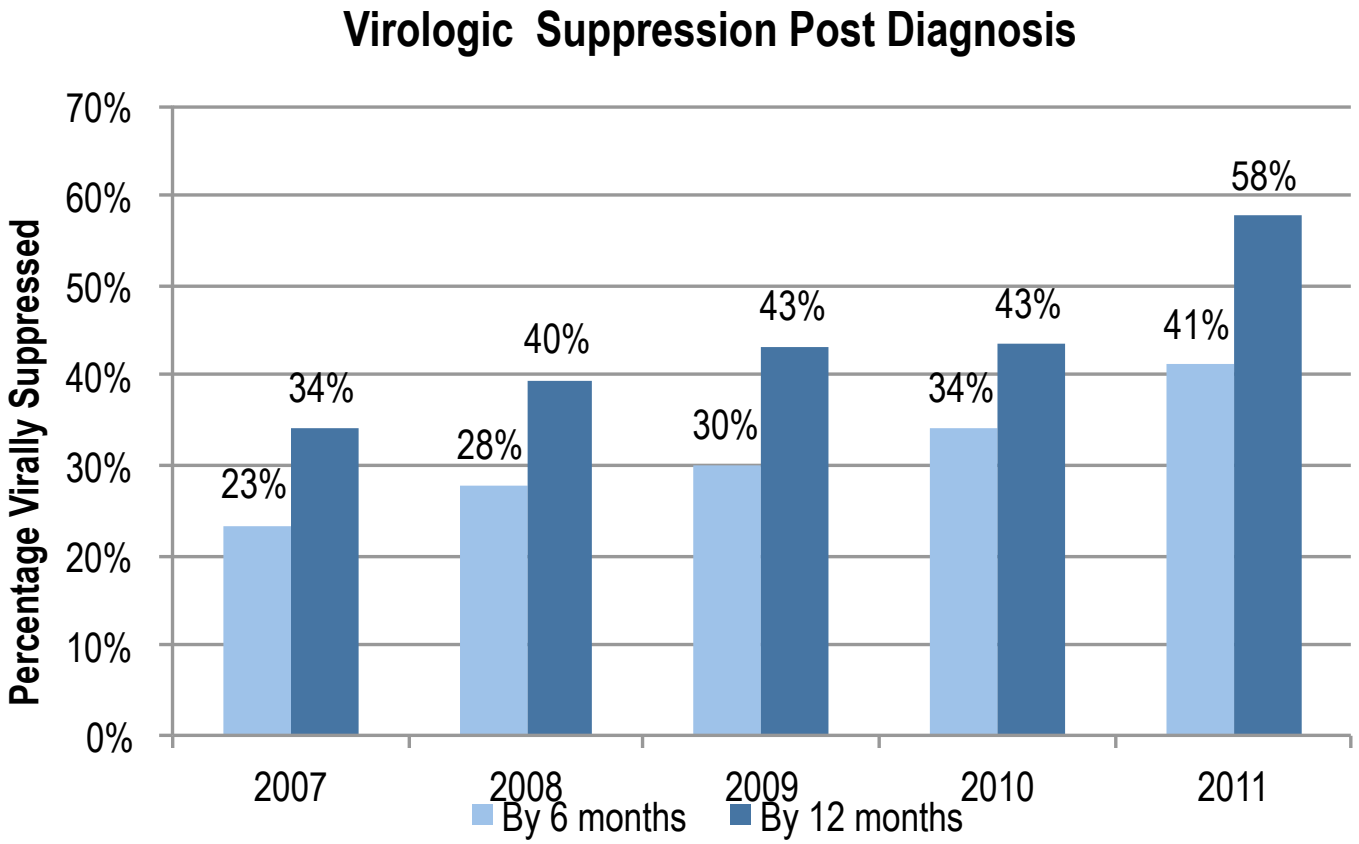


Figure 3. *Virologic Suppression within 6 and 12 Months of Diagnosis, New York City, 2007 – 2011. NYC Department of Health and Mental Hygiene, June 2013.*

The Treatment Cascade and Methodology at Harlem United

In response to the NHAS and the HIV Care Continuum set by President Obama, Harlem United has implemented an agency-wide Treatment Cascade initiative, which incorporated coordinated efforts across multidisciplinary

teams. Consistent with NHAS, the initiative at Harlem United also aimed to reduce the number of new HIV infections, increase access to care, and improve health outcomes for those living with HIV through the provision of integrated services across the agency. To kick off the efforts, a baseline treatment cascade was obtained based on data of newly diagnosed individuals from 2011 to 2012 [Figure 4].

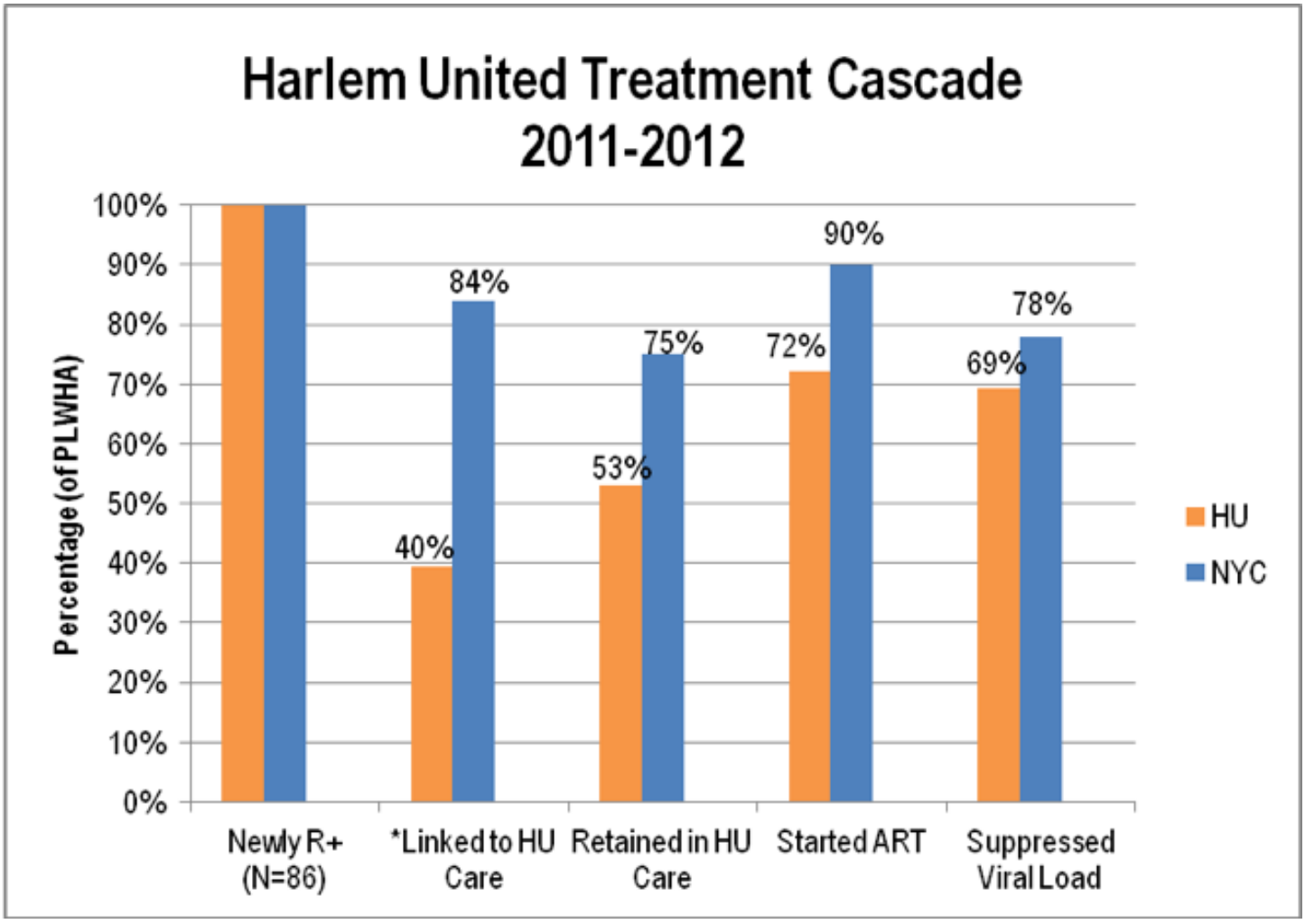


Figure 4. *2012 Baseline Treatment Cascade Using the 2011-2012 data as baseline, targeted interventions for each stage of the cascade were developed and implemented in 2013.*

Testing and Linkage to Care

Inadequate linkages to testing and care are major barriers to the management and retention of chronic and infectious diseases such as HIV, particularly for minorities. New York State Treatment Cascade for viral load suppression

shows that once a person receives HIV testing and a positive confirmatory result, linkage to care strategies and interventions are the first step in engaging patients in care (CDC). Preliminary assessments at Harlem United showed that Blacks were two times more likely to not be engaged in care in comparison to non-Blacks. With minorities making up majority of the HU community [clients served], it is important that we ensure our clients not only gain access to care, but are also successfully linked to care as well. The absence of symptomatic HIV as well as related illnesses greatly increases a person's opportunity to lead a "normal" life, with culturally appropriate programmatic and social support.

Studies show that linkage to care (LTC) immediately following diagnosis leads to rapid and sustained virologic suppression and also decrease the likelihood of developing resistance to ARV drugs. A person living with HIV may restart the care continuum [Figure 1] many times throughout the life of the disease[5] [6] therefore it is crucial to provide linkage early in the continuum as PLWHA often require more than one linkage encounter. By providing successful linkages, not only do we work toward the ultimate goal of 85% of PLWHA virally suppressed at the individual level, but we also work to decrease the transmission of the virus on a community level as well (NYS Guidelines).

At Harlem United, we have identified proven methods and pathways for linkages [Figure 5], specifically pathways that lead to our own clinics, mental health, and social support services. The first step is educating clients at the time of their diagnosis about the benefits of engaging in care and their role in preventing further transmission. Our trained care navigators work to establish a client specific care plan and identify services that may assist these individuals.

In efforts to enhance YMSM service delivery through the HU treatment cascade, the Prevention, Education & Support Services division implemented a four pronged strategy to increase access to primary care and biomedical interventions. A workgroup was formed to assess how to increase internal access to Harlem United services. The goals of the workgroup were to:

1. Implement Mobile Health Services in the field based YMSM CTR

5 Mugavero MJ, Norton WE, Sagg MS. Health care system and policy factors influencing engagement in HIV medical care: piecing together the fragments of a fractured health care delivery system. Clin Infect Dis. 2011 Jan 15; 52 2:S238-246.

6 Gardner, E. M., McLees, M.P., Steiner, J.F., Del Rio, C., Burman, W.J. (2011). The spectrum of engagement in HIV care and its relevance to test-and-treat strategies for prevention of HIV infection. Clinical Infectious Disease, 52(6): 793-800.

program

2. Engage high-risk YMSM/YTG in care

3. Integrate Recovery Support Services into HOME programming targeting YMSM

4. Improve access to linkage to care services for HIV-positive (new/ Known) YMSM

Figure 5. *Linkage to Care Services available at Harlem United*

Meeting once every two weeks starting in June 2013, the work group initially assessed the current venues serviced by the mobile testing team and volume of HIV positive clients engaged by testing services. 2012 data showed 23% of those YMSM who test positive were successfully linked to care. After examining data on preferred sites, times and locations, the workgroup then evaluated the capacity of the program based on current staffing.

Through Triad and CQI meetings, HOME staff ensured that patient navigators were

adequately scheduled at high-impact venues to conduct more outreach at clubs, bars, and "invite-only" or private events. The Testing and LTC teams coordinated staff to participate during testing shifts and incorporated LTC testing readiness activities during low-yielding hours. Training and education were crucial for staff ownership and engagement [Figure 6]. The workgroup developed an LTC readiness pamphlet for clients during pre-test encounters that promoted general health care, regardless of HIV status. The team also identified weekend and evening healthcare access points within the community and worked to create linkage agreements in addition to increasing access to an evening and weekend van for LTC testing encounters.

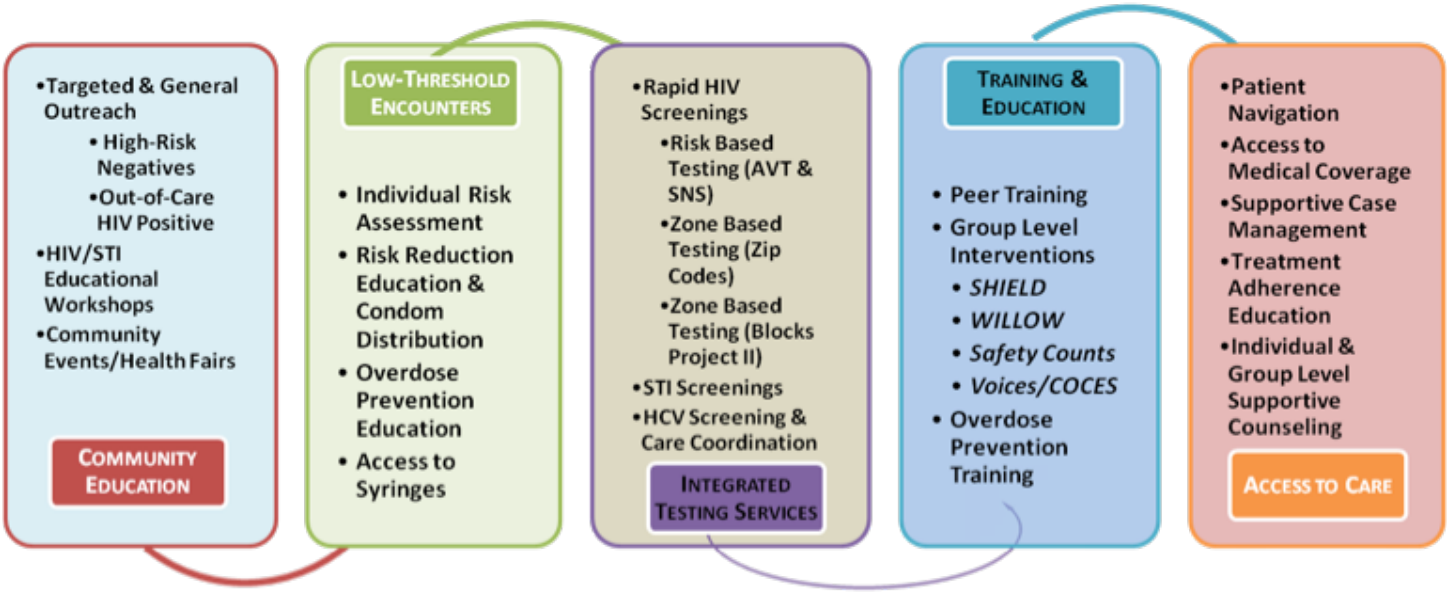


Figure 6. *Methods of Engagement through Prevention and Medical Services*

Retention

The second stage of the cascade involves ensuring that PLWHA are engaged in care. Through engagement in Primary Care, PLWHA are exposed to preventive healthcare interventions and services to promote changes in health behavior including adherence to medications. In the long run, retention in care will minimize HIV transmission thereby reducing the population burden of HIV, decrease healthcare costs by improving HIV-specific health outcomes, and

reduce emergency department visits and hospitalizations.[78]

The challenges in retaining PLWHA in care include factors at the individual/personal level, such as forgetting the appointments or unexpected social reasons, but could also span across factors at the structural level, such as lack of transportation/food/clothing, complex health system, stigma, health literacy, and social connectedness.[9] [10] [11] Research has found that individuals from certain demographic subgroups (i.e. African Americans, younger individuals, those with less education and lack of health insurance) are more likely to miss their medical appointments. In addition, individuals who have history of or current substance use, have lower perceived social support, are unemployed, and have psychiatric illnesses are more likely to have poor retention in care. As Harlem United's community served is characterized similarly to the socio-demographics subgroups found to be at higher risk for not engaging in care, it is important to gauge whether the barriers are personal or structural so that appropriate interventions to retain PLWHA in care can be generated accordingly.

To address barriers to retaining PLWHA in care at Harlem United, a CQI project team was formed in July 2013. The team consisted of Primary Care staff (i.e., Medical Office Assistant, Director of Quality Management), Access to Care (ATC) staff (i.e. ATC Managing Director, Patient Navigation Coordinator), and the Director of Program Evaluation. The objective of the CQI project was to prevent clients from falling out of care and to facilitate re-entry into care for PLWHA. By breaking down patient characteristics and PC visit data, the team identified a group of individuals who chronically no-show to their PC appointments. This group is considered "high risk", i.e. has multiple co-morbidities and other co-existing issues, and is also the most difficult group to contact and recall due to their transience. Based on this data, the team developed targeted interventions including:

- Daily huddles between PC Medical Office Assistants (MOA) and Patient Navigation (PN) Coordinator on high risk clients who miss their PC appointments to ensure actions are taken before clients fall out of

7 Horstman, E., Brown, J., Islam, F., Buck, J., Agins, B. (2010). Retaining HIV-Infected Patients in Care: Where Are We? Where Do We Go from Here? Clinical Infectious Diseases, 50:752–761

8 Gardner, E.M., McLees M.P., Steiner, J.F., Del Rio, C., Burman, W.J. (2011). The Spectrum of Engagement in HIV Care and its Relevance to Test-and-Treat Strategies for Prevention of HIV Infection. Clinical Infectious Disease, 52(6): 793-800

9 Ibid 11

10 Ibid 7

11 Mugavero, M.J. (2012). Getting HIV-Infected Patients Into Care: What Are the Barriers? Medscape Education Internal Medicine, Faculty and Disclosures, CME/CE Released 7/20/2012

care.

- Creating a tracking system using the agency's electronic medical record to document outreach activities
- Incorporating harm reduction techniques, motivational interviewing, and addressing patients' more immediate needs such as drug use in order to support reengagement efforts into care

Viral Load Suppression

The ultimate goal and final step of the HIV care continuum is to achieve sustained Viral Load suppression. Recent guidelines from the U.S. Department of Health and Human Services recommend initiating ART when CD4 cell counts reach 500 counts or below.[12] Early initiation of ART not only improves HIV-related health outcomes, but may also prevent the development of other chronic diseases, such as heart disease, kidney disease, and cancer. From a public health perspective, early treatment helps lower viral load burden in the community and lower transmission rates.[13] [14]

However, as illustrated in figure 2, it is estimated that only 36% of the people living with HIV in the United States are prescribed ART and among these individuals, 76% have suppressed viral loads.[15] These numbers suggests that there are barriers to ART success for HIV-infected individuals in care: delay or failure to initiate therapy, lack of persistence with therapy, poor adherence, and resistance to ART medications.

Among the four major barriers, adherence to ART is a critical factor that determines the achievement of sustained Viral Load suppression, reduced risk of drug resistance, improved overall health, quality of life, and survival, and decreased risk of HIV transmission. Similar to retention in care, adherence to ART is influenced by various factors related to behavioral, structural, and psychosocial barriers. Examples of these factors include social situation and clinical condition of each individual, prescribed ART regimen, patient-provider relationship, homelessness, poverty, stigma, limited access to medications.

12 Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents. Department of Health and Human Services. Available at

13 Ibid 16

14 Alcorn, K. (2009). When to start HIV treatment: Cohort studies disagree on how early. AIDS Map, February 2009

15 Centers for Disease Control and Prevention (2012). Linkage to and retention in HIV Medical Care. Available at http://www.cdc.gov/hiv/prevention/programs/pwp/linkage.html

Using the recommended multidisciplinary team approach31, Harlem United conducted monthly case conferences for unsuppressed clients beginning in December 2013. The case conferences were attended by medical providers, nursing staff, mental health staff, Access to Care (ATC) staff, health home care coordination staff, and a pharmacy consultant. Case conferencing allowed the opportunity to assess each client's needs in order to achieve adherence and propose solutions from different perspectives. In addition to case conferences, chart reviews are conducted on an ongoing basis in order to further identify root causes for poor adherence. Findings from chart reviews are used as additional data to design targeted interventions for each individual.

Results

Through the delivery of tailored interventions and services throughout 2013, Harlem United continues to progress in its support of the National HIV AIDS Strategy. Unique to our initiative, there were multiple services that could be utilized as entryways to link or re-engage clients to care.

Testing and Linkage to Care

Although the sample was smaller, the numbers in the 2013 treatment cascade show promise compared to those of the 2012 treatment cascade. These improvements can be attributed to targeted interventions provided at each stage of the cascade as part of the agency-wide Treatment Cascade Initiative. Results showed a 4% increase in the number of individuals tested and connected to care and 18% increase in the number of individuals that complete their first primary care medical appointment. These results [Figure 7] further support the NHAS HIV Care Continuum as it shows by connecting positive testing encounters to care within 48 hours of testing positive, they are more likely to engage and remain engaged in care.

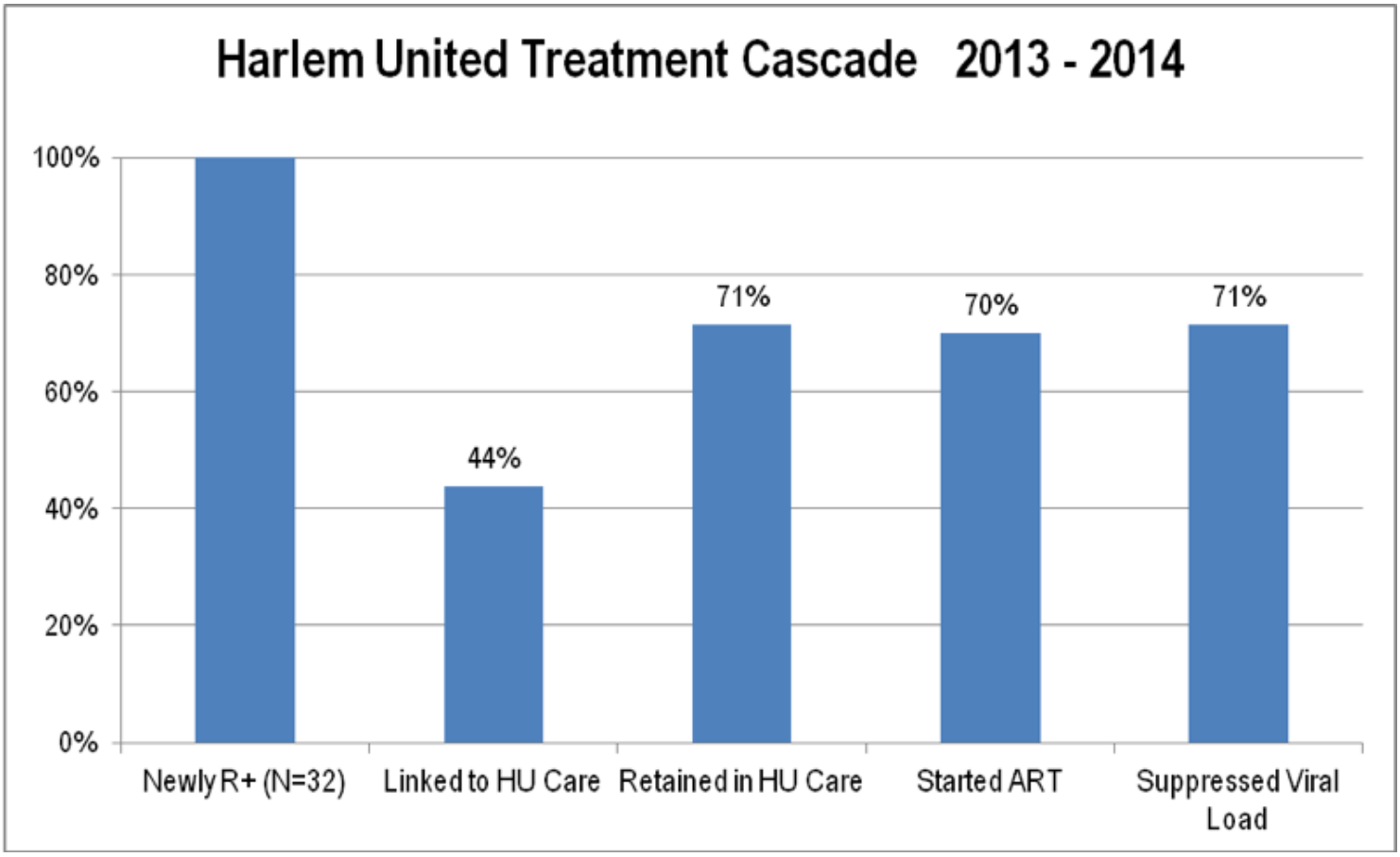


Figure 7. *Harlem United 2013 Treatment Cascade*

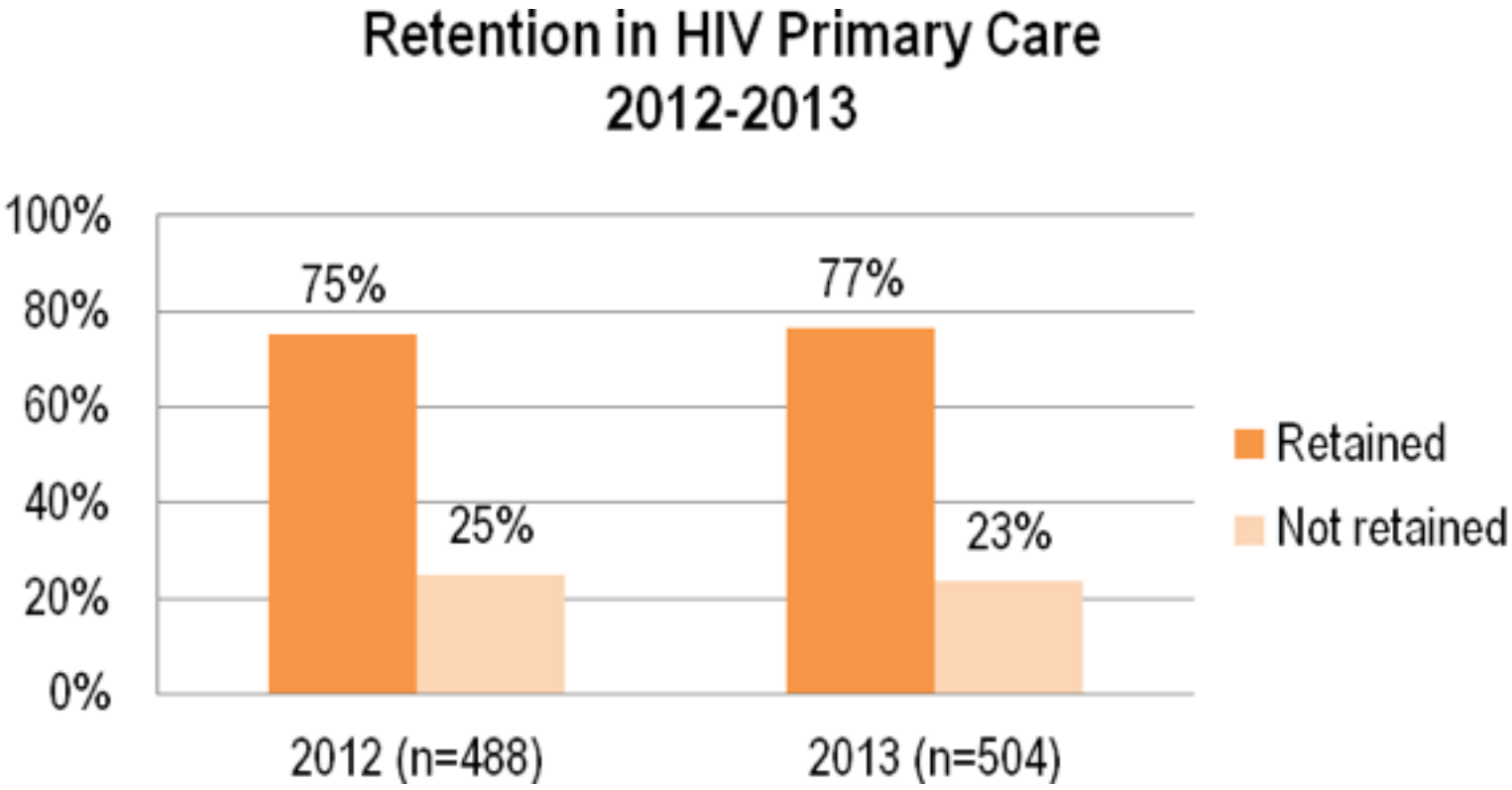


Figure 8. *Retention rates in HIV Primary Care at Harlem United for 2012 and 2013*

Retention

Based on huddles that took place from July 2013 – May 2014 [16], 372 "high risk" clients were outreached by the ATC Patient Navigation team; the outreach activities included phone calls, letters, home visits, and face-to-face encounters in the office. The PN team was successful in scheduling PC appointments for 129 of 372 clients. Of the 129 clients who were scheduled PC appointments, 82% attended the appointments; these clients may have been lost to care had they not been outreached by the ATC PN team. Some of the services that the PNs provide to ensure that clients attend their appointments include reminder phone calls and escorts.

Despite the fact that an experimental study was not conducted to measure the impact of the daily huddle strategy on retention, we observed a slight increase in retention rate[17] from 2012 to 2013 as illustrated in Figure 8. As the goal of the daily huddle strategy is to prevent clients from falling out of care, the slight increase in retention rate could be an indication of success of the daily huddle strategy.

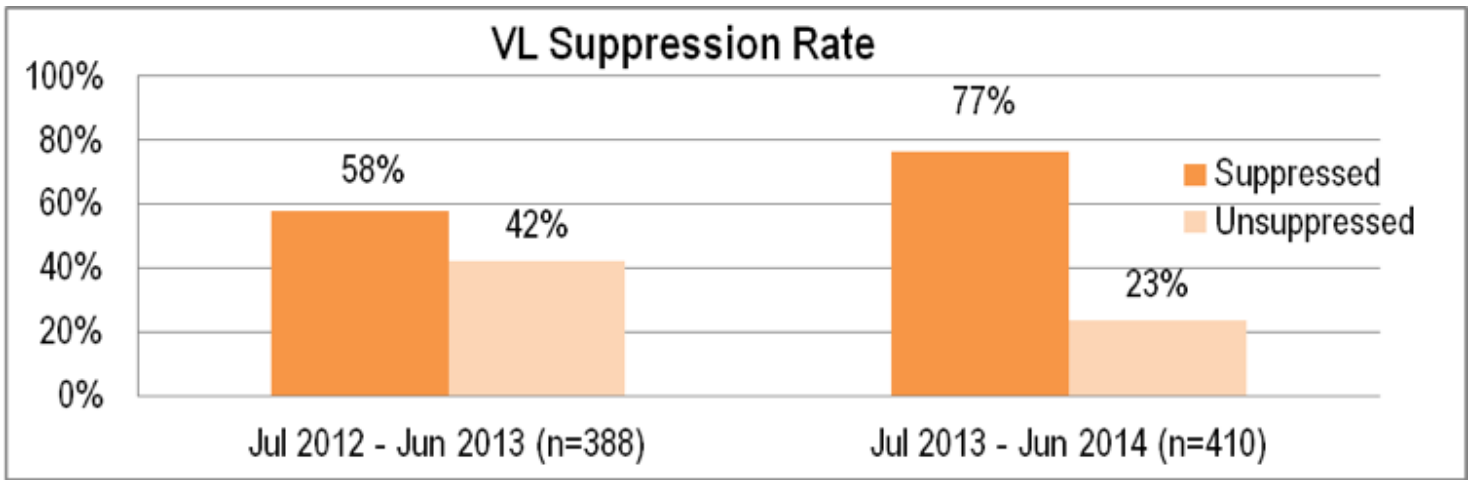


Figure 9. *Viral Load Suppression assessed from July 2012 to June 2013 and July 2013 to June 2014.*

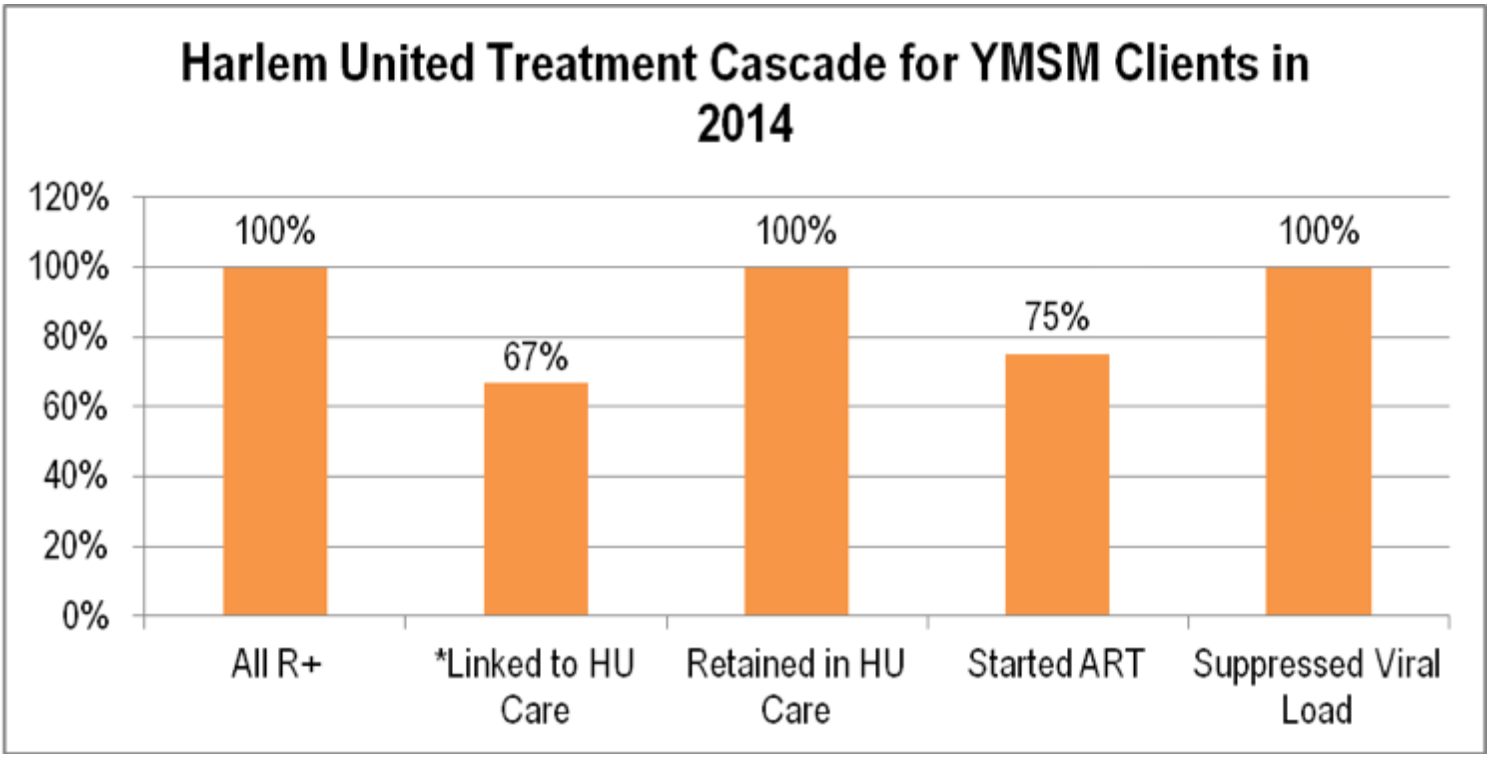
Viral Load Suppression

Although case conferencing did not begin until December 2013, the importance of actively managing clients' Viral Load had been re-emphasized to medical providers in relation to the agency-wide Treatment Cascade

16 Daily huddles did not happen during the months of December 2013 – March 2014 due to staff turnover

17 Retention is defined as the number of individuals who have at least one Primary Care visit in each half of the year

Initiative. As a result, medical providers have been monitoring and managing clients' ART more closely than before. The combination of actively managing clients' ART and the case conference strategy resulted in a significant increase in Viral Load suppression from 2012-2013 to 2013-2014[18], as demonstrated in Figure 9.



Discussion

With each client presenting their own unique set of complexities, a continuum of treatment support services is necessary to achieve adherence and retention. Through the use of the multidisciplinary team approach, Harlem United has bridged its services, allowing each department to play integral roles in helping clients to achieve a sustained viral load suppression. It was important as well for health services to assess its capacity to provide services to a new population subset. Already, in 2014 we continue to see scaling up of programs to meet goals set forth by the state. In looking at a small sample of YMSM clients who were newly diagnosed as HIV-positive, we can successfully report 67% have been linked and retained in care, with 75% of those individuals starting on ART and showing suppressed viral load.

18 Based on HRSA definition, only clients who were "in-care" (i.e. had two labs, either CD4 or VL, at least 90 days apart within 12 months)

The testing team has added new sites in partnership with the mobile health team after the number of HIV positives showed increased prevalence in upper Manhattan. Focusing on the sex stroll and transgender community, a needs assessment was recently performed for the newly added site to determine the client profile as well as assess current access to medical services and health coverage. Staff has since been trained on changes to sites, scheduling, intake, clinic flow, and education and counseling. Staff was also introduced to the new warm handoff system developed to ensure the clients' trust and comfort in transitioning from testing to the mobile health services unit. The workgroup has also identified and integrated additional supportive services to the mobile health services unit such as ACA enrollment, ESAP services, Voces [voices] intervention in the mobile waiting area.

To continue improving engagement in care, the PC Retention team has started developing a mini survey to identify client-level barriers. Findings from this survey will be used to develop targeted interventions at the client-level. Lastly, to ensure Viral Load Suppression, a formal CQI project team will be formed in 2014. This team will meet regularly to identify barriers to medication adherence, identify possible solutions to improve medication adherence, and test proposed solutions. With these scaled up efforts put in place, Harlem United is getting closer to meeting the NHAS goals. In the long run, the incremental improvements achieved in each stage of the cascade will eventually decrease the prevalence and incidence of HIV.

2013 POLICY IN REVIEW AND FUTURE IMPLICATIONS

Game Changers and an Evolving Healthcare Landscape

Informed by systematic analysis and program evaluation, Harlem United translates lessons learned from its comprehensive programs and services to advance responsive public policy and resource allocation, while also using policy to generate innovative programming.

The agency has always had a voice on federal, state and local legislative, regulatory and budget issues. Historically, Harlem United's effective and forceful policy voice has been the agency's leadership amplified by the community, clients and staff. 2013 proved no different.

Several recent "game changers" continue to evolve the healthcare landscape in New York City, State and across the United States, such as: The passage of the Affordable Care Act (ACA), the execution of the National HIV/AIDS Strategy, the redesign of New York State's Medicaid program, the extension of Ryan White HIV/AIDS Treatment Extension Act, the shift from fee-for-service to managed care and other care coordination modalities.

These are coupled with similar "game changers" in our knowledge of HIV, including biomedical advances such as the FDA's approval of Truvada as Pre-Exposure Prophylaxis (PrEP), the conceptualization of the treatment cascade, the knowledge that suppressed viral load reduces transmission, and the classification by the Department of Health and Human Services that HIV infection is a chronic condition, at the same time as it establishes a strategic framework to provide optimum health and quality of life for individuals with multiple chronic conditions.

In 2013, many of these shifts were realized with even sharper focus in budget and legislative advocacy, including:

- Analysis, subsequent advocacy to mitigate the impact of sequestration and fiscal cliff;

- Analysis, advocacy to mitigate loss of $18 million to New York City's Ryan White Part A funding;
- Co-sponsored the innovative public forum series, Talking Transition's AIDS-specific forum and facilitated a break-out group on women;
- Finally, a major win for Harlem United in 2013 was the passage of a new Hepatitis C Law - (S2750/A01286) - sponsored by Senate Health Committee Chair Kemp Hannon (R-Nassau) and Assembly Member Kenneth Zebrowski (D-New City), whose father, a former Assembly Member from Rockland County, died from complications related to hepatitis C at the age of 61. By helping New Yorkers born between 1945 and 1965, the age group with the highest infection rate, learn their hepatitis C status, the new law is helping those with chronic infection access care and treatment.

Hepatitis C, a virus that is transmitted by blood-to-blood contact, is a leading cause of serious liver disease and is now the cause of more deaths nationwide each year than HIV/AIDS. Because people infected with the hepatitis C virus usually have no noticeable symptoms for years and even decades, many are diagnosed too late to fully benefit from treatment and care. According to the CDC, there is an estimated 3.2 million people infected with the hepatitis C virus nationally and 75% of them are people born between 1945 and 1965, the age group that is most likely to develop hepatitis C-related disease in the next 5-10 years if left undiagnosed and untreated. Most people have been infected either during medical procedures before 1992 when the United States introduced universal blood product screening, or from injection drug use with non-sterile syringes. The New York State Department of Health (DOH) estimates there are over 200,000 New Yorkers living with hepatitis C and majorities do not know they are infected, which early detection can help prevent.

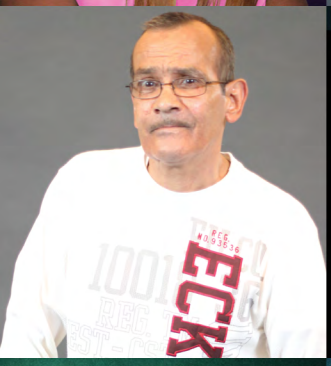
The law, which took effect in January 2014, is modeled after new guidelines from the Centers for Disease Control & Prevention (CDC) issued in 2012 and New York's successful HIV testing law adopted in 2010. The US Preventive Services Task Force (USPSTF), which insurance providers often use to decide which services to cover, also recommended one-time Hepatitis C screening baby boomers this past June. This comes at a pivotal moment when newly available medication can cure a majority of people with chronic Hepatitis C infection, and even more effective treat-

ments with fewer side effects are expected to be approved in the next 1-2 years.

Harlem United's organizing principles remain firm, but we will continue to adapt our policy and advocacy work to meet the demands of this fast-moving complex environment. This will continue to enable us to provide compelling and real time examples of the ways in which our policy priorities can, and do, support the outcomes of initiatives such as those discussed within this year's report. With an integrated service portfolio in housing, healthcare and preventive services, Harlem United remains committed to improving community and individual health.





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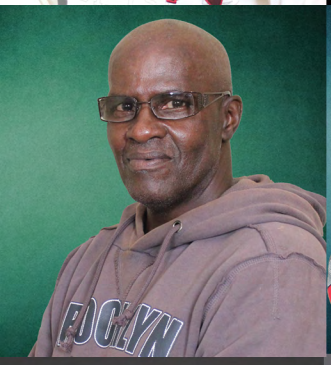






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