

Kentucky HIV Prevention Plan 2007



Prepared and Compiled by the
Kentucky HIV Planning and Advisory Council
in collaboration with the
Kentucky Department for Public Health
HIV/AIDS Branch



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KEY TO ABBREVIATIONS

AA	African Americans
AAMSM	African American Men who have Sex with Men
ADD	Area Development Districts
AED	Academy for Educational Development
AHEC/HETC	Area Health Education Center/Health Education Training Center
ASO	AIDS Service Organization
BFHC	Bluegrass Farmworker Health Center
CBO	Community Based Organization
CDC	Centers for Disease Control and Prevention
CLI	Community-Level Interventions
CRCS	Comprehensive Risk Counseling and Services
CTRPN	Counseling, Testing, Referral, and Partner Notification
DEBI	Diffusion of Effective Behavioral Interventions
DHAP-IRS	Division of HIV/AIDS Prevention-Intervention Research and Support
DIS	Disease Intervention Specialist
DL	Down-low
DPH	Department for Public Health
EW	Empowerment Workshop
FTE	Full Time Employee
HC/PI	Health Communications/Public Information
GLI	Group-level Interventions
GMOC	Gay Men of Color
HAR	Hispanics at Risk
IDU	Injecting Drug User
ILI	Individual-level Interventions
KDE	Kentucky Department of Education
KHCIP	Kentucky Health Continuation Insurance Program
KHPAC	Kentucky HIV/AIDS Planning and Advisory Council
KIPWAC	Kentuckiana People With AIDS Coalition
KPOL	Key Peer Opinion Leader (MSM intervention)
LWA	Living With AIDS
MSM	Men who have Sex with Men
MSM/IDU	Men who have Sex with Men/Injecting Drug User
MSMOC	Men who have Sex with Men of Color
PCM	Prevention Case Management
PCRS	Partner Counseling and Referral Services
PLWHIV	Persons Living With HIV
PMI	Prevention Marketing Initiative
PS	Prevention Specialist
PSE	Public Sex Environment
PSI	Postponing Sexual Involvement
PWA	People With AIDS
RRW	Risk Reduction Workshop
RTR	Reducing the Risk
SISTA	Sisters Informing Sisters about Topics on AIDS
TA	Technical Assistance
WAR	Women at Risk
YAR	Youth at Risk



SECTION

1

KHPAC OVERVIEW

INTRODUCTION AND OVERVIEW OF THE COMMUNITY PLANNING PROCESS

The Kentucky Department for Public Health (DPH) initiated the community planning process in 1994 in response to the Centers for Disease Control and Prevention (CDC) Announcement #300. The state was divided into three regions for the purpose of Human Immunodeficiency Virus (HIV) prevention planning for the 1994 application for funding. The designation of regions was based on HIV and Acquired Immune Deficiency Syndrome (AIDS) case data in Kentucky, existing Area Development Districts (ADD), and HIV Ryan White Care consortia boundaries. In 1998 a single statewide HIV Prevention Community Planning Group was formed with representation from the existing regions. In 2005 the HIV Prevention Community Planning Group began the process of merging with the existing Governor's HIV/AIDS Advisory Council, with the addition of a care component to the planning process. This integrated group was named the Kentucky HIV/AIDS Planning and Advisory Council, indicating the primary roles of planning and advising. In March of 2006, KHPAC had its inaugural meeting. KHPAC works closely with the staff of the DPH, HIV/AIDS Branch, to ensure that HIV prevention and care planning effectively identifies the needs of the people of the Commonwealth of Kentucky.

The mission of KHPAC is to identify issues and develop public health policy recommendations to prevent further HIV/AIDS infections in Kentucky, and to serve populations currently infected.

KHPAC advises the Kentucky Cabinet for Health and Family Services (CHFS) on the formulation of HIV and AIDS policy. KHPAC monitors the responsiveness of CHFS, and ensure that recommendations are being considered and followed, as prescribed by the CDC's guidelines for HIV/AIDS Prevention community planning. KHPAC offers programmatic recommendations regarding Health Resources and Services Administration (HRSA) activities. Specifically, KHPAC advises regarding Ryan White Title II Services.

KHPAC JURISDICTION AND COMPOSITION

Kentucky is comprised of 120 counties. For HIV/AIDS planning the state is divided into three regions: North Central, Eastern and Western. The North Central region includes Jefferson and the six surrounding (mostly rural) counties. All seven counties in this region make up the North Central Area for Development District (ADD). According to the December 31, 2005 cumulative statistics, this region has 2003 (approximately 46%) of the State's total 4320 reported AIDS cases. Jefferson County is the most populated county in Kentucky and is the only urban county in the North Central region. The majority of the region's cases (1825 or 91%) are reported for Jefferson County (Louisville).

The Eastern Region includes the easternmost nine ADDs with a total of seventy-one counties. The two major urban centers of the Eastern Region are Lexington and the Northern Kentucky Area immediately south of Cincinnati, Ohio. The remaining counties are mostly rural. The region has 1561 (36%) of the State's December 31, 2005 cumulative AIDS cases reported. The majority of the regional cases are reported for the Bluegrass ADD (835 or 19% of the state's cases) and the Northern Kentucky ADD (356



or 8% of the states cases). Fayette County (Lexington) accounts for 598 (38%) of the Bluegrass ADD's cases. The remaining ADDs reported AIDS cases ranging in number from 33 to 89.

The Western Region represents the western most five ADDs with a total of forty-two counties. Most of the Western Region is rural with small cities, with no major urban areas. The Western Region accounts for 756 (18%) of the state's December 31, 2005 cumulative AIDS cases reported. The five ADDs reported AIDS cases ranging in number from 120-177.

The initial membership of KHPAC was comprised of 27 members. Various factors including new meeting times and changes in agency representation, to name a few, has led to a reduction in this initial membership. Current KHPAC membership consists of 23 members. The Executive Committee which functions as the Membership Committee is in the process of reviewing applications to KHPAC. According to the mandates of KRS 214.640, KHPAC consists of 2 standing members, the Commissioner for Public Health and the Commissioner for Medicaid Services. In accordance with CDC, HRSA and KRS 214.640, KHPAC also consists of representatives from other state agencies that provide HIV/AIDS health care and/or education, physicians, representatives of community based organizations (CBO), experts in epidemiology, behavioral and social sciences, program evaluation and health planning; individuals living with HIV, and individuals who reflect the characteristics of the current and projected epidemic in Kentucky. Membership on KHPAC also ensures geographic representation. KHPAC geographic representation is outlined using 5 geographic regions; Western, North Central, Bluegrass, Northern and Eastern Kentucky. These delineations help to ensure that urban and rural areas are adequately represented.

The following is a regional list of agencies represented on KHPAC.

EASTERN REGION

Cumberland River Comprehensive Care Center

BLUEGRASS

AIDS Volunteers, Inc.

NORTHERN

AIDS Volunteers of Northern Kentucky (AVNK)

Northern Kentucky Independent Health District

NORTH CENTRAL REGION

Sisters and Brothers Surviving AIDS (SABSA)

WINGS Clinic

Volunteers of America

Louisville-Metro Health Department

WESTERN REGION

Kentuckiana People With AIDS Coalition (KIPWAC)

Owensboro HIV/AIDS Task Force

Heartland CARES, Inc.

Kentucky HIV/AIDS Advocacy and Action Group

Matthew 25

Infectious Disease Associates



Table 1

Kentucky HIV/AIDS Planning and Advisory Council Characteristics
(as defined in the CDC Evaluation Guidance)

Age							
< 19	19-24	25-34	34-44	45+	Total		
0	0	2	6	13	21		
Gender							
Male	Female	Transgender	Other	Total			
14	6	1	0	21			
Sexual Orientation							
Heterosexual	Bisexual	Gay	Lesbian	Other	Unknown	No response	Total
8	0	9	1	1		2	21
Ethnicity							
Hispanic/Latino			Non-Hispanic/Non-Latino			Total	
2			19			21	
Race							
American Indian/Alaska Native	Black of African American	Native Hawaiian/Pacific Islander	Asian	White	No response	Total	
0	4	0	0	17	0	21	
Geographic Distribution							
Urban Metropolitan	Urban Non-Metro	Rural	Suburban	Other	Total		
11	7	1	2	0	21		
Expertise							
Community Rep.	PLWHA or affected	Community Org.	Intervention Specialist/Service Provider	HIV Care Provider	Medical Provider	Total	
8	10	4	2	4	1	29 ¹	
Expertise Cont.							
Behavioral or Social Scientist	Evaluation	Health Planner	Epidemiologist	Mental Health	Other	Total	
3	2	1	1	1	2	10 ¹	
Representation of HIV Exposure category							
MSM	MSM/IDU	IDU	HRH	Sex with transgender	Sex with transgender/IDU	No specific risk	Total
8	2	1	4	1	0	8	24 ¹
Representation of other populations through personal life experience							
Substance Use	Sex trade	STDs	Homelessness	Partners or family members of PLWHA	Corrections system	Total	
9	2	0	1	3	3	18 ¹	
Agency representation							
Faith Community	Non-minority CBO	Mental Health Services	Academic institution	Corrections	State/ Local Education Agencies	Total	
3	10	1	0	0	0	14 ¹	
Agency representation Cont.							
Community Rep.		Minority CBO	Health Department HIV/AIDS	Substance Abuse Services	Homeless Services	Research Center	Total
7		0	2	1	0	0	10 ¹
Agency representation							
HIV Care and Social Services	Business and Labor	Health Department: STD	Other Non-Profit	Other	Total		
9	0	0	0	1	10 ¹		
HIV Status							
Living with HIV/AIDS		Not living with HIV/AIDS		Unknown	No response	Total	
9		11		0		21	

¹ – Total is unduplicated, but members may be counted in several categories

N.B. KHPAC Characteristics does not take into account the two standing members of KHPAC.



KHPAC MEMBERSHIP RECRUITMENT & ORIENTATION

KHPAC members are primarily recruited through personal referrals. The Executive Committee is responsible for reviewing applications, interviewing applicants and making membership recommendations to the full KHPAC body for approval. Once KHPAC approves individuals for membership, the applications are sent to the Governor's Office for appointment.

KHPAC members underwent a two (2) day orientation at General Butler State Resort Park on March 13 and March 14, 2006. New KHPAC members are provided with a Kentucky HIV/AIDS Planning and Advisory Council Handbook which includes KRS 214.640, the CDC HIV Prevention Community Planning Guidance, the HRSA Planning Body Duties, KHPAC by-laws and membership structures, a copy of the current HIV Prevention Plan and grant, a copy of the previous Year-End Report, an orientation guide to community planning, and other pertinent information necessary for the participation on KHPAC. Each new member is asked to attend an orientation conducted by the DPH HIV Health Policy Specialist and the Executive Committee, where they are also briefed on the current activities of KHPAC.

KHPAC members are placed into a 'Fellowship of Three', which consists of a former Advisory Council member, a former CPG member and a new member. These 'Fellowships of Three' provide a form of mentorship for all members during this first year of integration.

Each KHPAC Member is required to participate on one of the standing committees: Care and Prevention or Policy and Promotion. This year KHPAC met as a collective group so that all members could learn the various aspects of each component of KHPAC.

COLLABORATIONS AND AFFILIATIONS

INSTITUTIONAL AFFILIATIONS OF CO-CHAIRS

The State Co-chair for KHPAC is Stephen Ulrich, HIV Prevention Program Administrator for the Department for Public Health. The Community Co-chair is Robert Stone. Robert is from Owensboro, and volunteers as a street outreach worker for the Owensboro HIV/AIDS Task Force Inc., as well as facilitates an HIV + support group.

PROCESS FOR OBTAINING COMMUNITY INPUT BEYOND KHPAC MEMBERSHIP

If a particular demographic of HIV/AIDS community is not represented on KHPAC, input is obtained from individual interviews, invited representatives of organizations, focus groups, surveys, HIV Prevention Specialists (PSs) working with the affected communities, and input from the State MSM Initiatives, IDU Initiatives and Minority/High-Risk Heterosexual Initiatives Coordinators.

PROCESS FOR CONDUCTING BUSINESS & MEETINGS

KHPAC meets on the fourth Tuesday of every month. Length of meetings are dependant upon the agenda. Most KHPAC meetings are held between 9:30 a.m. and 4 p.m. KHPAC occasionally convenes bi-monthly. Regularly scheduled KHPAC meetings occur either in person or via video-conferencing.

The assigned HIV Health Policy Specialist coordinates the activities of KHPAC to ensure that the mandates of KHPAC are carried out. The meetings are facilitated by the HIV Health Policy Specialist, as well as members of the Executive Committee. KHPAC members receive a summary meeting report of every meeting held, the results of evaluations which are completed by members after each meeting



and any other information needed to prepare for the following meeting. These evaluations are used to improve the planning and advising process, as well as to facilitate an annual evaluation. If a problem occurs that the group cannot rectify or if clarification of an issue is needed, technical assistance is sought from or through the DPH personnel.

All KHPAC members sign a Disclosure of Conflict of Interest form, a letter of commitment to KHPAC, and a statement of confidentiality.

Major tasks are accomplished at each KHPAC meeting. The products of the committees and reports are submitted to KHPAC where discussion, clarifications, questions and answers, and input are encouraged. Decisions are made by consensus, but if this is not possible a majority vote is taken. In Kentucky, all meetings by government or government supported groups are open to the public. Additionally, there are occasions when a group, organization, or individual are asked to attend the meeting to provide pertinent information to KHPAC.

KHPAC ACCESS TO INFORMATION & UPDATES

To ensure that KHPAC has access to any pertinent information or updates that pertain to HIV/AIDS in the Commonwealth of Kentucky or nationally, DPH provides KHPAC with updates on HIV prevention and community planning in the form of National Alliance of State and Territorial AIDS Directors (NASTAD) bulletins and newsletters, journal publications, CDC updates, and other publications.

HIV/AIDS Branch staff attend meeting KHPAC meetings (on a rotational basis) to ensure KHPAC members have access to their expertise, and to ensure the collaboration between KHPAC and DPH. HIV/AIDS Branch staff also participate in monitoring and evaluating the planning and advising process. The supplemental guidance for CDC Community Planning Groups dictates that "HIV Prevention Community Planning Group(s) should have access to current information related to HIV prevention from evaluation of programs and the behavioral and social sciences, especially as it relates to the at-risk population groups within a given community. Planning group members should also be routinely updated about relevant new findings of behavioral and social scientists." ("Supplemental Guidance on HIV Prevention Community Planning for Non-competing Continuation of Cooperative Agreements for HIV Prevention Projects", CDC, page 9).



SECTION

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Priority Populations
2005

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WHAT ARE THE PRIORITY POPULATIONS FOR HIV PREVENTION?

ORDER OF PRIORITY POPULATIONS

On March 20, 2006, a draft of the Epidemiologic profile was mailed to KHPAC members for review. On March 28, 2006 KHPAC held the first official meeting. The Epidemiologist presented the Epidemiologic Profile, detailing the contents. Based on the Epidemiologic Profile and current anecdotal evidence, KHPAC members re-prioritized the target populations.

Per CDC's Advancing HIV Prevention Initiative, those living with HIV are prioritized as the highest target population. The major change in prioritization for 2007 was the reversal of the injecting drug use (IDU) and the high-risk heterosexual (HRH) populations. According to the epidemiology of HIV/AIDS in Kentucky, 14 % of AIDS cases were infected through injection drug use, while 13% were infected through heterosexual contact. While the Epidemiological Profile indicates a slightly higher incidence of HIV/AIDS in the IDU population, KHPAC decided that since the difference in incidence is only 1%, HRH would be ranked higher than IDUs.

Two primary justifications were given for the change in prioritization: 1) It is more difficult to identify individuals in the IDU population than it is to identify individuals in the HRH populations, and therefore target prevention efforts towards these populations. 2) Trend data and anecdotal evidence shows that the rate of HIV infection in HRH populations is on the rise, particularly among women and youth.

Prioritized Target Populations

1. HIV+
2. MSM
3. HRH
4. IDU
5. MSM/IDU



TABLE 4

Ranking of Risk Population Categories Used in CDC's Evaluation Guidance						
Rank	Raw Score	Population	Sub-population (Percents represent the proportion of living cases within each population as of 12/31/03)		Sub-Rank	CDC Definition of Population
1	45	MSM	HIV + ♂ White >29	66%	1.1	Intervention will address the HIV prevention needs of men who report sexual contact with other men or with both men and women.
			HIV + ♂ Black/Hispanic >29	17%	1.2	
			HIV + ♂ White 13-29	11%	1.3	
			HIV + ♂ Black/Hispanic 13-29	6%	1.4	
			HIV – MSM		1.5	
2	28	Heterosexual Contact (with PWHIV, MSM, MSM/IDU, IDU)	HIV + ♀ White >29	24%	2.1	Intervention will address the HIV prevention needs of persons who report specific heterosexual contact with a person with, or at increased risk for, HIV infection (e.g., sex with an IDU, a bisexual male, or a person known to be HIV-positive or to have AIDS).
			HIV + ♀ Black/Hispanic >29	23%	2.2	
			HIV + ♂ White >29	17%	2.3	
			HIV + ♂ Black/Hispanic >29	14%	2.4	
			HIV + ♀ Black/Hispanic 13-29	10%	2.5	
			HIV + ♀ White 13-29	7%	2.5	
			HIV + ♂ Black/Hispanic 13-29	4%	2.6	
			HIV + ♂ White 13-29	2%	2.6	
			HIV – Heterosexual		2.7	
3	37	IDU	HIV + ♂ Black/Hispanic >29	36%	3.1	Intervention will address the HIV prevention needs of people who are at risk for HIV infection through the use of equipment to inject drugs (e.g., syringes, needles, cookers, spoons, etc.).
			HIV + ♂ White >29	26%	3.2	
			HIV + ♀ Black/Hispanic >29	12%	3.3	
			HIV + ♀ White >29	11%	3.4	
			HIV + ♂ Black/Hispanic 13-29	5%	3.5	

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			HIV + ♂ White 13-29	3%	3.6	
			HIV + ♀ Black/Hisp. 13-29	3%	3.6	
			HIV + ♀ White 13-29	1%	3.7	
			HIV – IDU		3.8	
4	25	MSM/IDU	HIV + ♂ White >29	51%	4.1	Intervention will address the HIV prevention needs of men who report both sexual contact with other men and injection drug use.
			HIV + ♂ Black/Hisp. >29	34%	4.2	
			HIV + ♂ White 13-29	13%	4.3	
			HIV + ♂ Black/Hisp. 13-29	2%	4.4	
			HIV – MSM/IDU		4.5	
5	8	Mother at Risk for Perinatal HIV Transmission	HIV + ♀ Black/Hisp. 13-29	N/A		Intervention will address the HIV prevention needs of women who have HIV or are at risk of becoming infected <i>and</i> who are pregnant and, thus, at risk of transmitting HIV to their infant.
			HIV + ♀ Black/Hisp. >29	N/A		
			HIV + ♀ White 13-29	N/A		
			HIV + ♀ White >29	N/A		
			HIV – Mother at Risk for Perinatal HIV Transmission	N/A		
6		General Population	HIV + ♀ Black/Hisp. 13-29	N/A		Intervention will not be targeted to any specific groups whose behavior puts them at high risk for HIV infection. These interventions may be aimed at enhancing awareness of HIV transmission modes and prevention, supporting prevention-enhancing social norms, and providing information or education.
			HIV + ♂ Black/Hisp. 13-29	N/A		
			HIV + ♀ Black/Hisp. >29	N/A		
			HIV + ♂ Black/Hisp. >29	N/A		
			HIV + ♀ White 13-29	N/A		
			HIV + ♂ White 13-29	N/A		
			HIV + ♀ White >29	N/A		
			HIV + ♂ White >29	N/A		
			HIV – General Population	N/A		



EXPLANATION OF PRIORITIZATION TOOL

The prioritization tool is attached as an appendix to this document.

The factors chosen for prioritization are fairly self-explanatory except for “Riskiness of Population Behavior.” In this category, points were assigned relative to the most typical risk behavior in each target population. For populations that practice multiple risk behaviors, the highest risk behavior in which they participate was used. For instance, while MSM/IDU participate in injecting drugs, receptive anal intercourse, and insertive anal intercourse, the highest risk behavior is regarded to be injecting drug use, which is assigned 5 points. The assigned multiplier would then be multiplied by this number in order to generate the final score for the specific factor. Scores for each factor were added together to obtain the final point totals for each risk population. The final point totals are listed in Table 4.



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SECTION
3a
ASSESSMENT

RESOURCE INVENTORY

COMMUNITY BASED ORGANIZATIONS PROVIDING HIV PREVENTION

Agencies funded in part with CDC Cooperative Agreement funds are indicated with the KHPAC logo: 

American Red Cross (ARC) is located in nearly every county in Kentucky. The number of ARC employees range from one or two in the smaller communities to more than 300 in the Louisville Chapter. Budgets are also diverse, with smaller chapters having budgets of a few thousand dollars to in excess of a hundred thousand dollars in Lexington and Louisville. There is disparity in the provision of HIV/AIDS services among counties, with smaller, more rural counties believing that there is "no problem" in their community (thus no reason for services) to the larger, more urban chapters offering quite a range of services. HIV/AIDS services include the distribution of brochures, AIDS 101 training, peer training for adolescents, African American AIDS 101 training, Hispanic AIDS 101 training, rural and church leader AIDS 101 training, prison personnel training, and a program specifically entitled "AIDS in the Workplace" which is designated for businesses and industries. (502) 589-4450

AIDS Services Center Coalition (ASCC) is a coalition of agencies whose primary goal is to direct the public to appropriate AIDS service agencies, literature distribution, and provide a HIV/AIDS resource directory. The agency has an extensive volunteer network. (502) 574-5490

House of Ruth provides social, emotional and financial support to people living with HIV/AIDS in the Louisville/Jefferson County area. (502) 587-5080

WINGS Clinic located in Louisville is a Ryan White CARE Act Title III grantee. WINGS provides both clinical and support services for HIV/AIDS patients and their affected families. This clinic project provides primary and infectious disease care, adult and pediatric nutrition services, adult support groups, social services, legal services, family & mental health counseling, as well as liaisons to community services. 502-852-5203

 **Sisters and Brothers Surviving AIDS (SABSA)** is a support group located in Louisville for all HIV positive people and their friends and family. SABSA provides education and emotional support specific to the needs of those living with HIV and more specifically to the needs of the African-American community. However, everyone is welcome regardless of gender, race, sexual orientation, creed, religion or ethnic background. (502) 231-3871



AIDS Interfaith Ministries (AIM) of Louisville provides support services to individuals living with HIV/AIDS and their families. (502) 574-6085

Matthew 25 AIDS Services, Inc. located in Henderson is a Ryan White CARE Act Title II, Title III and CDC Prevention PA04064 Grantee. They are a provider of primary health care to PWHIV and LWA, in Daviess, Henderson, Union and Webster counties. Services include medical case management and referral, a buddy program, literature, spiritual support and referral, financial assistance and referral, a speakers' bureau, support groups (positive, family and friends), transportation and prevention education for the community and medical professionals. Matthew 25 also distributes HOPWA funds and does counseling and testing for HIV (blood and oral testing). (270) 826-0200 www.matthew25clinic.org

 **AIDS Volunteers, Inc. (AVOL)** located in Lexington, KY is a community-based organization that provides HIV and AIDS education, prevention initiatives, service programs and financial assistance to persons infected and affected by HIV disease in all of Central and Eastern Kentucky. Some of the services provided by AVOL include: a speakers' bureau, support groups, financial assistance, case management, transitional housing for those who are homeless and HIV+, a community residence for those in the end stages of AIDS, community outreach, condom distribution, educational programs and materials, and prevention activities. The agency employs 10 full-time staff members including an Executive Director, Volunteer/Community Outreach Coordinator, two Housing Program staff members, four HIV Prevention Specialists and a Director of Client Services who coordinates the Direct Client Services Program and the Chemical Dependency Assessment and Referral Program. Funding for AVOL comes from community donations, fund raisers and grants from private foundations, as well as local, state, and federal sources including HUD (HOPWA) and the United Way. Approximately 75-100 volunteers are consistently involved throughout the year for day to day operations, programs and services, volunteer caregivers and fundraising events. Program referrals and linkages are through the health departments, other volunteer organizations and HIV Care Coordinators. (859) 225-3000; Fax (859) 225-9244; www.AIDSVolunteers.org.

AIDS Volunteers of Northern Kentucky (AVNK), located in Florence, KY was founded in 1990. AVNK seeks to understand and address the emotional, educational, social, spiritual and physical needs of the people in Northern Kentucky and surrounding communities who are living with HIV/AIDS, and the needs of their families, partners, friends and caregivers. AVNK strives to inform the general community about HIV/AIDS related issues for purposes of education, mobilization, prevention and advocacy. AVNK provides a number of services including three support groups, a monthly dinner/social, healing weekends, respite care, emergency financial assistance, memorial services, outreach to minority communities, World AIDS Day services and Healing Weekends. (859) 331-4719

AIDS Volunteers of Cincinnati (AVOC) located in Cincinnati, OH is a community-based organization that provides a wide variety of services to individuals diagnosed with HIV/AIDS and to the broader community, especially high-risk populations where HIV exposure is more likely. Although AVOC primarily serves Cincinnati and southwest Ohio, they offer many of their services to individuals and groups in Northern Kentucky. These services include community outreach, prevention and education presentations, street outreach to women in underserved communities, testing and counseling services, an informational and referral hotline and a speaker's bureau. (513) 421-AIDS (2437).



The I.N.D.Y (I'm Not Dead Yet) Project founded in 1994 serves Northern Kentucky. INDY is an organization dedicated to the enhancement of life for individuals affected by HIV and AIDS by providing social outlet in a variety of environments and frameworks with one basic goal in mind: having fun! Members and sponsors attend and host picnics, movie nights, dinners, camping trips, art events and parties. The group is dedicated to the proposition that through the joy of celebrating life there is hope and healing, and celebration is best engaged through groups of like minded individuals. (513) 343-9999.

University of Cincinnati Hospital, Holmes Clinic located in Cincinnati, Ohio is the Infectious Disease Center for the University of Cincinnati Hospital. Holmes Clinic provides medical services to individuals diagnosed with HIV/AIDS and is funded primarily through Ryan White Title III funds. Holmes Clinic provides these services to individuals from several states, and a significant percentage of individuals diagnosed with HIV/AIDS and living in Northern Kentucky use Holmes Clinic for their infectious disease care. In addition, Holmes Clinic conducts partner testing for patients of the clinic. (513) 584-6977

The University of Cincinnati Emergency Room also has a grant to conduct HIV testing and counseling services with patients who are seen through the Emergency Room. This program targets high-risk individuals who receive their primary medical care through the Emergency Room. If an individual is diagnosed, a referral is made to Holmes Clinic. (513) 584-5700

Bluegrass Care Clinic (BCC), located in Lexington is a Ryan White CARE Act Title III grantee. The BCC provides both clinical and support services for HIV/AIDS patients and their affected families in 63 counties through Central and Eastern Kentucky. The BCC staff are trained to provide harm reduction information and counseling regarding drug use, sexual activity and other high risk activities for HIV transmission and infection. In addition, the BCC also provides pre/post test counseling and testing. (859) 323-5544; Fax: (859) 257-2040; www.mc.uky.edu/bluegrasscareclinic.

Moveable Feast (MFL) is a nutritional support program, serving people living with HIV disease and their dependent children living in the Lexington/Fayette County area. Clients receive social support and a hot, freshly cooked dinner five days a week. MFL can also serve as a referral source to other ASOs in the region. All services are completely free of charge. (859) 252-2867; www.feastlex.org.

Episcopal Diocese AIDS Ministry, located in Lexington, provides care and support through bi-annual social dinners. All meals and additional limited supportive services are provided free of charge. The Episcopal Diocese AIDS Ministry can also serve as a referral source/linkage for other ASOs in the region. Contact: Lisa – lisainky@adelphia.net.

The Salvation Army of Central Kentucky, located in Lexington, operates a free medical clinic. The medical clinic, operated by the University Kentucky's College of Medicine, provides exams and physical therapy, and HIV pre/post test counseling and testing. (859) 252-7706

 **Owensboro Area HIV/AIDS Task Force, Inc.** is a non-profit CBO funded by donations. This agency serves its clients with emergency financial assistance, transitional housing, and acts as an advocate with property owners, utility companies, Social Security, HOPWA and other community service agencies. Volunteers also provide community outreach services with HIV prevention and risk reduction programs to targeted populations and various communities, medical professionals and local organizations. The Task Force dispenses printed risk reduction



materials, condoms (male and female), dental dams, needle cleaning kits and crack pipe cleaning kits. The Task Force also goes into public sex environments (PSE) offering similar services, as well as HIV testing. Members of the Task Force are state certified pre and post-test counselors as well as certified to administer OraSure for HIV testing. Members are also certified to inspect potential housing for clients wishing to obtain HOPWA funding. The Task Force is a certified partner of the Balm in Gilead. A support group for PWHIV is in place. They act as a referral source to all the available assistance programs for clients. The Task Force has some HIV positive members who have made presentations at several high schools, a program describing the emotional, physical and financial stresses of being HIV positive. (270) 683-6018 www.owensboroaid.org

 **Heartland CARES, Inc.**, located in Paducah is a non-profit organization, serving people with HIV and AIDS in the Western Kentucky and Southern Illinois regions. The mission is to provide various components of care needed for persons living with HIV and AIDS regardless of ethnicity, gender, religious, beliefs, sexual orientation, or ability to pay, and to provide education and prevention to the general public to help stop the spread of HIV and STDs. Medical services are primarily supported through Ryan White Title III funding. The clinic also has numerous supporting services, which include Ryan White Title II Care Coordinator Program, HOPWA Grant Emergency Assistance, Supportive Housing Grant Assistance, SAMHSA-CSAT Grant, HOPWA SPNS and HOME Grant. Heartland CARES houses the Western Kentucky Prevention Team that is responsible for HIV/AIDS prevention in 42 counties. (270) 444-8183

 **Volunteers of America, Inc. (VOA)** in Louisville provides HIV prevention education, focus groups, and risk reduction workshops to drug users, men, women, and youth at risk. The prevention services offered include pre-test and post-test counseling, factual information about reducing HIV risk factors associated with drug use and sexual behavior, alcoholism and drug abuse assessments, and referrals to HIV related and non-related resources as needed or by request. VOA also provides an AIDS Housing Integration Project, which offers technical assistance to shelters, housing providers, and housing developers to help establish and implement new housing programs for homeless and low-income persons with HIV/AIDS. VOA also holds the HIV Services' contract, and provides case management services for PWHIV. This includes intake and assessment, goal setting, conflict resolution, crisis intervention, referral to community services, emergency financial assistance, linkage to rental and utility assistance, entry into support groups, mental health and substance abuse counseling. (502) 635-1361

The AIDS Project, located in Louisville, provides HIV prevention, education and testing services. Programs include staff led volunteer outreach teams that go to local bars, community fairs and special events. Services include condom distribution, counseling and testing, and referrals while practicing harm reduction techniques. (502) 608-0586

North Central AHEC/HETC: The mission of the North Central AHEC is to promote healthy communities through innovative partnerships. This is accomplished by providing educational support services to health professions students and health care providers, community health education and programs to encourage health professions as a career choice.

In order to address HIV prevention in Kentucky's growing Hispanic community, the Kentucky DPH has identified agencies providing other services to our Hispanic population and provided capacity building assistance to help these agencies provide HIV prevention activities including HIV antibody testing.



North Central AHEC/HETC collaborates with Area Health Education Centers across the state who recruit individuals from Hispanic communities, provide training, and utilize them to conduct HIV prevention activities in their communities. AHECs in Lexington (covering 5 counties) and Covington (covering 4 counties) currently conduct outreach in Hispanic communities, provide HIV testing, and conduct two community level intervention (Juntos and Promotores de Salud). A third AHEC in Louisville conducts similar activities with African-American communities.

North Central AHEC/HETC also collaborates with the Bluegrass Farmworker Health Center to provide additional outreach to migrant farm workers as well as testing.

The Lexington and Covington AHECs as well as the Bluegrass Farmworker Health Center have been extremely helpful in providing interpreters and assisting Hispanic clients receive services from other service providers who lack Spanish speaking employees.

Bluegrass Farmworker Health Center: Located in Lexington and Richmond, KY, the Bluegrass Farmworker Health Center (BFHC) serves a primarily migrant/ seasonal farmworker population among eight counties in Central Kentucky. The migrant health center's service area includes: Fayette, Scott, Bourbon, Clark, Madison, Garrard, Jessamine and Woodford counties. Spanish is the primary language of approximately 96% of the BFHC clients.

The BFHC strives to optimize clients' health outcomes by providing affordable, culturally appropriate primary and preventive health care in settings that embrace the Hispanic culture and language.

BFHC values: Client-centered care, client advocacy, excellent health care for clients, extensive client-centered referral and tracking system, optimal client outcomes, life long learning, fiscal responsibility, high degree of respect among staff members. The clinical and outreach staff are fluent in Spanish and English.

Through a partnership with the DPH HIV/AIDS Branch, BFHC counselors and educators work with farm workers on the work site and in residences as well as utilize referrals to the actual clinic for medical needs including HIV/AIDS.

Hazard Perry County Community Ministries is located in Hazard. Their purpose is to meet community needs through supportive services (outreach and case management), crisis aid, homeless shelter, transitional housing and childcare. (606) 436-0051

Harlan Countians for a Health Community located in Baxter, is a coalition of healthcare providers, consumers, and other interested agencies whose purpose is to improve healthcare in Harlan County. (606) 573-6115

Westlake Primary Care, located in Columbia, provides information and educational AIDS material, prevention kits with condoms, confidential testing and pre and post-test counseling. 270-384-4764

LESBIAN/GAY/BISEXUAL ORGANIZATIONS PROVIDING HIV PREVENTION SERVICES

Lesbian/Gay organizations: Include **GLSO**, **Lambda** on the University of Kentucky campus, **Pride Alliance** on the Eastern Kentucky University campus, **Common Ground** at the University of Louisville, **Diversity Coalition** at Western Kentucky University, **T-Unity** at Transylvania



University, **Alliance** at Murray State University, **ACE League** at Berea College, and **Unity** at the Northern Kentucky University. All provide educational interventions and support for at-risk populations, referrals, condom distribution and advocacy services. The service area includes primarily students, but is available for the community. The number of clients is not known at this time. Fiscal resources include institution funding and contributions. Program referrals and linkages are with local agencies, CBOs, and Care Coordinators.

FAMILY PLANNING CLINICS PROVIDING HIV PREVENTION SERVICES

Family Planning Clinics are offered through Health Departments throughout the state. These clinics provide counseling and condom distribution. Total number of clients served is not available at this time. Fiscal and personnel resources include state and local monies and paid staff. Clients are women of childbearing age and sexually active men. Program referral and linkages include specialists as necessary, local Counseling and Testing sites, and CBOs.

Planned Parenthood has existed in Kentucky for more than 64 years. Planned Parenthood provides services in a large portion of Kentucky. The Louisville office has 16 employees and an operating budget of approximately \$600,000. More than six thousand clients are seen annually in the Louisville office by either doctors, nurses, medical assistants or nurse practitioners. Services include distribution of condoms and prevention brochures, programs on AIDS 101 and Safer Sex and peer education for teens and youth. Planned Parenthood contracts with local health departments to provide free and confidential HIV testing for women by appointment. In addition, health department staff in Lexington provide onsite HIV testing at Planned Parenthood on a walk-in basis one day each week. Males have been referred to other agencies in the past, but the agency is increasing its focus on young men. Most clients served are females under age 19 through 39.

YOUTH SERVICES PROGRAMS PROVIDING HIV PREVENTION SERVICES

Department for Human Services/Juvenile Detention Louisville provides formal presentations, video-based programs and peer counseling/peer presentation programs. Approximately 75-80 programs are done annually with services provided to approximately 75-80 youths. The organization reports 136 individuals employed who are designated education providers. The population served is approximately 50% white, 50% black, under age 23, and has equal distribution between males and females.

Morehead State University's Delta Sigma Theta Sorority provides HIV/AIDS Prevention materials to students on campus through community outreach efforts and presentation. Main target are individuals who come from rural areas of Kentucky.

University of Kentucky's Multicultural Center provides HIV/AIDS Prevention materials to students through community outreach as well as collaboration with AIDS Volunteers, Inc and Lexington Fayette County Health Department to provide testing.

STATE PROGRAMS PROVIDING HIV PREVENTION SERVICES

DPH Targeted HIV Prevention Program is funded with state money and began in 1992 as a means of ensuring that those populations at highest risk of HIV infection were being served. The health departments were asked to identify areas of need and individuals not receiving



prevention interventions through CDC funded programs. The following five (5) local health departments, located throughout the state are eligible to receive funding under this program: Barren River District Health Department, Lexington-Fayette County Health Department, Louisville Metro Health Department, Northern Kentucky District Health Department, and Purchase Area District Health Department.

DPH Core Health Education Program provides basic HIV/AIDS information and materials through nearly every local health department in the state. Programs are provided to the general public, health care professionals, and to public and private schools.

Kentucky DPH Review/Approval of continuing education for health professionals mandated by state law: This program reviews and approves, rejects, or approves with recommendations, all courses that any individual, health care provider, health education provider, etc. wishes to provide Continuing Education Units to professionals. The program requires six content areas: epidemiology, transmission, medical treatment, legal, and appropriate attitudes and behaviors, to be included in each course offering.

DPH HIV Care Coordinator Program provides coordination of services for individuals living with HIV/AIDS. Prevention of transmission education, including safer sex and latex distribution is provided by the Care Coordinators.

Local Health Departments in each county provide on-site counseling and testing, condom distribution, and health care worker education. Off-site partner notification is also provided upon request or agreement from an infected person. Court ordered testing and court mandated risk reduction programs are provided. Many health departments (particularly those receiving Targeted HIV Prevention Program funds) employ health educators to provide street-outreach, one to one counseling, group and community outreach. Fiscal resources are federal, state and county funding. Counseling and testing is done by either social workers or nurses who have completed a certification program provided by the State. Program referrals and linkages include the Care Coordinator Program and local resources where available.

Maternal Child Health provides a variety of programs and services that include RTR and condom distribution, literature/brochure distribution, and prenatal 076 Protocol through local health departments. The HIV/AIDS Prevention Program Coordinator, in collaboration with the Adult and Child Health Branch participated in the Association of Maternal and Child Health Programs (AMCHP) Action learning Lab in September 2004. This program is composed of various disciplines from areas in the state who will come together to address perinatal HIV transmission in Kentucky. This team will focus on eliminating perinatal transmission through enhanced education of health care providers, general public and focus groups. This program consists of meetings that will run through 2006.

KENTUCKY GOVERNMENTAL DEPARTMENTS

Kentucky Department of Education (KDE): In 1990, the Kentucky Education Reform Act (KERA) was passed. KERA requires that local schools and districts determine the curricula used. The Program of Studies mandates the content to be taught at each grade level. Communicable diseases, communication strategies, peer pressure, decision-making, and abstinence are contained in the Program of Studies. KDE provides professional development and technical assistance on evidence-based curricula. Some of these programs are “Reducing the Risk” (RTR), “Making Proud Choices”, “Making A Difference” and “Postponing Sexual



Involvement” (PSI). KDE, DPH HIV/AIDS Branch, Kentucky Parent Teacher Association, State Substance Abuse Program and other prevention providers co-sponsor training programs for peers and other individuals who provide prevention education to individuals in and out of school and individuals in alternative living settings such as faith-based organizations and juvenile justice facilities. The number of individuals served is not available at present.

KDE also finances and coordinates the Kentucky AIDS Prevention Education Technical Review Committee. This committee is responsible for reviewing a variety of educational materials including curricula, reference books, magazines, and videos.

Kentucky Department of Mental Health/Mental Retardation (Division of substance Abuse): Provides drug prevention education in schools throughout Kentucky. Also provides funding to treatment facilities.

CORRECTIONS/PUBLIC SAFETY PROVIDING HIV PREVENTION SERVICES

Jefferson County Corrections includes four county facilities housing offenders who have committed crimes. Their programs also include drug rehabilitation. Services include individual or group counseling, distribution of prevention brochures, free and confidential counseling services. The annual budget and number of employees are unknown at this time; however, their staff does include licensed counselors, physicians, and nurses. Client profile is 20% white, 80% African-American, 90% male, and 10% female. Ages among this population range from 18 to over 66.

Lexington-Fayette County Detention Center includes a recently built facility to house inmates. HIV counseling and testing is made available on site weekly, in close coordination with the Lexington-Fayette County Health Department

Life Line Recovery is a drug/alcohol rehabilitation program for incarcerated men in Louisville. Services include distribution of prevention brochures, group counseling, and educational programs in safer drug use, AIDS 101, and safer sex. Clients are over 18 and are equally divided between males and females, African-Americans, and whites. Size of budget and staff are unknown, but the staff sees an average of 50 men a month.

Federal Medical Center, Lexington provides medical treatment and educational programs to staff and inmates. Size of budget and personnel levels are unavailable at this time. Funding sources include government sources and inmate fund-raising activities. Program referrals and linkages include the University of Kentucky Medical Center, CBOs, and the ARC. The Lexington-Fayette County Health Department provides counseling and testing by request at the facility.

RELIGIOUS ORGANIZATIONS PROVIDING HIV PREVENTION/SERVICES

Religious Organizations known to actively support prevention efforts and support services in the Lexington community include the **Metropolitan Community Church, Integrity** (Episcopal), **Dignity** (Catholic), **More Light** (Presbyterian), AIDS-friendly parishes and **HIV/AIDS Ministry Team** (Catholic diocesan effort), and **Unitarian-Universalist Church**. Number of clients served is not available at this time, but their client base is their membership. There is much variety in funding sources, personnel resources and program referrals/linkages.



SECTION
3b
ASSESSMENT

GAP ANALYSIS

The dedication of a number of key individuals has ensured that HIV prevention takes place with much more effectiveness and frequency than it would without the consistent and positive efforts these individuals put forward. That said, there are numerous serious gaps that remain that are of concern.

More effective implementation of the contracts has brought to the forefront increasingly accurate assessments of what is being completed effectively in Kentucky, given the limited amount of available funding and that some areas are less effective in practice than on paper. This assessment highlights the continued need for documented accountability and for more specific targeting of at-risk populations than has been required in the past. Recent and long-term epidemiological data support these recommendations.

The DPH will provide KHPAC with an annual report on the summary of interventions carried out for that year. With the legislative change in 2004, making it a law for HIV reporting by name, HIV data will be available in 2007. The CDC has projected full implementation of the Program Evaluation Monitoring System (PEMS) for Fall 2006, which will provide more accurate intervention data.

A crucial gap in prevention efforts statewide are those targeted toward transgender communities. While epidemiological data indicates that transgender people do not comprise a large portion of those who are HIV+ in Kentucky at this time, the number of HIV+ transpeople statewide and nationally is increasing significantly. This conclusion is supported both by anecdotal evidence from Kentucky HIV care and service providers and by research being done throughout the U.S., and makes transgender-specific prevention efforts imperative. Given the difficulty many transpeople have in obtaining legitimate employment with reasonable compensation and health insurance coverage, the incidence of sex work for money and the use of non-prescribed/non-monitored hormones and silicone injected with shared needles increases this population's HIV risk dramatically. However, there are currently no CDC-promulgated DEBIs that address transgender identity and experience, and there is very little training available to educate HIV prevention professionals and care providers about them. This failure to recognize the unique aspects of transgender life creates significant barriers for those who do prevention outreach, but could be remedied in large part through the education of providers and the development of appropriate intervention strategies.

Another crucial gap in prevention efforts, is the lack of recognition of the indirect effect of substance use on the spread of HIV infection. The risk for HIV associated with substance use involves more than the sharing of IDU paraphernalia. Substance use (i.e., methamphetamine, alcohol, ecstasy, etc.) is, in fact, a major factor for the spread of HIV infection and other sexually transmitted diseases. Substance abusers have increased lower inhibitions and, often times engage in sexual relations with multiple partners. There are also those substance abusers who



trade sex for drugs, and consequently may find it hard to place limitations on what they will and will not do. Drug use can reduce a person's commitment to use condoms and practice safer sex. Currently there are no prevention programs that target substance use apart from intravenous drug users.

EASTERN AND NORTHERN REGIONS

Due to staffing limitations and funding, HIV prevention outreach for all targeted populations in the Eastern region of Kentucky is still not enough to effectively cover the 72 counties this region covers. Travel in this region and the limited funding for such makes it difficult to effectively reach all areas of the Eastern region.

The DPH has tried to identify and provide capacity building to the Eastern Kentucky region, and has made an impact through local churches and countywide fairs, but there is still a need for increased outreach in the more rural areas of the region.

General STD awareness and HIV prevention is not provided adequately in the Lexington-Fayette Urban County public schools. There is no long-term project currently targeting youth under the age of 21 with HIV prevention education and risk reduction information.

The IDU population is still not being effectively reached, particularly outside of Lexington-Fayette County, where outreach to IDU is extremely difficult. Within Lexington-Fayette County, some collaborations have been made with local drug treatment centers, but there are still many centers and agencies who choose not to participate.

The transgender population is not included in the list of prioritized populations due to lack of data, nor are there any approved DEBIs for this population. This makes it difficult to perform outreach with this high-risk population, since their needs are unique and do not fit appropriately with those of any other prioritized population.

NORTH CENTRAL REGION

Prevention efforts in the Metro Louisville area should be better coordinated. Service providers should strive to avoid duplication of services/efforts. More collaborative efforts among all HIV service providers should be facilitated.

The loss of three-quarters of the region's minority Community Based Organizations (CBOs) has resulted in a significant gap in reaching communities of color. (There were only four minority CBOs serving the region's seven counties prior to this loss, though the region's HIV+ population is disproportionately comprised of people of color).

There is a major gap in reaching transgender communities, youth 25 and under and adults 50 and older.

High Risk Heterosexual (HRH) HIV cases are increasing, in part, due to (1) the lack of HIV testing before, during, and upon release from incarceration, (2) the exchange of sex for money or drugs, and (3) bisexual activity. There is a gap in targeted prevention efforts in these areas.



Prevention monies spent on the HIV+ population, the number 1 prioritized population, need to be focused on providing strategies for HIV+ individuals to live healthy lives, protecting the general public and the long term health of HIV+ individuals.

WESTERN REGION

The rate of HIV infection in Western Kentucky has shown that prevention efforts are in place but the need continues to grow. HIV+, MSM, HRH (primarily minority populations), IDU, MSM/IDU are those populations at greatest need in Western Kentucky.

Gaps in HIV education and prevention can be seen in the lack of consistent HIV education in high schools, the lack of prevention efforts in corrections facilities or the work place and the lack of HIV education for the general population. The ruralness and the large travel region (42 counties) of Western Kentucky complicates the efforts to provide widespread education and the reduction of stigmatization of the disease.

Other gaps identified in the Western region are the lack of consistent mental health services and substance abuse programs which outline the need to target non IDU drug users.

FUNDING AND ACCOUNTABILITY

The most important factor KHPAC has taken into consideration is that sizable efforts be taken with the limited amount of funding available to reach the most individuals at risk for contracting HIV with evidence-based harm reduction interventions. In the past, we have been unable to document that such interventions are occurring with any sustained approach. The evaluation of DEBI interventions (to be conducted at the end of 2006) which have targeted all at risk population will provide further information regarding the effectiveness of prevention interventions. The importance of the most cost-effective use of funding of the grant cannot be overemphasized.

It is crucial to prioritize interventions for HIV positive individuals. Programs utilizing HIV positive persons in the delivery of prevention services are lacking statewide. Lack of funding has seriously hampered the implementation of prevention case management for persons living with HIV. HIV + people across all risk categories are underserved. The best interventions for people living with HIV are peer education programs that use harm reduction.

An increased proportion of individuals reached through interventions have been designated to be HIV + within all target populations.

COUNSELING AND TESTING

A 2000-2001 evaluation of counseling and testing programs indicate that support staff at testing sites, at all levels, do not have adequate training in testing protocols, confidentiality, anonymity, client privacy and potentially awkward situations in a manner that promotes a successful program. Recommendations resulting from that evaluation and responses and goals to achieve those recommendations are listed below.

1. Site administrators and directors should raise HIV CTRPN to a higher priority, and should do so by hiring adequate numbers of staff, ensuring that anonymous and



confidential testing procedures are appropriately explained, and defining a clear policy which assesses client needs and protects confidentiality and anonymity.¹

- This may be a reality in some areas of the state. The local health departments across Kentucky receive block grants from the State Health Department that are used to meet prioritized needs. Funds are allocated based on the highest prioritized need in that county. HIV may not rank very high in a given county and would receive less funding. David Raines will identify the health departments with the highest traffic related to STDs and the DPH will offer counseling and testing update and sensitivity training in these areas. Training can be offered but cannot be mandated.
2. Advertising and community outreach should be increased to raise awareness and utilization of HIV counseling and testing sites in Kentucky.
 - Press releases will be done four to five times a year highlighting prevention activities. The DPH has established a link on the DPH website to add prevention and CTS information. All Health Departments have access to the state training calendar (www.KY.TRAIN.org). The counseling and testing training has been approved by TRAIN for CEU's. Tom Collins works very closely with Debbie Bohannon to make sure trainings are listed on the training website.
 3. Counselors' training should be modified so that counselors receive training on HIV CTRPN goals, prevention and behavior change counseling including the discussion of risk factors and development of risk-reduction plans, discussion of homosexuality and more specifics of risk behaviors, and how to counsel an HIV positive client.
 - The HIV/AIDS Branch used the CDC sponsored curriculum "Fundamental of HIV Prevention Counseling" as the foundation of the required training that all local health department nurses must complete before providing counseling and testing services. This curriculum addresses all the above mentioned subjects. Tom Collins completed the CDC course on the fundamentals of HIV counseling and testing in 2002. Beverly Mitchell completed the course in July 2005. Tom has trained numerous health department and CBO staff on counseling and testing and OraSure since he became certified in addition to the quarterly trainings conducted by David Raines. Update training will be offered to all counseling and testing sites, but the DPH cannot force staff to receive update training.
 4. Continued counselor and site coordinator training should be required on a regular basis.
 - The DPH can offer training but it is not required by law, a change in legislation would have to take place for it to be mandatory.
 5. Support staff should receive training on handling phone inquiries, the difference between anonymous and confidential testing, and ways of insuring privacy on the phone and at check-in.

¹ Zimmerman R. et al. Evaluation of HIV Counseling, Testing, Referral, and Partner Notification Services of the Kentucky Department for Public Health. HIV Prevention Research Program, University of Kentucky, 2001.



- The DPH will research videos that are available on sensitivity training, and if needed, develop a video to use with recommendations that staff receive updated training every five years. The DPH will also offer the two day counseling and testing training to all new counselors.
6. A site coordinator should be designated for each HIV CTRPN program.
 - All nurses working at local health departments are required to receive counseling training. HIV testing in rural areas does not occur often at the health departments, as the nurses have numerous other responsibilities. With low numbers of clients coming in for testing in these areas, it is not possible to achieve this at this time with the staffing and funding that is available.
 7. A regional coordinator should be appointed for each region.
 - As stated previously, this is not practical or possible in every region based on available resources and current responsibilities.
 8. The state should consider consolidating HIV counseling and testing services so a smaller number of sites will have truly sufficient resources and staff to be adequately trained, more experienced, and comfortable on a regular basis with protocols and sensitive issues.
 - It is state mandated that every county in Kentucky will have a counseling and testing site at each local health department. It would require a regulation change to incorporate this. The latest recommendations from CDC are that all people be tested. It is not practical to require persons to travel a long distance to be tested if testing is not available in their area. This would create a barrier for testing. Rather than consolidate sites, the DPH will offer more update training to staff in rural areas.
 9. An internal monitoring system should be developed. This would include regular feedback concerning the extent to which CDC protocol and guidelines are being met.
 - An objective listed under PCRS is to conduct regular site visits.
 10. OraSure and OraQuick testing should become available statewide. Health departments and districts need to have funding available or should be encouraged to seek outside funding to provide OraSure and OraQuick testing kits and training.

OraSure is not the appropriate testing method in local health departments. OraSure testing was intended to be used in outreach settings to reach people that may not come to their local health department. We encourage blood draws to screen for other STDs in a clinical setting. Ora-Quick or another form of rapid testing could be used to increase the number of people actually learning their serostatus, but it may decrease testing for other STDs requiring a blood-draw.

CONTRACTS & EFFICACY OF INTERVENTIONS

Training was conducted in 2005 with Prevention Specialists on DEBI implementation. Prevention Coordinators conduct periodic site visits to ensure the core elements of DEBIs are



being completed. A full evaluation of the effectiveness of DEBIs will be conducted at the end of 2006.

CULTURALLY SPECIFIC INTERVENTIONS

Culturally appropriate interventions in CDC defined risk populations are inappropriate for youth, rural communities, transgendered people and injecting drug users. Meaningful prevention efforts in rural areas and among youth remain largely non-existent. State law prohibits access to sterile injection equipment. Relying on education about cleaning syringes with bleach and the distribution of syringe cleaning kits gives a false sense of security to the IDU community and inadequately addresses the very real prevention needs.

There is a need for targeted funding for culturally specific outreach in storefront facilities, that is, facilities and settings removed from health departments and other government buildings. Such storefront settings, we believe, would facilitate community building in CDC defined at-risk individuals.

REDRAWING THE REGIONAL BOUNDARIES OF HIV PREVENTION CONTRACTS

Kentucky is divided into three geographic regions: Eastern, North Central and Western. We believe the sheer enormity in size of the Eastern and Western regions is a barrier for effective prevention work. The Eastern region consists of 72 counties; the Western region consists of 42 counties. We believe it is imperative that the DPH study the possibility of dividing the state into more than three regions. Creating smaller regions would entice smaller CBOs, especially in the rural regions of the state, to vie for and be awarded prevention contracts with the state.

CAPACITY BUILDING

The lack of funding to non-governmental contracted CBO's does not allow for capacity building. Efforts have been made to identify and fund potential new CBOs in underserved areas, however they do not exist.

SYNOPSIS

1. Capacity building needs to be encouraged and funded to non-government contracted CBOs for geographic underserved areas of the state and within areas currently dependent on CBOs unable or unwilling to embrace harm reduction strategies.
2. While the epidemic continues to extend throughout all geographic areas of the state, prevention funding does not allow for consistent outreach efforts, especially in rural areas.
3. The ability to test for HIV in the general population continues to improve. Complete HIV epidemiology does not exist due to recent legislation providing for named reporting. The numbers of AIDS reported remains statistically the same.
4. New generations of GLBT populations are informed on the issues, however continued education remains a priority.



5. Partners of individuals in risk groups, transgendered people and neo-natal at risk remains underserved.
6. High risk populations in incarcerated, Hispanic and rural populations remain underserved or highly underserved. Racial disparity persists in access to services.
7. Access to sterile injection equipment remains limited due to state law.
8. While remaining committed to harm reduction, secondary prevention efforts in most cases remain insufficient.
9. Continued support for state conferences on HIV/AIDS and the African American and Hispanic Leadership conference is indicated.
10. Volunteers are not mobilized in significant numbers and community building is extremely limited.
11. The state and the recipients of HIV prevention contracts remain pro-active in seeking to resolve the gaps.
12. Collaboration between DPH and the Department for Education would assist in the inclusion of HIV education in individual school district curriculum.

CONCLUSION

Except for in a few metropolitan areas, prevention efforts across the state are hit and miss. A consistent, sustained plan which includes collaboration with other agencies, community development, and harm reduction interventions reaching individuals in CDC defined risk categories that can be fully documented is sorely lacking.

There is a lack of linkages between the HIV/AIDS Branch and other agencies that have HIV prevention resources, including the KY Department of Education, mental health programs, substance abuse programs, family services, correction facilities, and the STD and TB programs.

A lack of linkages between the HIV/AIDS Program and the STD Program adversely impacts prevention efforts statewide. The new PEMS system will help identify information for the HIV/AIDS and STD programs. The DPH will document linkages with other government agencies and where prevention efforts are lacking, they will make every effort to resolve those issues.



SECTION
3c
ASSESSMENT

Prevention Among HIV+ Kentuckians: Interviews with Care Coordinators and Medical Staff

Jeff A. Jones, Ph.D., Alisa Bowersock, MPH, and Tina Webb, MPH
University of Kentucky Center for Prevention Research, Kentucky School of Public Health
July 2003

I. Overview

The Health Resources and Services Administration (HRSA), a branch of the U.S. Department of Health and Human Services, administers the key federal programs funding both HIV prevention efforts and care for HIV+ people living in the United States. In recent years HRSA has placed considerable focus upon getting HIV+ Americans into the care system and increasing an emphasis on prevention involving individuals who are already infected with HIV.

Funded by the Lexington-Fayette Urban County Health Department, this study examines current models and practices in prevention case management among the numerous agencies that provide care to HIV+ Kentuckians. We interviewed individuals ranging in care roles from HIV/AIDS education specialists to infectious disease physicians. These care workers interact with HIV+ clients at different points in their flow through the care system and thus have both direct, daily contact with clients and interactions within multiple and different contexts.

The overall findings are that the care providers working with HIV+ clients largely feel adequately trained to do prevention management with positive clients even while they would welcome additional training in areas such as mental health and prescriptions' effects on clients' emotional states. Most providers already perform some type of questioning and probing with clients about risky behaviors. Such questioning, however, often is haphazard with providers holding off on such discussions until they have built a rapport and level of trust with clients. There is no model employed with prevention efforts with HIV+. Instead, individual providers rely upon their own experiences with clients in guiding their approach to sensitive confrontations over risky behavior. Unlike neighboring Indiana, Kentucky law and higher prior mandates to provide client care leave many care providers with few tools for enforcing safer behaviors or compelling disclosure of risky behavior by a client. Indeed, most providers feel more heavy-handed and confrontational styles of addressing clients' behavior ultimately alienate clients and are counter-productive. Providers instead focus on positive reinforcement and education.

Most providers interviewed for this study could readily categorize their clients into High, Elevated, and Average risk groups based on their perceived likelihood to be engaged in risky behaviors. While the Kentucky HIV/AIDS Care Coordinator Program is currently looking into adopting a uniform risk assessment screen with clients, there currently is no standard procedure for regularly assessing clients' risks. The current system of referring clients engaged in high risk behavior to a specially trained prevention case manager also relies largely upon a client self-disclosing risky behavior or a client's behavior making a provider suspicious. With many clients have infrequent contact with their care coordinator and individual providers having increasingly



larger client caseloads, the one-on-one rapport and tracking of clients often is an unrealized ideal among providers.

This report summarizes the practices and challenges reported by care providers. It ends with recommendations for an inter-agency, four-part, repetitive model for integrating prevention case management among HIV+ Kentuckians into current care practices.

II. Methodology

This study relies primarily upon two sources: prior research into HIV in Kentucky and a series of qualitative interviews with twenty-nine care providers. These care providers work in ten different areas of Kentucky and often have clients from large, multi-county territories if they serve a rural population. They come from both urban and rural areas and include individuals employed as:

- Agency administrators
- Care coordinators
- Family practice physicians with a number of rural HIV+ patient
- Infectious disease physicians
- Nurses
- Physician assistants
- Prevention case managers
- Health educators

Interviews with providers lasted between twenty minutes and an hour and included both telephone and in-person interviews. The various providers have worked in HIV/AIDS prevention, education, or client services anywhere from two years to over a decade depending upon the individual provider. The educational backgrounds of interviewees largely fall into two categories: social service providers with backgrounds in social work and healthcare workers with degrees in medicine, nursing, or a related medical field. One interviewee has a background in education and does not work directly with HIV+ clients. This interviewee instead works with teachers, principals, and school staff around issues of HIV/AIDS education and policy.

III. The Challenge of AIDS in Kentucky

Various previous research efforts contribute to the contextualization of this disease in various parts of the Commonwealth. Because of its initial appearance in Kentucky among men who have sex with men, AIDS continues to carry the stereotype that it is a disease of 'gay disease' or at the very least one stigmatized as linked to promiscuity, substance abuse, and/or prostitution. These perceptions continue to make Kentuckians fearful of seeking testing, disclosing a HIV+ status, or even being seen entering a small town Title II clinic. Briefly, here are various perspectives on HIV/AIDS in Kentucky drawing upon epidemiological, risk behavior, perception, and historical studies to provide a larger context for HIV/AIDS in Kentucky:

Numbers of AIDS Cases, December 31, 2002:

AIDS* cases, both living and deceased:	3,867
Kentuckians currently living with AIDS*:	2,061
Kentuckians diagnosed with AIDS* in 2002:	184

*Because of reporting problems with the unique identifier system used for HIV case reporting, Kentucky currently only reports cases of full-blown AIDS and not the number of individuals who are HIV+ but who have not been diagnosed with AIDS. Source: Kentucky HIV/AIDS Semi-Annual Report, December 31, 2002, Kentucky Department for Public Health.



Demographics of Kentuckians Diagnosed with Full-Blown AIDS, December 31, 2002

Source: Kentucky HIV/AIDS Semi-Annual Report, December 31, 2002, Kentucky Department for Public Health

Sex: 87% male, 13% female

Race: 68% white/European-American, 29% black/African-American, 2% other

Age at Diagnosis:

13 to 19:	1%
20 to 29:	18%
30 to 39:	47%
40 to 49:	25%
Over 49:	9%

Mode of Transmission:

MSM*:	56%
IDU**:	13%
Heterosexual:	11%
undetermined:	11%
MSM & IDU:	6%
Hemophilia:	2%
Transfusion:	1%

HIV and Kentucky's Teens

Source: Kentucky Youth Risk Behavior Survey, 1997, 1999, 2001. Kentucky Department of Education

The Youth Risk Behavior Survey only surveys students in typical public high schools. Private schools, alternative schools, teens that have dropped out of school, and adjudicated youth are not surveyed. The 1997 data is weighted. The 1999 and 2001 data are unweighted. The 2003 numbers will be weighted but are not yet available.

% of Teens Who Report Having Received Education about HIV/AIDS:

1997:	88
1999:	88
2001:	87

% of Teens Who Have Had Sexual Intercourse:

1997:	54
1999:	55
2001:	53

% of Teens Who Have Had Intercourse with Four or More Partners:

1997:	18
1999:	17
2001:	17

% of Teens Who Have Had Intercourse in the Three Months Prior to Being Surveyed:

1997:	39
1999:	36
2001:	42

% of Sexually Active Teens Who Used A Condom the Last Time They Had Intercourse:

1997:	57
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1999:	60
2001:	56

Number of Pediatric and Adolescent AIDS Cases in Kentucky

Aged Birth to 12 at Time of Diagnosis:	28
Aged 13 to 19 at Time of Diagnosis:	29

Source: Kentucky HIV/AIDS Semi-Annual Report, December 31, 2002, Kentucky Department for Public Health

HIV/AIDS and School Policies in Kentucky

Source: Kentucky School Health Education Profiles, 2002, Kentucky Department of Education

The School Health Education Profiles surveys principals and lead health teachers in all of Kentucky typical (non-alternative) public middle and high schools.

% of Schools With Written HIV/AIDS Policy:	32
% of Schools Teaching Abstinence As Most Effective Method to Avoid HIV Infection:	97
% of Schools Teaching How to Effectively Use A Condom:	42
% of Schools Teaching Where to Get Valid Information on HIV and HIV Services:	81
Where Required HIV Components Are Taught:	
Science class	33
Physical education (PE) class	33
Home economics or consumer science	43
Life skills or family education class	56
Special education classes	27

Adult Kentuckians Views on HIV/AIDS

Source: Behavior Risk Factor Surveillance Survey, 2000, US Centers for Disease Control and Prevention

% of Adult Kentuckians Who Believe They Have No Risk of Becoming Infected with HIV:	70
% of Adult Kentuckians Tested for HIV Who Did Not Receive Results:	18
% of Adult Kentuckians Who Were Tested for HIV But Who Did Not Receive Counseling Regarding Results:	68
% of Adult Kentuckians Reporting They Have Been Tested For HIV Other Than When Donating Blood:	40
% of Adult Kentuckians Reporting They Have Been Tested for HIV in the Last 12 Months Other Than When Donating Blood:	37



When Adult Kentuckians Believe HIV Education for Children

Should Begin:

Never:	2%
Kindergarten	8%
Elementary School:	74%
Middle School:	12%
High School:	4%

% of Adult Kentuckians Who Would Urge Their Teen to Use
a Condom Upon Discovering the Teen is Sexually Active: 88

A Historical Overview: AIDS in Lexington

With the author's permission, the following excerpt from the appendices of **Hidden Histories, Proud Communities: Multiple Narratives in the Queer Geographies of Lexington, Kentucky, 1930-1999** and provides a historic backdrop to AIDS and how one Kentucky community responded to the pandemic. It illustrates the initial fear around the disease and the changing attitudes of public and private funding towards the disease. Because of the disease's initial impact upon men having sex with men, HIV/AIDS has become a significant aspect of the modern history of gay and lesbian Kentuckians. Please note that the author uses the word *queer* not in its pejorative meaning but as a collective term for lesbians, gay men, bisexuals, transgendered individuals, and other sexual variants. This use is in line with various feminist, social theory, and queer theory writings upon which the author's work draws.

The AIDS pandemic has shaped Lexington's queer (and especially queer male) communities since the early 1980s. While the Centers for Disease Control issued its first warnings in 1981 about the disease that today we know as AIDS, the first mention of the disease locally was in the February 1982 GSO Newsletter:

"Some recent articles in the New England Journal of Medicine and elsewhere have discussed new evidence of the apparent link between certain cancers (Kaposi's sarcoma) and opportunistic infections and homosexuality."

This article ponders whether the use of poppers and other inhalants in the gay male bar culture was affecting queer men's immune systems. That same year the first case of AIDS will be identified in Kentucky.

Three years later the Lexington Herald-Leader is reporting that Kentucky has had 20 diagnosed cases of AIDS and that 15 of these early victims have died. While one newspaper article describes the late Eric Wolken, an early AVOL [AIDS Volunteers of Lexington] activist, as the first Lexingtonian to go public with his HIV status, a 1986 article describes the progressing illnesses of Bob Torrey and his partner Joe Santana and is the earliest public record of an out HIV+ Lexingtonian. By February 1985 the newspaper is also reporting that local blood supplies will begin to be tested with the new HIV antibody test. By this time the fourth person to die of AIDS has passed away in a local Lexington hospital. By August of that year Dr. David Ammerman, the medical director of the Lexington-Fayette County Health Department, is stating that the public position of the Health Department is that the HIV test cannot predict who will get AIDS



and thus they discourage people from taking it. He also reports he is frustrated that local gay men are reluctant to change to condom use and safer sex techniques.

The fear of AIDS and the backlash against queer people begins to show itself in Lexington around this time. In 1986 at the height of the AIDS panic the US Supreme Court rules in Bowers v. Hardwick that states can criminalize private consensual sodomy in a decision that only discusses same-sex sodomy. The Georgia law in question covered both mixed-sex and same-sex sodomy. In Lexington by 1986-1987 a number of local queer bars and organizations are closing (Brezings, Café LMNOP, Amber Moon, the Circus, etc.) Police sting operations to entrap queer men under Kentucky's sodomy law have led in 1986 to the arrest of Jeffrey Wasson. When GLSO sought funding from the United Way of the Bluegrass in 1986 in part to provide HIV/AIDS prevention services, the United Way turned the group down and made a public point of saying that GLSO was a one issue advocacy group that was too controversial to fund. Nationally, Delta Airlines' lawyers argued in 1986 that a queer crash victim's life was worth less than fellow heterosexual passengers' lives because the queer man might have had AIDS. Interviewees [Note: 106 individuals were interviewed for this historical study.] say that anyone learning they were HIV+ kept the news very quiet due to the stigma and discrimination people living with AIDS faced. Interviewees recall these Reagan years as a time of fear and despair that slammed a door on the far more tolerant and open years of the late 1970s.

Lexington's queer communities did respond to the disease. In a 1985 newspaper article Steve Abrams, then president of GLSO [Gay and Lesbian Services Organization] and student leader of GALUS [a University of Kentucky gay and lesbian student group], described the Lexington queer communities as disorganized and unprepared to handle the magnitude of need being generated by AIDS. Later in that year, however, the Imperial Court under Emperor Greg Lee and Empress Renee Alexander (Ron Bradley) began raising thousands of dollars to help support the founding of Louisville-based Community Health Trust. By 1986 Lee was also the first HIV/AIDS coordinator at the Fayette County Health Department. The Episcopal Church also was one of the first local groups to respond by offering some care to people living with AIDS through what would become the Episcopal Diocese AIDS Ministry. Public funds were slow to materialize. In 1986 the Reagan administration issued a statement that treatment for people with AIDS was not a federal concern but one for the states. Combined with the refusal of public funding groups like the United Way to help prevent the disease's spread among queer communities, the angry invigoration of 1987's March on Washington, and the subsequent founding of ACT-UP (AIDS Coalition to Unleash Power) in New York City, a local grassroots response picked up steam. The Imperial Court continued to help through fundraising in the queer community. By 1988 AVOL had formed under the auspices of GLSO as a charitable prevention and later service organization dealing exclusively with HIV/AIDS. That same year the US Congress banned discrimination against people with AIDS. In large part through the lobbying efforts of strait Kentucky AIDS activist Belinda Mason and her father, state representative Paul Mason, the Kentucky General Assembly passed the 1990 AIDS Omnibus Law establishing the HIV/AIDS care coordinator program statewide and requiring training of health workers about the disease.

Combined with a conservative backlash against greater queer visibility in the 1970s that AIDS only augmented through images of diseased queer pariahs, this disease had a huge impact on queer communities locally. While the disease primarily infected queer



men, both lesbians and gay men became stigmatized. The despair, fear, and death of many out gay men and the resulting losses in community at least contributed to if not altogether caused the mid-1980s' closure of a number of local community organizations and queer bars. Nearly a decade after feminism had politicized lesbians, AIDS had politicized queer men by the late 1980s and set the stage for alliances across gender lines towards common queer political and social aims. AIDS also led to a greater public rejection of the free love ideals of the 1970s' sexual revolution for ones of assimilation, monogamy, and the replication among queers of values around marriage and family. Organizing to combat AIDS also led to the creation of a number of local groups such as AVOL and Ebony Male. Source: Hidden Histories, Proud Communities: Multiple Narratives in the Queer Geographies of Lexington, Kentucky, 1930-1999, Jeff Jones, Lexington, KY: University of Kentucky dissertation

Care providers interviewed for this study of prevention among HIV+ Kentuckians also repeatedly allude to the changing nature of HIV/AIDS care. Several point out that when initial federal funding was made available in the early 1990s, the average HIV+ Kentuckian lived for about two years. Care often centered on making a client comfortable. Prescriptions of narcotics for pain were sometimes used to provide comfort in the later stages of the disease. A surplus in funds also allowed agencies to provide housing and utility assistance.

Today, however, new classes of medicines have greatly extended the life spans and level of health of clients. HIV+ Kentuckians are living longer and new clients continue to enter the system without significant increases in federal or state funding. The new drugs also are often expensive. The result has necessitated the removal of supplementary services such as housing and utility payments so that these funds can be directed towards covering prescription costs. Care providers report that a number of clients who were diagnosed in the 1980s or early 1990s sometimes are resentful of having agencies that no longer can provide both additional services and more one-on-one attention from staff that now have larger caseloads to manage.

The Impact of Risky Behavior by HIV+ Kentuckians

Gauging the impact of risk behavior by HIV+ Kentuckians is difficult to measure in many ways. Certainly every newly diagnosed HIV+ client in the state contracted the virus from another HIV+ person or a body fluid produced by a HIV+ person. While in many cases the initial carrier of the virus is unaware of his or her status, there are also disturbing evidence of HIV+ Kentuckians who knowingly engage in risky behaviors that endanger both themselves through secondary infections with other types of HIV or other sexually transmitted diseases and pose risks of infecting others.

For instance, a quick search of the Internet using a search engine finds sites such as www.barebackcity.com and www.bareback.com that feature personal ads by HIV+ Kentucky men seeking to have oral and anal sex with others without using a condom. In a survey of clients in the Kentucky HIV/AIDS Care Coordinator Program, the 2002 Kentucky HIV/AIDS Needs Assessment also found that a significant number of respondents had engaged in risky behavior in the last year:

Risk Behaviors

NM= not in a monogamous relationship

M= in a monogamous relationship

Behavior

Lifetime

Past Year



Injecting illegal or non-prescription drugs	20%	3%
Unprotected vaginal intercourse (NM)	24%	4%
Unprotected vaginal intercourse (M)	26%	8%
Unprotected anal sex (NM)	47%	15%
Unprotected anal sex (M)	40%	16%
Unprotected oral sex (NM)	49%	20%
Unprotected oral sex (M)	46%	23%
Shared syringe	15%	2%
Had sex while drunk or high	56%	20%
Had sex with a man and woman at same time	17%	3%

These numbers only reflect individuals who chose to return the survey. These numbers are thus not weighted. Individuals who report becoming infected by injecting drugs were especially underrepresented in responses. Still, around one in four clients report some type of risky behavior in the last year.

The high cost of phenotyping and genotyping HIV has largely deterred screening HIV+ Kentuckians for co-infections with other strains of HIV-1 or HIV-2. AIDS cases in the United States are predominately multiple strains of HIV-1, which appears to be more virulent, more infectious, and likely to have been entered humans originally through consumption of primate meats in central Africa. HIV-2 was not detected in the United States until 1987 and appears to be a related virus to HIV-1. HIV-2, however, is generally less virulent, less infectious initially, and likely to have passed into humans from the sooty mangabey rather than through chimpanzees. HIV-2 is found primarily in western Africa. Five known cases of HIV-2 exist in Kentucky, and the treatments for HIV-1 do not appear to work effectively against HIV-2. The risk now exists of HIV+ Kentuckians not only becoming infected with different strains of HIV-1 but also with HIV-2. The prevalence of such co-infections is not currently known. Interviewees, however, do believe the majority of their clients have also contracted gonorrhea, syphilis (especially in Louisville), or genital warts (especially common among HIV+ Kentucky women).

The overall challenges are clear:

- Most Kentuckians do not believe they are at risk for contracting HIV.
- A significant minority of HIV+ Kentuckians report risky behaviors such as unprotected sex, sharing needles, and abusing substances before sex.
- While various existing drugs combat the multiple strains of HIV-1, the advent now of HIV-2 in Kentucky raises the specter of an entirely new viral infection requiring expensive genotyping and different drug strategies.
- Caseloads for care providers continue to rise while funding is not keeping pace with increases in clients.

IV. Existing Practices

Every care provider interviewed for this study who works with HIV+ clients reports conscientious attempts to educate clients about risks of co-infections and unsafe behaviors. All talked about the need for building a rapport with clients to establish a level of trust and openness. Most approaches consist of positive reinforcement of healthy living decisions and referrals to other agencies for therapy dealing with issues of clients' substance abuse, mental health issues, and/or depression. While there is no overall model for prevention case management used by all the agencies we interviewed, this general approach of a) trust-building, b) probing for possible risky behavior, and c) referral for specific mental and emotional health issues appears to be fairly uniform across the state. A search for models used in other states found none that



had been scientifically tested. Most models dealing with prevention among those already positive are based upon approaches used to prevent initial infections. These secondary infection models have also only been introduced within the last few years at pilot sites such as Los Angeles.

Training

Almost all of the interviewees felt they had been well trained to talk with clients about non-compliance with appointments, taking medications, and healthy behavior changes. The majority, however, said they would welcome additional training especially in the areas of mental health, cultural competence, and drug interactions. Information on how to effectively deal with prisoners recently released from prison and the jail syndrome some experience is also listed by interviewees as helpful. While most interviewees express greater knowledge and comfort levels in working with most populations, several specifically report a lack of knowledge about Mexican immigrants' cultural expectations and communication norms when dealing with care providers.

Experiences in Talking with Clients about Unhealthy Behaviors

The care providers interviewed offered several suggestions for having a dialogue with an HIV+ client about risks:

- Be open and non-judgmental. Do not convey shock about a personal disclosure.
- Approaches should be individualized to each client and take place on various levels as rapport and trust for the client increases.
- Messages should be repeated at least 16 times and be consistent. The same core message of healthy living should come from providers throughout various agencies.
- Clients often fear they will lose benefits or a provider's support if they disclose a risky behavior. Dialogues must always begin with 1) acknowledging this fear, 2) stating what the client already gets from the provider and that these benefits will not be affected by disclosure, and 3) stating what if any actions will be taken by the provider as mandated by state policies (partner notification, referrals to a prevention case manager, etc.)

Categorizing Clients by Compliance

While currently the care coordinator program does not categorize clients based upon compliance with healthy life choices, the program may soon introduce a client assessment tool developed in Oregon. The assessment forms can be viewed at:

<http://www.dhs.state.or.us/publichealth/hiv/cmstdrds.cfm#forms>

Although providers do not have a uniform system for categorizing clients, most could readily identify the type of clients the providers felt were non-compliant. These assessments fall into two methods generally:

- 1) **Contact Compliance:** Out of ten clients, seven are generally felt to be compliant in keeping appointments with providers, regularly taking their medicine, and avoiding risky behaviors. About two out of every ten clients routinely miss appointments and do not take their medicines properly. Interviewees felt this group had a higher risk of also being non-compliant in their behavior choices. The third and highest risk group, however, consists of clients who rarely have any contact with providers. Clients who are abusing illegal or prescription drugs are especially likely to avoid contact with their



care coordinators when heavily abusing drugs. Interestingly, this avoidance does not seem to hold true for alcoholics who do continue seeing their providers even when heavily drinking. While providers see the majority of clients as compliant in their behavior, several care coordinators point to even this group as having elevated risks when vacationing. For about 70% of clients, the existence of a strong support group (family, friends, co-workers, etc.) helped by not only providing support but by also serving as a de facto surveillance system monitoring the client's behavior. When on vacation away from family and friends' eyes, even very stable clients were known to engage in high-risk behaviors.

In effect, this categorization provides a means to target prevention efforts:

- Universal prevention efforts (est. 70% of clients) with increased efforts before a client goes away for vacation or work
- Targeted prevention efforts (est. 20% of clients) focusing on clients who miss appointments and fail to take medications properly
- Intensive prevention efforts (est. 10% of clients) focusing on clients who skip appointments and rarely see providers

2) Personal Risk Factors: Interviewees also readily provided a checklist of personal factors that they often associated with risky behavior in their clients:

- Substance abuse
- Depression
- Low self-esteem
- Mental illness
- Childhood abuse
- Current abusive situation
- Homelessness
- Recently released from prison or jail

These factors could be readily used to create a simple screen to categorize clients for universal, targeted, or intensive prevention efforts.

Physicians

We interviewed five physicians for this study who have large caseloads of HIV+ Kentuckians. The physicians are located in rural, small town, and urban clinics. Their perspectives on prevention case management varied considerably. One physician specifically does not ask about patients' behavior so as to not bias the physician's interactions with the patient. This one physician views his role as one of providing quality medical care to all patients. He does not feel his role is to question patients about risk behaviors or to provide prevention counseling. The other four doctors, however, felt they interacted more with their patients including asking questions about their behavior. One felt, however, that his patients' would lie about their behavior if they worried about his reaction or having these behaviors noted in their charts. All five mentioned that they often did not see clients for very long and thus were probably not the best people for conducting prevention case management. They would refer patients with non-compliant behavior to local care coordinators.



Issues Specific to Particular Populations

Several interviewees mention that African-American clients of all sexual orientations and gay/bisexual-identified men are generally more open and comfortable in discussing intimate and sexual behaviors. Heterosexual white women on the other hand tend towards a reticence in talking about sexual matters that sometimes poses a barrier for care coordinators. One care coordinator also worries that she is lacking cultural competence in working with Mexican immigrant clients beyond initial language barriers.

Reaching African-American men who have sex with other men is another challenge for care coordinators. Several felt that homosexuality and bisexuality are highly stigmatized among African-American communities to the point that most MSM clients who are black do not self-identify as gay or bisexual. In the past programs such as Lexington's Ebony Male house parties provided a relatively confidential, social space for African-American MSM to gather and talk intimately about questions and concerns. These house parties have been discontinued and replaced with an empowerment workshop approach where attendees are paid a small sum of money if they attend three sessions. A prevention specialist who works closely with empowerment workshops feels that they are not as effective as the former house party approach. In a number of cases the attendees do not come back after the first meeting because of a lack of interest. This specialist feels that for African-American MSM and possibly also for other groups such as Hispanic immigrants that the more personal house party approach would work better.

Several interviewees also discuss challenges they have in serving Hispanic migrant clients. Many of the clients do not speak English well and are also functionally illiterate in both English and Spanish. Low levels of education and different cultural norms also pose other challenges. For instance, two care coordinators in different parts of the state find that their Latino migrant clients from Mexico and central America often will only take their medications if they are not feeling well. When they feel well, some even erroneously think they are now cured of their HIV infection. Medication bottles are sometimes returned mostly full with pills mixed together. At least one married couple who recently had a child have had a difficult time in understanding that their child could have been born HIV+. Care providers who interact with the Hispanic immigrant population also find that many clients rely upon traditional spiritual healing and herb medicine to cure them. One suggested identifying and approaching such traditional healers and engaging them in the fight to get clients tested and regularly taking their medications.

Several care providers also pointed to the use of *ambassadors* in reaching clients who were withdrawn. Several agencies have engaged the help of other HIV+ clients in talking with clients who are depressed, withdrawn, or non-compliant. Thus, a heterosexual white woman might better open up to another heterosexual white woman who shared other life experiences as well as their shared HIV infection.

The Carrot and The Stick

Several prevention workers also point to Indiana as having prevention tools not open to Kentucky providers. According to case workers who work in both states, Indiana law requires a person to disclose their HIV status if they share body fluids with another person. Case workers must also report such non-adherent behavior if they learn that a client has not informed their partner. The fine is a maximum of \$10,000. One case worker familiar with Indiana feels that this law provides some actual teeth to prevention case management. In Kentucky prevention case management must rely largely upon positive reinforcement and has few enforcement



options other than those addressing other communicable diseases. Most providers, however, express the belief that laws punishing non-disclosure would only lead to less openness and more frequent lying.

Kentucky Law

KRS 311.990 Enacted in 1998, this law makes it a felony to donate blood or organs if a person knows they are infected with HIV.

KRS 529.090 Enacted in 1992, this law mandates HIV testing and treatment for individuals convicted of prostitution. It also enhances penalties for individuals who prostitute themselves after learning of their HIV infection.

V. Recommendations

Recommendations from this study are compiled jointly with the work of Dr. Rick Zimmerman's group studying similar prevention case management questions among outreach workers and Kentuckians infected with HIV. Please see the joint recommendations.



Prevention Among HIV+ Kentuckians: Interviews with Outreach Workers and Kentuckians Living with HIV/AIDS

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University of Kentucky Institute for HIV, STD, and Pregnancy Prevention
July 2003

Overview

The Lexington Fayette County Urban Government Health Department and State Department for Public Health contracted Rick Zimmerman of the Institute for HIV, STD and Pregnancy Prevention, and Jeff Jones of the Center for Prevention Research to conduct a State-Wide Needs Assessment of secondary prevention efforts targeted towards persons living with HIV and AIDS (PLWHA). In this joint study, three groups of people participated in either focus groups or one-on-one interviews: 1) Outreach Workers; 2) Care Coordinators and medical service providers; and 3) People living with HIV and AIDS. The purpose was to assess the degree to which service providers in Kentucky are discussing secondary prevention strategies with people living with HIV and AIDS and whether there is an ongoing and consistent dialogue with PLWHA about the importance of protecting themselves and others and whether risk reduction plans are formulated that are client focused and tailored to individual needs.

The research methods and the qualitative and quantitative findings for each subgroup are divided into three separate sections: 1) Outreach Workers; 2) Care Coordinators and medical service providers; and 3) People Living With HIV and AIDS. Because of Dr. Jones' past experience conducting research with the care coordination system, his team conducting interviews with care coordinators and medical service providers and Rick Zimmerman's team conducted interviews with outreach workers and people living with HIV and AIDS.

Research Methods:

From April-June 2003, one on one interviews were conducted with current and former outreach workers and their supervisors throughout Kentucky. Of the 32 outreach workers listed in the directory of the State Department for Public Health, an effort was made to contact all 32, with 30 completed interviews. Interviews with outreach workers occurred in Lexington, Louisville, Paducah, Bowling Green, Mayfield, and Ft. Mitchell, Kentucky. Outreach workers (n=23), as well as outreach workers who also have a supervisory role (n=4), and former outreach workers (n= 3) who had moved on to other positions, were interviewed for a total of 30 interviews. All interviews were conducted at outreach workers' offices.

The purpose of the interviews, which lasted approximately 90 minutes, was to gather qualitative data to assess the degree to which outreach workers have contact with clients who they know are HIV positive and the extent to which they engage these clients in discussions about secondary prevention. In addition to these qualitative interviews, outreach workers also completed a brief 17 item survey (see Appendix A). As can be seen in Table 1, 56% of the 30 outreach workers interviewed were males, 60% were White, and 40% were between the ages of 25-40. Forty percent of respondents said they have a graduate or professional degree (Table 1).



Table 1: Demographics of Outreach workers who were interviewed (n=30)

	%
Males	56
Females	44
Ethnicity:	
White	60
Black	40
Education Level	
High School or less	16
GED	8
Associate's	8
Bachelors	24
Graduate/Professional	40
Trade School	4
Age	
18-24	4
25-40	40
41-50	32
51 +	24

As can be seen in Table 2, almost all outreach workers said they were trained in prevention Case Management and Orasure testing (83% and 92%, respectively). While all outreach workers felt "very comfortable" discussing the importance of using condoms with gay/bisexual clients, fewer (71%) reported feeling "very comfortable" talking with IDUs or IDUs who are HIV positive about safe injection (Table 1).

	%
Trained in Prevention Case Management	83
Trained in Orasure testing	92
Level of comfort talking with:	
Gay/bisexuals about using condoms	
Very	100
Somewhat	0
IDUs about safe injection	
Very	71
Somewhat	29
PLWHA about using condoms	
Very	96
Somewhat	4
IDUs who are HIV + about safe injection	
Very	71
Somewhat	29



Qualitative Findings - Outreach Workers

Typical Day in the Field

Outreach workers were asked to describe a typical day in the field. This question brought about a wide range of answers and it became evident that there are no typical days for outreach workers. In fact, there doesn't seem to be a consensus on how outreach workers' roles and job descriptions are defined, nor whether outreach workers are still outreach workers if they do not leave their office. In addition to street outreach in gay bars, bookstores and public sex environments, outreach workers conduct risk reduction workshops at places such as drug court, alcohol and drug abuse treatment centers, spouse abuse centers, and Job Corps. Others visit prisons and do HIV testing, as well as offer educational seminars, STD awareness and HIV education in the school system. When asked about services provided directly to PLWHA, there seemed to be some overlap in the role of the outreach worker and care coordinator. Outreach workers run support groups for HIV positive individuals and their families, provide food, transportation, and childcare referrals, as well as provide risk reduction counseling through one on one sessions and support groups. Overall, outreach workers perform a wide variety of tasks, *"Really, you get to wear a lot of hats and do a lot of everything around here."*

Street Outreach

The outreach workers who do street outreach travel in pairs, often with walkie-talkies, and have a code system to be able to alert partners quickly in dangerous situations. Many were assigned certain high-risk groups, such as MSM or IDUs, which involved certain target zones in their geographic communities. Most bring literature and prevention materials to distribute, as well as male and female condoms, lubricants, and dental dams. They usually walk around parks or designated areas, for example, beauty shops, bars or other places where a bowl of condoms will need to be replenished and talk to people they encounter. Most outreach workers become well known in the community in which they served as the "condom person" and are often asked for condoms when off duty.

Designation as "Condom Person" creates an in road for safe sex dialogue:

The designation of being the "condom person" becomes the primary mechanism for reaching at risk communities to begin a dialogue about HIV prevention. *"First thing I'll ask is, 'Do you need supplies? Do you need condoms? Do you need lube?' And then just have some type of dialogue with them that would be meaningless probably for a minute or so ... and then you get to know them and you get into, What are you doing? What really is happening today, are you sex-trading? ' "*

Outreach workers emphasized the importance of building "trust" and becoming a consistent presence in a location, which allows for more in depth conversations to take root. One outreach worker commented, *"It's all about trust. It's all about getting your face out in the streets and being seen by people."* Another commented, *"When we are in an unfamiliar place, we'll drive by and see if in the gathering we have a gatekeeper. We ask the gatekeeper to holler at us when they see us come by, so everybody will know the car and then we'll come back... We'll park about a block away and walk to them and those who feel uncomfortable will leave. First move we go through is not to make people feel uncomfortable."* Another commented, *"A lot of folks, they'll take the supplies from us and not want to hear very much. But... you can always slip a little tidbit of information every time you meet them. If you keep meeting the same folks you can*



just keep drilling them you know one piece at a time, before you know it they got a lot of information."

When conducting outreach in bars, a few outreach workers reported that MSM are burned out on prevention messages. *"People around here are burned out. They are burned out on outreach. But if you are giving them stuff then they're happy. I give them little key chains."*

Secondary Prevention Discussions with PLWHA

Most outreach workers expressed confusion when asked to describe the difference between primary prevention and secondary prevention. With the exception of two of the workers interviewed, most in the course of their outreach activities never know a person's HIV status unless they test the person or the person discloses his/her serostatus. They explicitly do not ask about serostatus and treat all people they encounter on the street the same. When they do know someone is positive, they are reluctant to discuss risk reduction as it relates to their status on the street because they want to guard that person's privacy and maintain the trust they have established. Outreach workers described a tremendous amount of gossip on the street and sometimes within their own agencies about who is positive and they deliberately distance themselves from this dialogue. Some workers said that if they push too hard, clients won't come back. *"I become a problem. If I know you are HIV positive, I would prefer you use a condom but that's about as far as it goes... From there on I'm their case manager and their counselor, my role is to see what your needs are... Because let's be honest they just don't want to hear about all that."* Another commented, *"You know you start digging into somebody's personal life in the African American community, they don't take to it kindly. They'll become real resistant, you're running the risk of them not coming to you anymore."*

Two outreach workers reported that they explicitly did have conversations in the street with people they know to be HIV positive, however these conversations tended to focus on the client's health status and their needs. *"We definitely won't call anybody out but if they're open to it, I'll ask 'Are you out here protecting yourself?' I'll ask if they are taking care of themselves. If they're open to it we'll talk about their meds., what meds. they're on."*

In some instances after a risk reduction workshop or after passing out condoms in the street, a client might approach an outreach worker and quietly disclose his or her serostatus and ask additional questions. In other cases, outreach workers have handed out their phone numbers and HIV positive clients will call and ask for assistance. Under these circumstances, outreach workers discuss risk behaviors, fears of disclosing to partners and services available to them. However, overall most outreach workers did not describe different objectives or strategies that they would employ when working with seronegative or seropositive clients.

The post-test counseling session is the most commonly cited circumstance during which an outreach worker would have conversations about risk reduction with an HIV positive client. Outreach workers describe making sure that appropriate referrals, care coordination and services are lined up and that the file is flagged before the client arrives. Common reactions to attempted discussions about safe sex immediately following a post-test include, *"I am never going to have sex again", "I feel dirty", "I don't feel like I can have sex..."* Clients are often said to be so overwhelmed by the news and so resistant to having sex again that they *"don't even get prevention supplies (after a post-test counseling session)."*

One outreach worker provided a more nuanced description of secondary prevention. He was expressly trained in HIV prevention case management and had a designated caseload of HIV



positive clients. *"The new theory is that the prevention methods in the past have all been focused on people that don't have it. Getting them prevention supplies and stuff so they don't get it. The new theory is let's change our focus to preventing the people that have it from giving it to other people."*

He described developing personally tailored risk reduction plans that he and his clients discuss and modify over time. *"We'll sit down and we'll come up with some goals. We'll list them. We'll list what they want to change. Say this person says they have unprotected sex 10 times a week, we'll say 'alright maybe one of the plans is to (use condoms) at least 75% of the time.' Then we'll meet every once in a while and see where we're at. And if they are doing it 75% of the time, the next time they come in maybe we'll change the goal to 100% of the time."* A key to success when working with HIV positive clients is consistent contact with his caseload. *"I'll call all of my clients once a week and let 'em know about stuff going on next week and let 'um know 'Hey.'"* He provides Tarc tickets, gas cards, and phone cards to insure his clients have a means for getting to services, medical appointments and support groups. *"There's no excuses here because I make sure they are all covered, 'Oh well you don't have a phone? Well here's a phone card.'"*

Conversations about secondary prevention with his HIV positive client base occur during one-on-one sessions or during support group activities but not during the course of his regular outreach activities. His descriptions of these street outreach activities were very similar to other outreach workers interviewed.

Secondary Prevention and Substance Abusers

When outreach workers were asked about their interactions with drug users, most did not describe these conversations as distinctly different for HIV positive and HIV negative clients. Workers tended to define substance users by the drugs they used, identifying two basic categories, injection drug users (IDUs) and crack users. IDUs were said to be difficult to find, *"There's not shooting galleries like you'd find in New York or Chicago. There's not needle exchange here either. That makes it kind of hard."* One Lexington outreach worker commented that the IDU community is *"underground, some are starting to shoot crack/cocaine. In some of the senior citizen housing developments there is drug trafficking, people cleaning out diabetes needles and reselling them. I told my co-worker we have got to get this stuff down cause nobody is going to believe us. But since we can't give them clean syringes, they don't want nothing to do with us. Buy used syringes from an 80 year old woman, that's where we are."*

Crack use was described as much more common and crack users easier to find. When outreach workers counsel them they focus on the risks of transmission from sharing crack pipes, although they suggest that the greater risk factor is sex for drug exchanges.

One outreach worker described the difficulty of working with drug users when they "slip-up." *"When they start using they don't call. You won't see them. They just disappear. Even though I call them, you won't hear from them, they won't answer the phone. A lot of times they'll call me after a while when they stopped using and say, 'You know, I had a little spill, but I'm back now.' There's a lot of guilt and shame in drug addiction, that's why I always call them when someone leaves, and say, 'Hey, no matter if you're drunk or high or whatever you can always call me for services.'"* Clients tend to think that if they are actively using drugs they cannot access any services, *"A lot of people think that we run hand and hand and we don't. We are two separate entities here and if you're not getting services over there you can still get services from me."* One identified barrier is that someone who is high or intoxicated cannot enter the building,



"...the only time that I have any interaction with someone that is actively high or using is when I go out to their house, which I do. I go to their houses quite often."

Another worker explained that it's difficult to help someone when they are caught up in the throws of addiction, s/he said, *"you know, the IV drug users, Maslow's hierarchy of needs, if he's not got a house to live in, if he's not got food, then AIDS is not a problem. It is not a priority. I see crack addicts come in and say, 'Oh, I know this is horrible, but my life is so out of control ...I know I'm screwing up, but I've got to eat. I've got three kids.' So to us, we're thinking, 'well, good God these people need education.' Not really. Most know. Most know that they're doing what they're doing and the risk. It is just a matter of present need."*

Harm Reduction & HIV Risk Behaviors

Few outreach workers explicitly described using a harm reduction philosophy when working with clients. However many incorporate elements of this approach in their interactions. One interviewee contrasted this approach to a more medical model, *"Medical folks work from a 'let's fix it' philosophy, and a lot of prevention folks work from a harm reduction philosophy. That's very, very different. I seen an AIDS doctor that seen track marks on somebody's arm and says, 'Screw you, I'm taking you off of everything until you can be clean.' Of course the thing they don't understand is that it's a life long process, sobriety, sexual addiction, alcohol and drug addiction. People have moments when they fail."*

Barebacking – Sign

Risk behaviors, such as barebacking, were described by outreach workers as having different meanings within at-risk communities. *"You know when the barebaking buzz come about well, Hell, they thought it was godawful. It was 'God forbid anybody not use condoms.' I don't use condoms and I work here. I have a relationship with a partner and it's a trust issue. It's a bond with each other. I have your life in my hand. You have my life in your hand. I'm trusting you. We are a committed couple. I'm trusting you not to play around on the side and infect me. And that's as good as a commitment as you can get without a legal document saying you're committed to each other. That's not understood in the heterosexual community."* He continued, *"What if someone slips up? Sure it happens. Then you have an issue of when you've got to come home and say, 'oh we've got to use condoms.' But most don't do that because they are afraid of losing the support, the house, the lifestyle that they're used to. So they don't - and 8 out of 10 gay men contract the disease from inside a relationship. The higher ups here don't get it, they'll never get it."*

Barebacking and Erectile Dysfunction

Only one outreach worker suggested that there are other reasons that underlie a male's inconsistent condom use. (S)he commented that many outreach workers get frustrated by the inconsistent condom use of their clients and yet don't ask about the reasons for this behavior. *"A lot of female counselors tend to think that men are being contrary assholes. Anybody that is on heart or blood pressure medication or any kind of serious medication are gonna have erectile problems. And a condom on top of that?"*

Myths about HIV Risk Behaviors

Several of those interviewed described persistent myths that exist in the MSM communities. They often gauge their success by the degree to which they are able to dispel these myths.



Several areas of ambiguity included: oral sex is safe; it's okay to have unprotected sex if you and your partner are infected; you cannot give HIV to others if you have a low viral load; and that there is no such thing as re-infection. Clients will say to each other, *"Oh they will tell you all that just to get you to use condoms."* Those selling marijuana don't believe oral sex is a risk factor so *"they'll trade dope for favors."* Others, particular African American females, were said to believe *"if they're big and fat that they don't have AIDS because everybody who's infected is thin or skinny."*

Outreach workers described the unintended consequences of repeat testing in MSM communities. *'Sometimes they'll come in and they've done this whole block of unprotected sex again. They'll get tested and it'll come back negative, 'Cool'. But the third or fourth time, 'Well hell I have done this for decades and I have never caught anything. You're just chicken little here. You're just saying the sky is going to fall. It's not. It hasn't.' We end up desensitizing them.'*

Burn-out - Indigenous vs. Non-Indigenous Outreach Workers

There was a substantial difference in the degree of work-related stress outreach workers described when comparing the responses of those who come from at-risk communities to those who do not self-identify in this way. "Indigenous" workers uniformly describe an inability to escape the stress of their job. *"If you can leave this job at 4:30 then it's different for you. I had a week in the past 3 months where 3 different friends contracted HIV. I can't leave it. I can go just about anywhere that a gay man would go in this community and I'm bombarded with 'What are you doing here?'... I am like the sex police. They'll ask, 'Who are you looking for? Are you looking for a partner?' Clients are real leery of using names of workers because if you know a case manager's name, then you're positive. Personally, it's real hard because I am a gay male and I live in the middle of all of this."*

Similarly a former injection drug user commented, *"Yeah, it's difficult because it's my people. It's the people I hang with."* Another commented about the struggle of creating social distance between themselves and the drug scene *"I don't go into crack houses... you have to think about things. You just don't run out there and shoot yourself in the foot. I have to protect myself in certain situations."* Others described the risks of being taken advantage of by your own community. *"I can't let them use me too much. I need to be aware of the traps they may have set... It's hard when you make appointments for them... give 'em cab vouchers, food from the food bank, and see them selling the food they get from the food bank... Some of 'em I have been around for 10, 20 years. But then I have to let go or they'll drag me with them."*

Many indigenous workers said that they entered the field due to a personal, significant event in their lives. Some witnessed first-hand the stigma that a loved one experienced being diagnosed with HIV, and others were former drug users, and/or gay, and/or were HIV positive themselves. As one outreach worker explained, *"It seems like a pretty good decision to participate in an area where life has wounded me."* Another one opined, *"You almost have to live in that person's shoes in order to do this work."*

Despite the additional stressors of coming from the community, one indigenous worker explained, *"I feel like I have a step up on everybody else because I know a lot of people. A lot of the street level prostitutes, a lot of the faces have changed but the game is still the same. Some old faces will say, 'What's up?' I've got a foot in the door already when a lot of people can't get in."* Another commented, *"We can identify with the clients we work with. We know why*



they are at a public sex environment, we know why they are at a bookstore and we know why they are sitting at a gay bar and just drinking."

A key component that helps indigenous and non-indigenous workers deal with the stress of the job is the autonomy they feel when in the field. *"I have the ability to work as a free agent for myself, by deciding to turn left or turn right, you know not having to meet in supervision."* Another outreach worker commented, *"One of the things I like about (this job) is that I am largely self guided, self- directed. I really work well under those circumstances."* Others described the importance of getting time off to get away from the work. When comp time was eliminated in one agency, one worker's strategy for dealing with stress was gone. *"My comp time was my mental health time because it allowed me to get out of here at 3:00. If I have 2 or 3 in a row that are awful, I'm shell shocked from it. You are doing this spiel 6 times a day and you're like, 'Okay did I just say that or did I say that?' That's basically why I am leaving because the comp time is not there."*

Hardest Parts of the Job

Outreach workers were asked what the hardest parts of their job entailed. The answers varied. Several discussed venues that they wanted to do outreach in but are unable to gain access. *"The strip clubs and truck stops don't want us in there and that's where most of the sex is going on. We get arrested if we go in truck stops."* Others commented that while they could get into gay bars, straight clubs won't let them in. *"I tried to explain to the (owner), 'Look man you run the club. People come here and drink and go home with people they don't know and that's how it's spread. The heterosexual rate is equal to the homosexual rate right now. And he's like, 'Really? Well I think you guys should stay in the gay bars.'"* Another outreach worker commented, *"Not being able to pass out condoms in certain areas, like schools, religious areas."* Another explained, *"It's pretty tough to hear about horrible experiences."* Others described being *"spread too thin."*

Best Parts of the Job

Outreach workers also gave varied responses about what they felt was the best parts of their job. Some said that making a difference in peoples' lives and helping them was the best part of their job, whereas one explained that flexibility, and *"never (having) a dull moment"* was what (s)he liked the best. Other responses were: *"seeing people and being with people"*, *"always learning something new"* and *"creating connections between people in a small group that wouldn't have formed the connection otherwise."* One said that, *"the camaraderie and the gracious remarks we get from strangers, as well as having your finger on the pulse of the community."*

Measuring Success

Success was defined as *"when a light bulb goes off and they say, 'a-ha' and you are dispelling myths and they believe you."* Others explained that simply helping one individual was success. Having realistic expectations and being cognizant of the little victories along the way was how many described success. Others suggested, *"I usually measure success when they don't call all the time. When they don't seem as dependent. Usually the calls we get are bad news calls, so we kind of gauge success by a person working. Whether they are employed, in a relationship. But there is always that anomaly when a person's gone so far underground through shame and despair, we have to watch out for that."*



Supported by the State Department for Public Health

In general, almost all the outreach workers interviewed felt very supported by the State Department for Public Health and their own agencies. *"(The State) provides us with so much information. And the CDC is pretty good, like now with the whole club drug rage they give us trainings about how they're made. What they contain so that we can tell our clients."* *"We have our quarterly trainings... you know right on target about what's changing. We have our Orasure training and PCM (Prevention Case Management) training and public sex environments that the State provides..."* Another worker commented, *"Every three months we'll have a class. They're real good at covering different areas."* Another commented, *"It would be great to list all the different trainings we have been through. It would be really good should I ever leave the health department and go somewhere else. They get all the prevention specialists from around the State to come in and do technical assistance trainings, how to reach Hispanics, MSMS, IDUs and African Americans."*

While most felt very supported by the State Department for Public Health and their agencies, there was a persistent theme of the lack of prestige and status that goes along with being an outreach worker. *"Your direct supervisor may be good with what you are doing but they're just kind of like, 'oh you're going through the park and giving out condoms to gay men that are having sex in bushes. We don't really want to put that in our annual report.'"*

Skills Most Used on the job – Counseling Skills:

When outreach workers were asked what skills they use the most in their jobs, the most commonly reported skills were listening and counseling skills. Several outreach workers said it was important to read between the lines as well. *"You've got to be able to read into stuff, read into what people aren't saying or how they're wording it. Or my gut feeling about somebody, I'll go with it."*

When asked about their primary goals and objectives, outreach workers commented *"making sure that everyone knows where they can come to get tested for HIV"* and *"why it's important, and how the visit is going to go. What to expect."* One explained that, *"with some of the kids, I'm not that concerned that they remember the epidemiology and etiology of everything, but if they know what puts them at risk and if they know where to go to get tested, then I'm happy."*

Training and Skills Needed

Outreach workers were asked what skills they needed in order to do their job better. Different ideas emerged. One outreach worker who had been in the field for many years explained that (s)he would like to have trainings offered on burnout. *"I've laid awake worried about people [who tested positive] and had to tell their partners."* Outreach workers expressed that the pay is too low to hire a compassionate person with experience, but instead "greenies" are hired fresh out of college with absolutely no experience. Then when they have the experience to be functional as an outreach worker, it is too late because they get burned out and leave. It was suggested that having someone to debrief with at the end of the day and talk about the emotional issues that *"got to you"*, would be extremely helpful. The organization Hospice was given as an example of where this currently occurs. At Hospice, *"you would cry with people that knew you understood. Because you go home to your spouse, they don't want to hear it. It's depressing, it's godawful. They don't want to hear it. You can't ever get rid of it."* It was also suggested that training at conferences – especially how other states do outreach work – would enable outreach workers to *"re-charge their batteries."*



Several workers suggested that they needed trainings on how to reach the Hispanic community and expressed an interest in learning more about substance abuse and HIV infection. One outreach worker commented, *“Addiction is not something I have had personal experience with... being able to talk with people who are on some level, you know, so they see the connection. It’s obviously an area that I just don’t feel real adequate in.”*

Most of the outreach workers had been trained in Orasure testing and felt comfortable conducting the test. Many explained that it had a lot of advantages over the traditional blood test, although not all of the outreach workers interviewed preferred it. Most of the outreach workers had given a positive test, and said that it was very difficult for them. But most admitted that the person receiving the positive test had already had a pretty good idea that (s)he was positive.

Another outreach worker said *“I would love for the state administrators to follow me around for a week. Sit here and listen to the issues, the emotion, the fear, the pain.”* One outreach worker explained that the State could assist more by building a coalition that facilitated all outreach workers to work better with one another. (S)he was aware that other outreach workers (mentioned AVOL specifically) are out on the streets, but (s)he never sees them. For example (s)he said she wants to go to rest areas and truck stops and do outreach work, but the people in Frankfort claim that outreach workers do not have permission to go to interstate areas and that it is out of their jurisdiction. (S)he suggested that outreach should network with these agencies and find out who if anyone is doing this work.

All the outreach workers interviewed received on-going supervision and mentoring. Most felt it was helpful. The VOA model was well regarded which included weekly meetings with your supervisor, group meetings with other outreach workers, as well as having your counseling sessions periodically taped to get feedback on your counseling skills

Other Venues for Secondary Prevention - Medical Doctors

When outreach workers were asked who else in the health care/HIV prevention field ought to be working with PLWHA to encourage them to reduce their risk behaviors, outreach workers universally agreed that physicians should be counseling PLWHA about secondary prevention. While they believe this is a critical venue because of the physician’s inherent power and social status, they also reported that physicians are not adequately trained in how to counsel PLWHA about secondary prevention nor are they comfortable asking questions about personal risk behaviors. *“Everyday physicians need to ask more questions. Assess more history other than when you last had your period...”*

They also suggested that doctors need to provide more balanced information when delivering good news about low viral loads. One outreach worker commented, *“...When a (client’s) test result comes back in and (the viral) level is undetectable, (the client) has problems with what that means. There’s been a lot of confusion with ‘I can’t pass it.’ Or ‘I don’t need to use condoms.’ That really needs to be addressed by the physician. When the physician gives you these great test results, it needs to be reinforced.”*

One client suggested that nurses are also an important venue for secondary prevention and contrasted a nurse’s role with their own, *“I think the nurse - you know the medical thing... We still are kind of like narcs - we just get a little more play. You’re the police or you ain’t. A nurse is not the police. It takes us more time to build trust.”*



Other Venues for Secondary Prevention - Care Coordination

When outreach workers were asked who else should be conducting secondary prevention with positives, some thought care coordination might not be the most appropriate venue. *“I think a lot of us forget that there are people who are very aware of how to work the system. Somebody that’s helping you pay the rent, I’m not gonna tell them what I am doing. I’m going to say, ‘Yeah I had protected sex every time.’ I am going to try to convince them that I’m truly online with them and invested, anything to get that assistance.”*

Qualitative Findings – Care Coordinators (Provided by Jeff Jones, Alisa Bowersock, and Tina Webb)

Overview

The Care Coordinators are often the primary contact and information clearinghouse for PLWH. Established in 1990, the Kentucky HIV/AIDS Care Coordinator Program provides for the entire state and operates through six centers located in: Bowling Green, Fort Mitchell, Lexington, London, Louisville, and Paducah. Care coordinators in general and the ones interviewed for this study primarily have educational backgrounds in social work. The care coordinators provide a wide range of case management for clients including administering the KADAP (Kentucky AIDS Drug Assistance Program) and various food, housing, and hygiene voucher programs. In a survey of PLWH for the 2002 Kentucky HIV/AIDS Needs Assessment, the majority of Kentuckians living with HIV who responded to the survey say they would point a newly diagnosed individual to the Care Coordinators as a first source for information and help. In turn, the Care Coordinators’ primary responsibility is to get and keep clients in the care system.

Care Coordinators’ caseloads are on the rise as new medications extend the lives of existing clients while new clients continue to enter the system. Burnout and turnover in staff are ongoing issues for both the Care Coordinators and their clients. Care Coordinators also face anger and frustration from clients who entered the program in the early 1990s when there were more discretionary funds available for additional assistance for housing and utilities. A rising waiting list for KADAP, static federal funding, and a growing client base has forced the Care Coordinator program to cut back on a number of previous services to focus foremost financially on drug assistance for clients.

Existing Prevention Case Management

In the interviews, Care Coordinators all touch upon these issues of turnover, reduced services, increased caseloads, and the pressures of client demands. The Care Coordinators often have close relationships with their clients and repeatedly emphasize the same basic approach to prevention case management. Foremost is a focus on building trust with a client over time. As the coordinator and client build a relationship, the coordinator often then feels it is appropriate to probe more about client behaviors. Several Care Coordinators voice the belief that more direct confrontations about risk behavior often backfire: clients are more likely to *clam up...shut down...feel uncomfortable talking with their coordinator or outright refuse to come back in for services*. The Care Coordinators thus feel their prevention case management is often subjective and individualized. It relies upon first building a relationship with a client and then reaching a level of trust where more invasive questions do not threaten that relationship:



Yes. I'd say it's interesting. I'm older than most of my clients and so I think at first it takes them time to get comfortable with me. When I ask questions that are sort of invasive, I explain why I'm asking and why we need to be as honest with each as much as possible and how this info might be used to help others anonymously. A lot of times people say "I'm not interested in sex and I don't have sex with others." I say that is wonderful but if you do, I'm here to help you with them. I think the strategy we use is the approach of that there is nothing to be ashamed of about what you are doing but all about keeping you safe...and keeping yourself and your partner safe. You don't want to get re-infected or infect someone else. Even if you are saying you aren't active and not at risk, we talk about it and make ourselves available for questions if they enter into a relationship. I think that initially if we are confrontational that we drive people away. We can be aggressive about teaching and discussing and there is a place for confrontation but not at the beginning. Be positive and helpful and assertive. Later you can say you told me you weren't in a relationship and now I know you are and what are you doing to make it safer...but after you build a relationship.

These sentiments are consistently repeated more or less by every Care Coordinator interviewed at all six sites around Kentucky.

Care Coordinators feel they already do considerable prevention case management built around trust-building, increasing client self-esteem, and establishing a role of non-judgmental sounding board and information source. What is missing, however, is any consistent screening process to assess client risks on a routine basis. Clients who seem *stable* in one Care Coordinator's word often are assumed to be compliant in healthy living behaviors.

When asked, the Care Coordinators could all offer a categorization of their clients based upon their perceived likelihood of practicing unsafe behaviors such as unsafe sexual practices and substance abuse. Clients who fail to come for meetings with their Care Coordinator and/or who are largely missing in the system are viewed by Care Coordinators as likely at greatest risk. A second, lower level of risk is ascribed to clients who repeatedly miss appointments and fail to regularly take their medications. These clients' lives are often seen as *being in chaos* and *led more on the spur of the moment* often to the neglect of taking healthy precautions. One Care Coordinator estimated, however, that seventy percent (70%) of her clients are in stable lives with support systems and compliance to regular appointments, regular medication schedules, and a low risk of non-compliant behavior. She feels, however, that vacations pose a heightened risk for such clients because they are away from their support systems that also serve as something of a healthy behavior surveillance system. High risk clients also often have the following shared characteristics: substance abuse, a history of abuse as a child or adult, mental illness, recently released from prison, depression, and the lack of a support system. Several Care Coordinators say that clients regularly *tattle* on risky behaviors by fellow clients. Missing from the Care Coordinator program are the staff to regularly find and provide follow-up with clients who fail to come for care.

Who Should Be Doing Prevention Case Management?

The Care Coordinators perspectives on who should be doing case management varied somewhat. All agreed that everyone involved in clients' care should be responsible for working together on prevention messages in some way.

I definitely think that we should be responsible as one group, that being case managers and the care coordinator program. I think that there are several people that should be



responsible. I think that it should be the responsibility of everyone involved. It has been really cloudy in our state. I know that they have tried to separate who the prevention specialist are and who the care coordinators are, but I personally think that the care coordinator does as much as a prevention education specialist but we have a different targeted population. I think that we are equally responsible for prevention education because the best teachers are the clients themselves, and if we don't interact with them it doesn't happen. I think that it is the responsibility of many community based agencies, and the physicians in the medical offices. It is everybody's responsibility; it has been a cloudy issue trying to define the responsibilities of the two.

Beyond this common theme, responses varied. Several Care Coordinators voice a concern that their primary role of keeping clients in care posed problems for Care Coordinators as prevention case managers in a more confrontational role. Especially if prevention case management is carried out in a systemic, uniform fashion before a client-coordinator trust level has been built, the Care Coordinators can be placed in a conflict of interest between keeping clients in care and confronting them about risk behaviors.

Instead, the majority of Care Coordinators interviewed prefer some type of referral system to a prevention case manager with greater training in mental health counseling. At several sites something like this system already exists.

In my experience here I came from a child protection background and so I'm fairly comfortable with confrontation issues. I feel like that it is ok to be a "good cop/ bad cop" _____ is the bad cop and he has to talk about sex partners, needle partners, and who to contact. Clients don't particularly like him. So, when I get around to my clients and talk about their risk I get to be the good cop...(name of Care Coordinator who is speaking) cares about me...you have to take that role. I emphasize you have to be responsible. I think about the whole issue if the doctors and prevention people and the care coordinator people and nurses could all get together ...not on each client/not enough time...but decide who is going to be the good cop and who the bad so that the ball doesn't get dropped.

At a number of sites outreach workers somewhat double as de facto Care Coordinators. One of these sites works with clients from Kentucky and Indiana. A case manager from this site expresses a frustration also voiced in different ways by other Care Coordinators; the lack of enforcement tools.

One problem I see, is that in the state of Indiana it is the law to notify someone that you have HIV, and in KY you don't. There is criminal prosecution if you have sex with someone and do not tell them. Indiana Public Health Law-123-1988... in response to perceived threat of HIV in modes of transmission. If a positive person engages in a sexual or needle sharing behavior without notifying their partner prior to participating in the behavior they are considered to be non-compliant in addition to donating blood or plasma or tissue indicates non-compliance. Anyone including physicians can report non-compliance to the state department of STD and HIV and a confidential investigation will performed by a specifically trained investigator. A mental health approach is used for investigation, the client is referred for counseling and other services in compliance with the duty to warn laws. Anyone who reports them is not liable in any civil or any administrative disciplinary actions. The penalty is \$10,000 per occurrence within 72 hours. The laws are more strict in Indiana.



When asked about the benefits of stronger and more punitive laws such as the Indiana model, other Care Coordinators say they would have concerns that such a system would compel clients to lie more often to avoid fines and investigation. While they could not offer a compromise, several Care Coordinators wish there was a happy medium where clients could be encouraged successfully to practice safer behaviors but also where there were administrative tools to goad clients into healthier living. The general consensus of Care Coordinators is that everyone should be doing some type of prevention case management but more intensive efforts with clients should be referred to a local prevention case management specialist whose role is clearly defined as separate from other duties.

Qualitative Findings: Medical Personnel (Provided by Jeff Jones, Alisa Bowersock, and Tina Webb)

Overview

Most medical care for PLWH in Kentucky is provided by four clinics funded through Title II of the Ryan White federal funding program. These Title II clinics are located in Paducah (Hartland Cares), Henderson (Matthew 25), Louisville (WINGS Clinic), and Lexington (Bluegrass Care Center). Only Paducah's Hartland Cares has both a Title II clinic and Care Coordinator office at the same site.

Interviewees among medical personnel include a general physician with a large HIV+ client base seen at six rural clinics in southern Kentucky, infectious disease physicians, nurses, and physician assistants. When these individuals interact with PLWH varies considerably. In some cases a client will come for an initial post-diagnosis check. If healthy, visits may be repeated only every six months or once a year if the patient remains asymptomatic. In other cases, an illness on the part of the patient leads to a visit to the doctor and the initial diagnosis. As the disease progresses, contact with the Title II clinics increases. In some cases, clients frustrated with delays or repetitive messages from Care Coordinators may largely sidestep the Care Coordinator program and see only the clinic staff.

Current Prevention Case Management Practices

Prevention case management practices among medical personnel differ considerably. Nurses and physician assistants have the role of performing periodic client health assessments that ask about risky behavior. Some physicians review and use this information. The majority of physicians say they also specifically ask clients about risk behaviors as health risks. In the case of one physician, however, he specifically does not ask clients about risky behavior or review periodic risk assessments. For this physician, ignorance of such behavior allows him to treat all clients equally without value judgments about their behavior and health compliance. This physician feels his role is to provide health care and not prevention case management better suited to staff trained in social work intervention. The other medical personnel voice a consensus that they should be involved in prevention case management but not as the primary source of such interventions. Time limits upon medical staff and their focus on physical health do not allow them the training and time to do intensive case management.

Who Should Be Doing Prevention Case Management?

The medical staff feels that Care Coordinators as the primary contact for clients are in the best situation to screen for and direct prevention case management. As with the Care Coordinators,



a referral system to a prevention case management specialist is viewed as a good idea. Medical staff also voices the importance of building a relationship of trust with clients and individualized health and prevention plans.



PERSONS LIVING WITH HIV OR AIDS

Research Methods:

People living with HIV and AIDS were interviewed to assess the degree to which they discuss secondary prevention strategies with their service providers. Clients and patients were asked whether they had talked about the importance of protecting themselves and others and whether risk reduction plans were formulated that were tailored to their individual needs. To achieve this aim, eighty-three persons living with HIV or AIDS were interviewed in various geographical areas throughout Kentucky including Lexington, Louisville, Henderson County and Paducah. Forty-six subjects participated in 30 minute one on one interviews and 37 subjects participated in focus groups that lasted 90 minutes.

PLWHAs were recruited from the Bluegrass Care Clinic at the University of Kentucky, Heartland Cares Clinic located in Paducah and from care coordination offices at the Jefferson County Health Department and Matthew 25 in Henderson. Each participant was paid twenty-five dollars after completing the interview. During the course of these interviews, it became clear that few clients discussed interactions with outreach workers, therefore the sampling plan was expanded to include prevention case management clients from the Volunteers of America in Louisville (n=8) for a final sample of 83.

The interview guide asked clients about the hardest part of living with HIV. It asked about their experiences with care coordinators, medical services providers and outreach workers. It also included questions about the degree to which they discuss secondary prevention with service providers, family or friends, how and under what circumstances they disclose their HIV status or decide to use condoms with sex partners (Please see Appendix A for the interview guide). Coding and thematic analysis (Miles and Huberman, 1987) were used to identify major themes.

Each client, prior to the start of the interview or focus group, was asked to complete a brief survey that asked about his or her demographic characteristics. Listed in Table 1 are key characteristics of those interviews. We deliberately did not ask about risk behaviors in the survey to prevent socially desirable responses during the one on one interviews or focus groups. As seen in **Table 3**, the majority of people interviewed were White and male (49 and 60%, respectively). Almost half (47%) had a high school degree or less and the same percentage were between the ages of 25-40. Because of an overwhelming response to requests to participate in focus groups at Mathew 25 in Henderson, Kentucky, our sample had a disproportionate number of people from the Barren River Region (32%) as well as from out of state (19%), since Indiana residents are clients at the Matthew 25 Clinic and participated in the two focus groups held there. This disproportionate number most likely resulted in an underestimate of the overall access to outreach and care coordination services.

Table 3: Demographics of PLWH who were interviewed (n=83)

	%
Males	60
Females	40
Ethnicity:	
White	49
Hispanic	2
Black	42
Asian	0
American Indian	2



Other	5
Education Level	
High School or less	47
GED	12
Associate/Trade	19
Bachelors	14
Graduate/Professional	8
Age	
18-24	3
25-40	47
41-50	38
51 +	12
Area of Residence	
Barren River	32
Lexington	27
Louisville	10
Covington	8
Northern KY	4
Out of town	19

Qualitative Findings - People Living With HIV and AIDS

Discussions about Secondary Prevention

Among the people living with HIV and AIDS that were interviewed for this study, few described discussing safe sex with their care coordinators or medical providers and most could not recall interacting with an outreach worker. While participants are very aware of the importance of using condoms and struggle with when to disclose their serostatus and under what circumstances to use condoms, they do not have extensive discussions with service providers about these issues. When pressed, participants said that they tend not to talk to anyone about these issues and in only some cases, talk to friends or family. Conversations with friends and family members tend to be cautionary in nature, instructing others about the importance of using condoms so they *“don’t end up like me.”*

Outreach Workers

With the exception of three participants out of thirty, the remainder could not recall interacting with an outreach worker, even when this person was broadly described as someone *“who hands out condoms in bars, bookstores, public areas or has workshops and presentations about safe sex.”* Although participants had extremely positive things to say about the agencies that staff outreach workers, such as the Jefferson County Department of Public Health and Volunteers of America, few could recall interacting with an outreach worker. Those who did interact with an outreach worker reported that these experiences were limited to obtaining condoms. However two of the eight prevention case management clients who were interviewed for this study provided slightly more information about safe sex discussions with their prevention case manager.



“...they say you can't teach an old dog new tricks, well that's a lie because you can... from putting a condom on and how you can put it on sexually to keep a person aroused and other ways to prevent other sexually transmitted diseases, and taking care of yourself.”

“Condoms, I never have to buy condoms. I always come here. Dental dams, female condoms they have everything.”

Care Coordination

Almost all of the PLWHA interviewed had tremendously positive things to say about care coordination services. The care coordinator was described as the one person they could talk to, the person who provided them with housing, medication, and transportation assistance and provided emotional support. Care coordination offices in each region were universally praised regardless of whether the client was recruited from an infectious disease clinic, local care coordination office or other venue.

“They are just really outstanding, she's always there, and she's always willing to help you. If she can't understand what you're going through, she'll hook you up with someone else that's going through the same thing or already been through what you're going through”

“Unlike the HIV doctor, the care coordinator has helped me tremendously on getting on patient programs. She's really good at doing that.”

“The most helpful person in the care system is my care coordinator... When I terminated (my job), they gave me a leave of absence, which cut my benefits off a lot sooner than if I had just quit. So as [name of care coordinator] was explaining our options of the continuing insurance coverage, she kind of brought that all into the fold for me.”

Not only are care coordinators described as providing immediate assistance with medications, bill paying, and housing needs, they are also universally praised for their ability to listen to their clients' concerns and provide emotional support.

“I feel comfortable talking to her about anything.”

“When I don't feel good, if I feel like I'm gonna get down or depressed or I need something, she comes through.”

Medical Providers at HIV Clinics

Physicians, specifically infectious disease doctors in HIV clinics, were praised for their medical care.

“In the health care system, the most helpful have been my doctors (at the Wing's Clinic) because I think we've got a good rapport to where I don't hide anything and she don't either. So, it's like...she's been doing it for about 18 years. So I was lucky with that one.”

“I think that my doctor at the WINGS clinic, she's helpful because she's very knowledgeable. She's got to be like probably the best infectious disease specialist in Louisville. She keeps her research up, you know.”



“One of the doctors at the clinic has been the most helpful, because he brought me through all my illnesses. He has been upfront with me. He has been there for me when I need him. The nurse would probably be second, because they’re kind of his backbone.”

Despite the positive experiences participants had with their infectious disease doctors or care coordinators, clients did not describe discussions with these service providers about safe sex, condom negotiation or HIV disclosure. Although large segments of the interviews were dedicated to how clients deal with these complex issues, stories about unprotected sex are extremely private and subject to scorn. Clients may be less likely to share these struggles with medical service providers whose acceptance, assistance and support they desperately need.

Condom Negotiation

Clients were asked how their diagnosis has changed their sex life and when and under what circumstances they use condoms. Responses to these questions fell into three broad categories: those more recently diagnosed who are determined to remain abstinent; those who demand the use of condoms at every occasion; and those who describe greater internalized struggles about condom use.

“Being HIV positive affects (my) sex life in that I’ve stopped having it basically... basically, it’s kind of, what do you call it, abstinence?”

“I could go in the priesthood... for some reason after you find out that you’ve got it, it (sex) loses its importance.”

Others described having sex but always using condoms. *“Condoms are used every time... No decision. No need to talk about it.”* Another participant commented, *“living with this and I’ve lived with it for about 12 years now, I don’t want to take the risk of putting anyone through what I’ve been through.”*

Still others described the difficulty of putting into practice their best intentions. *“Although abstinence is a personal goal, I ain’t gonna lie to you, I’ve had a couple of partners and I didn’t let them know about it... After being diagnosed, unprotected sex occurred with a couple of people... But I didn’t let them know about me. I know it was wrong, but it just got the best of me.”*

Many of the males interviewed described having a harm reductive approach to safe sex. *“I’m not requiring condoms every time... I do not allow people to perform oral sex on me without a condom. If I have any cuts in my mouth or anything like that—if they have any cuts on their penis, I don’t do anything. So, I’m aware of it and I’m not trying to control the situation, but I’m not an alarmist about it.”*

“I’d rather have sex and not tell them which I do at times, but it depends on how involved the sex gets. I mean if it’s just oral contact, it’s not a big deal, but when it starts getting a little more, then I either have to just say no or, you know.”

“If they want to use a condom, that’s fine. If there’s any, if they want to perform oral on me, if there’s any risk of my body fluid entering them, condom. And anal sex condom; but oral, no.”

Many male respondents described a pervasive dislike of condoms making safe sex even more problematic. *“To tell you the truth, I don’t use condoms period and that’s the reason I don’t have*



sex because I don't, I didn't like condoms. That's the reason I'm in the shape I'm in now because I never liked them."

Others described the lack of intimacy that HIV and AIDS create and how condoms exacerbate this social isolation. *"HIV affects a person's life tremendously, because sex with [a] condom is not intimate to me, so I never really get to be intimate with somebody."*

Still others described how condoms could interfere with established sexual rituals and jeopardize relationships with their sex partners. *"I love sex... I like it rough. And to me, sometimes I can't have rough sex because I figure that the condom'll bust. We've searched everywhere. I bet you I've got every kind of condom they make in the world at home in my drawer and it's like right now I can't have sex so that sucks... I think, damn, you know, I'm 27 and I can't get head no more and that's what he likes to do best and he's gonna leave me 'cause he can't do it..." I mean (using plastic protection) you hear plastic rattling, it's like, 'damn.' You know? And he's 38 and I'm 27, so he's older, so I mean at his age, he probably wasn't even used to condoms. The Trojans, he can't even get hard on the Trojans..."*

Disclosure of HIV Serostatus

Participants were asked how they decide when to disclose their serostatus to sex partners. Responses to this question varied. In some cases disclosure occurs right away despite risks of rejection.

"I'll tell them up front because they need to know...let them make their own decision because I'm not God, and I shouldn't make that decision for them."

"If you want anything to do with me, you're gonna know. And you know the old saying, I don't sleep on the first date. If you want to be with me, call me tomorrow and see if you still feel the same way. Then we'll talk about latex."

In other cases, disclosure is postponed especially in new relationships when it is uncertain where the relationship will lead. PLWHAs have experienced often intense rejection from family members, friends, and past sex partners and as a result may delay disclosure until the relationship is more established.

"I mean I just met someone and I'm telling' you what? It's too much trouble."

"It would have to be before I had sex with somebody, but it wouldn't necessarily have to be like on the first date. After I'm a little bit more comfortable with somebody."

"I dated somebody for two or three months and I told them going in. And when it was time to have sex, it was like it was shut down. And that's the only reason the relationship didn't work was because I was HIV positive. And then I had another relationship where I didn't tell. I said I'm not going to tell. It's like... I want you to get to know me first. I had sex, but it was protected sex. And when I told, they were gone."

"I tell them and they say okay, then they don't want to have no sex no more."

Some PLWHAs describe having a more "universal precautions" approach, using protection with new partners and not feeling compelled to bring up their HIV serostatus as long as they are safe. *"A guy that I met at work that I had safe sex with... he didn't know (my status). I didn't tell*



him. We use condoms. He's really a nice, [but] me and him didn't hit it off you know as a boyfriend-girlfriend thing."

Involvement with Exes

In many cases after diagnosis, PLWHA will return to a past relationship. Past relationships seem to offer intimacy without the fear of rejection, quell fears of infecting someone they don't know, and provide needed emotional support.

"The guy that I'm seeing (currently) is somebody that years ago I had contact with. He's my daughter's father, and we quit seeing each other and he's one of the ones that when I found out I had to give his name. And he was tested and he was negative. But he knows about me. I think meeting somebody new, it would be a hard thing for me to try to explain this and expect them to stick around"

"I just don't want to be the cause of somebody else getting sick. I will perform oral sex. I have a thing about having sex. I try not to do, except with my ex-boyfriend. That might sound weird but that's what I do..."

"My ex-husband who I've told, who knows I have it, he's real sorry for me that I have it. He kind of guards me against the world you know, thinking everybody would look down on me and everything. He tries to tell me that he's proud that I do take my medicine and try to do as good as I can, handle the disease as good as I can."

Condom Negotiation with HIV Positive and HIV Negative Partners

The qualitative interviews suggest that decisions about condom use are different for HIV concordant (both partners are HIV positive) when compared HIV discordant couples (one is positive and the other is not). In HIV concordant couples, there seems to be little attempt to use condoms.

"My ex-boyfriend, we're both HIV positive, we don't have to use a condom so we argue about that because I know that we still should. I know you can get a different [strain]... And we do sometimes and we don't sometimes and we go around and around on that."

"As far as wearing a condom is concerned, we don't... They tell me even though we're both HIV that we still ought, should use protection anyway. 'Cause we could infect each other even with different strains of it."

"My lover and I, both us happen to be positive... We tend not to practice safe sex, even though we know we're supposed to practice safe sex."

HIV Discordant Couples

With HIV discordant couples, condom negotiation was less uniformly described. In new relationships, the couple can become overcome by fears of infecting or becoming infected by the other person.

"I just met someone, and it's too much trouble... I am positive, and it's a constant worry about what if he gets sick or he'll wake up one day and say, 'I'm all through with this.' And then that



sucks—wears you down. So it's just a constant vicious cycle. They say, 'don't worry about it.' You can't not worry about it.

"As far as (my) wife is concerned, she's worried about her eventually turning positive and she's got other stuff on her plate as well... I mean, it's just a whole lot to deal with for her."

In some cases in serodiscordant couples, condom use is insisted upon and in others, especially long term relationships, it can be far more difficult to remain vigilant at every sexual encounter.

"I had a partner at that time when I found out, so we just practice safe sex. He never got it. As long as you're safe, you're not going to pass it. HIV's kinda hard to get."

"She (my wife) was positive. I was negative.... We were pretty much careful and everything except 'til we were married. After we got married or whatever, it just popped up... We were together for like a year and a half before I turned positive."

Relationship with the Infector

Among HIV concordant couples, participants frequently brought up who infected the other. Feelings of anger and resentment sometimes emerged, and the toll or worrying about your own health and the health of your partner was described as overwhelming.

"It's been really hard. I'm losing my hair. And they take the blood. I hate needles. It's just really hard and I get angry because my husband is the one who gave it to me, but he's not been as sick. So, it's... I feel like it's not fair."

"I got it from my husband, and he feels really guilty all the time. So, anytime I say something to him, he's just like taking it personally whether or not I'm angry at him or not."

Coping with the Disease

Participants were asked to describe the hardest thing about living with HIV. Many responded, "knowing you are going to die." Others suggested that they are not afraid of dying but of the dying process. "I'm not scared of dying, I'm just scared of dying with this."

Social Stigma of AIDS

Others commented that the social stigma of AIDS was the worst part about the disease.

"Word gets around quick... I'm not nervous 'till I go home... I wish I could leave my apartment during the daytime".

"(They think) that (living with HIV) makes you a dirty person, whereas in the same group of people, if we all had cancer, 'oh, I'm so sorry. I'm sorry this has affected you"

"It's like my kids are afraid for me to be around their kids. It's not because they want to hurt me, it's because they are afraid."

"My mother won't use the same bathroom as I do."

Others commented that the hardest part about living with AIDS was the medications. HIV medications were described as expensive, multiple and daily, always reminding them of the



disease. The expenses and the constant visits to the doctor as well as the side effects of the medications were said to interfere with everyday life.

"Not a day goes by that you don't know you HIV positive... You are on that six hour regimen or twice a day regimen or three time a day regimen... If you sleep late two or three hours, you might be afraid, 'I gotta get my pills so I can stay on top of this thing.' (You) never get a rest from taking your drugs."

"I have five different doctors.... When you have a job, you can't just say, 'Okay, I need to have this day off because I need to go to see the doctor. I need to have this day off, because my medications are just not agreeing with me today.' "

Depression

Almost all respondents described experiencing some level of depression at some point during the course of their illness. For many, counseling and psychological services are critically needed.

"Depression is the worst. It's the worst. 'Cause I thought I had my whole life ahead of me."

"Honey, depression, you do deal with depression. I went through it big time... "

(The hardest part of living with HIV is) *"having to look death in the face. It's always looming, it's always there.... And it just makes me feel like I'm not normal anymore."*

Necessity of Psychological Services

For those who receive psychological services, they report feeling much better about their lives and seem to view the sessions as extremely helpful.

My psychologist (through Life Skills), I lean on her a lot. I got to see her today. [laughs]

My sister and I got to Life Skills... I'm going to group here, and I've got a psychologist at Life Skills.

Those who do not have access to services describe a strong desire to seek and receive counseling. *"You know, me being HIV, I want mental help. I want somebody to talk to. I can get a lot of other things from my care coordinator... What I need really is mental help."*

"(As someone with HIV, mental help is desired), not help with my groceries. Cause if I don't want to live, I ain't worried about no groceries."

Care Coordination Services - High Turnover Rates

One of the few complaints about care coordination services was the high turnover rates. Those interviewed felt that once they got to know a care coordinator, the person left, making it difficult to open up to someone new.

"It takes forever to get a new one. And they don't know what's going on when you get there. You get to know them and they're gone, and you start all over again."



"We struck up a really excellent bond. Right when it got to the really comfortable level, she went to another job."

"In the twelve years I have been here, there's already been five care coordinators for the Barren River Region".

Crisis Hotlines - Not Adequately Staffed

Some of the clients brought up problems they had with crisis hotlines. They reported that hotlines are understaffed and those working the phones are not well trained. *"The crisis hotline, I'm sorry, but they're just a bunch of dummies. I mean they have no answer for you. If you're really in a crisis, they don't know what to do."*

" And it's ten minutes to five and you tryin' to get that call in [to make an appointment]... the first thing they gonna holler is you need to call the emergency line. What's the emergency line goin' to do?...My medicine, which I might have to have refrigerated, is shot to hell. But, I done paid a hundred and somethin' dollars for 3/4 medication that ain't no good no more."

Support - From Others Living with HIV and AIDS

Several participants reported that they received a tremendous amount of support from other people living with HIV and AIDS because of their shared experiences.

"We have something to talk about. We take care of each other. Like if one of us is in the hospital, the other one will take care of the house or sit with them or come help in recovery. We have a good support system between us... If one person's lonely or sad, they call the other one and like, one of my friends will be upset, I'll be like, "come on down." And he'll spend the night. He'll sleep on the couch, and we'll sit up and talk half the night."

Marginalization of Heterosexuals

Although many take advantage of support groups and one on one counseling sessions, some describe feeling alienated because of the single focus on homosexual transmission and gay culture. Those who became positive through heterosexual transmission felt their issues are marginalized and that the public and those infected treat AIDS as a gay disease. In minority and low-income neighborhoods where heterosexual transmission rates are high and homophobia pervasive, support groups are not fully embraced.

"One thing I want to say and I'm not against nobody or anything 'cause I'm just the same as anybody else, but like most of these things that I go to and it's not their fault or my fault, but they're gay. Most people are gay... If say, for instance, my boyfriend caught HIV and he went to one of those meetings. My boyfriend don't like—he calls 'em fags and that's rude. [But] he wouldn't want to share his feelings with gay people."

Recommendations

Recommendations from this study are compiled jointly with the work of Dr. Jeff Jones' group studying similar prevention case management questions among care coordinators and medical staff working with HIV+ Kentuckians. Please see the joint recommendations.



Prevention Among HIV+ Kentuckians: Evaluation of Existing Agency Practices and Recommendations for State Policy

Rick Zimmerman, Ph.D., Jeff Jones, Ph.D., Kathy Atwood, Sc.D., Alisa Bowersock, MPH, Jennifer Galland, MHA, Tina Webb, MPH and John Youngblood, MA

University of Kentucky Institute for HIV, STD, and Pregnancy Prevention, Department of Communication
and the
University of Kentucky Center for Prevention Research, Kentucky School of Public Health
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Overview

The Lexington Fayette County Urban Government Health Department and State Department for Public Health contracted Rick Zimmerman of the Institute for HIV, STD and Pregnancy Prevention, and Jeff Jones of the Center for Prevention Research to conduct a statewide assessment of secondary prevention efforts targeted towards persons living with HIV and AIDS (PLWHA). Dr. Zimmerman and his colleagues at the University of Kentucky Institute for HIV, STD, and Pregnancy Prevention have produced considerable and respected work on prevention efforts in Kentucky and Africa. Dr. Jones and his colleagues at the University of Kentucky Center for Prevention Research on the other hand have research expertise in evaluating the needs and client satisfaction with HIV/AIDS care providers. Because of the different nature of the work of outreach workers and care providers, this report actually consists of three sections:

1. This introduction provides an executive summary of this work. In this section, the two research groups have come together to produce joint recommendations on prevention case management for HIV+ Kentuckians.
2. Section two is the more detailed report on interviews with outreach workers and PLWHA, produced by the University of Kentucky Institute for HIV, STD, and Pregnancy Prevention.
3. Section three is the more detailed report on interviews with care coordinators and medical staff produced by the University of Kentucky Center for Prevention Research.

Views about prevention case management vary among individual workers and among different groups whose work brings them into various points of contact with HIV+ Kentuckians. Currently there is no standard, uniform model of prevention case management used throughout Kentucky. Rather, individual care coordinators, prevention specialists, outreach workers, and medical staff report personal efforts at prevention case management. These efforts largely share commonalities such as first building a relationship of trust with a client and relying upon positive reinforcement and self-esteem building with clients. While they have different roles and use varying assessment tools, three individuals based in Henderson, Lexington, and Louisville work specifically as prevention case managers. HIV+ clients report few instances of what they perceive as prevention case management. For outreach workers who provide education through various public forums including public sex environments, the HIV status of individuals is often unknown to the worker. Thus, role of outreach workers in prevention case management could be one of educating Kentuckians about prevention case management referral opportunities among other referral sources offered to individuals in the field. Care coordinators and medical staff also see a possible conflict of interest in providing both financial and medication support while attempting to conduct potentially confrontational prevention case management. Burnout, high levels of stress, and often blurred lines between service roles also place already existing burdens upon these groups.

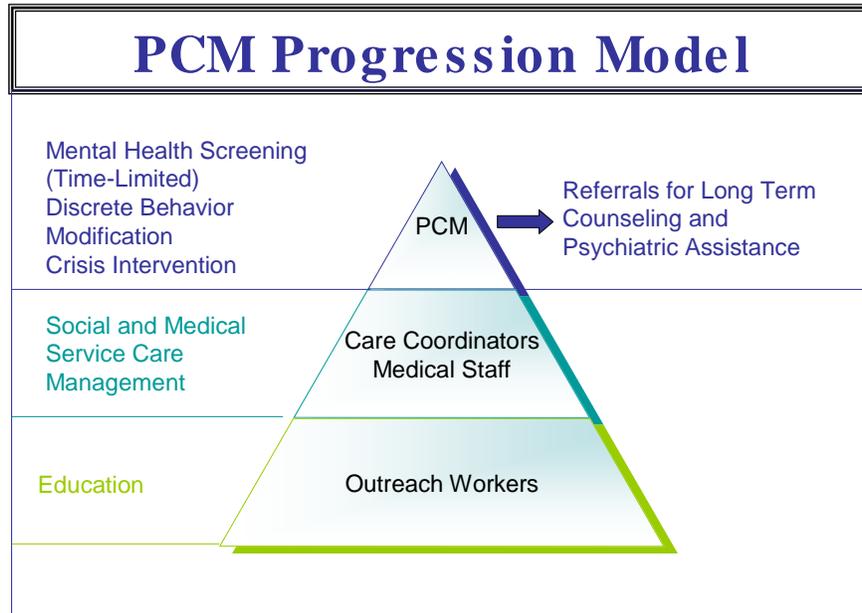


Instead, most agency workers suggest that a common prevention message needs to be conveyed to clients by everyone working with HIV+ clients. Intensive prevention case management is somewhat vaguely defined for many interviewees. In drawing together interviewees' hopes for prevention case management, the role of prevention case management consists of the following:

- 2 positions at each of Kentucky's 9 primary HIV sites (Title II clinics and Care Coordinator offices)
- The prevention case management (PCM) positions would work exclusively with HIV+ clients and their support networks.
- The PCM would serve as a referral service for outreach workers, medical staff, and especially care coordinators.
- The PCM will provide clients with:
 - *Crisis intervention counseling*
 - *Screenings for mental health needs*
 - *Support groups for specific behavior modification issues such as intimate/sexual relationships for couples where one or both individuals are HIV and support groups for PLWHA to deal with the day to day stressors of living with HIV. During these support groups the PCM should actively debunk community-specific myths about risks of transmission, strengthen condom negotiation skills and self-efficacy skills around safe injection, and increase HIV disclosure self-efficacy with potential sex partners.*
 - *Work with clients and supporters on time-limited, specific behavior modification issues and develop client-centered risk reduction plans that the PCM monitors and modifies over time based on the client's risks and progress.*
 - *Refer clients and supporters to long-term mental health counseling and assist in transitioning clients and supporters into counseling*
 - *Maintain an ongoing and trusting relationship with HIV positive caseload. Keep in close contact with clients to insure they get to medical/ social service appointments and support groups through the provision of narc cards, gas cards and phone cards and through frequent and consistent contact.*
- The PCM will also work with area mental health agencies in training their staff about sensitivity to HIV+ clients, their supporters, and issues specific to counseling these populations
- The PCM will specifically seek to contact and track clients who may be at risk as identified by a loss of contact with their physicians or care coordinators.
- The PCM will develop specific goals for when a client should attain a behavior modification and be discharged from intensive prevention case management.
- During support groups and one-on-one counseling sessions the PCM should consider the specific risk profile/s and ethnicities of the clients. The sessions must consider the varying decision-making processes that people go through when making decisions about safe sex and HIV disclosures. Based on our interviews, these decision-making processes may include:
 - a. Decisions about when to use a condom based on the sexual acts (oral, anal or vaginal);
 - b. Consideration of length and type of relationships (new, long-term, or ex);



- c. Concerns and issues based on whether the partner is positive or negative;
- d. Myths about infection and re-infection;
- e. The symbolic meaning of shared risk behaviors within a relationship (i.e., barebacking as a sign of trust) and the reality that many men living with HIV and AIDS cannot maintain an erection with a condom.



The figure above outlines the differing roles of HIV workers and how the PCM referral system would ideally work.

Other Findings

A General Model for Workers Outside of the Prevention Case Manager

1. We recommend that the state develop a comprehensive prevention strategy around this four-step model:

- A. **DESTIGMATIZE** - Each encounter with a client should seek to build trust, rapport, and openness that removes stigma from the client's HIV disease and fear of disclosing risky behaviors.
- B. **SCREEN** - Every client is at a different point in life and acceptance of his/her HIV status. Clients should be periodically screened by care coordinators and medical personnel for life factors and experiences that may place them at a higher need for more intensive prevention assistance.
- C. **EDUCATION** - Providers repeatedly point out that their clients are initially woefully ignorant of HIV/AIDS. Each encounter with a client should emphasize a core, repetitive prevention message that is consistent between agencies. These educational encounters should also set standards for what information a client should have after their first, second, fifth, etc. meeting with a provider.



D. **TREAT/REFER** - Every encounter should provide some type of treatment to the client whether medical, case management, positive reinforcement, or referral.

2. The Kentucky Department for Public Health should develop a comprehensive prevention strategy that includes the following:

- A core prevention message and perhaps logo that is disseminated among all agencies providing care to HIV+ Kentuckians is required. This message should ideally be repeated with clients at every contact with a care agency. Consistent, repetitive messages are critical to education.
- Supplemental messages targeting particular sub-groups among HIV+ Kentuckians would also be helpful.
- The comprehensive prevention strategy should include the role of each agency and provider in implementing this strategy.

This strategy message should also:

- Include a statement that disclosure of risky behavior will not impact the services rendered by a provider to the client.
- Outline for the client how the provider will use this information (partner notification, comments in client's chart, referral for intensive case management, etc.)
- Include a statement that the provider understands and embraces the need by all people for intimacy and will help clients meet this need in a healthy manner.

3. Because of the caseload demands on providers, agencies should introduce periodic screens such as the Oregon Client Assessment or Behavior Risk Assessment Tool to categorize clients into three levels of intensity for prevention efforts: Intensive, Targeted, and Universal. These levels should reflect both compliance to appointments and medications as well as high-risk personal factors such as mental illness, substance abuse, and childhood abuse.

The core components of any public health prevention strategy are to educate the public and empower them to eventually sustain their own healthy behaviors. Currently providers view Kentucky as having many excellent and caring workers who nonetheless lack any statewide, consistent message and method that is applied across agencies as a client flows through the care system. The experiences of Kentucky's hard-working HIV/AIDS care providers; however, gives significant insight into what an effective strategy should look like.

Executive Summary of Qualitative Findings Specific to Outreach Workers

- Because outreach workers have varied roles and responsibilities, there lacks consensus about what their core functions and goals are or should be.
- Condom distribution was described as the primary mechanism for beginning a dialogue about risk reduction.
- In the course of their street outreach activities, most workers do not know the serostatus of their clients, and those that do are reluctant to discuss secondary prevention on the street because of fears of divulging serostatus and violating trust.



- In some instances during street outreach, workers will be approached by clients who quietly disclose their serostatus. Under these circumstances, outreach worker may discuss risk reduction but their primary goal is to refer clients to care coordination.
- Overall outreach workers did not identify different strategies they use when working with HIV positive and HIV negative clients.
- Conversations regarding secondary prevention are more likely to occur during a post-test counseling session at the office. Messages about safe sex tend to fall on deaf ears, given all the complexities that the client is trying to process. After just learning their serostatus, they tend to respond they are never going to have sex again.
- One outreach worker, who is also a designated prevention case manager, provided a more nuanced description of secondary prevention. During one on one counseling sessions with his HIV positive clients, he develops personally tailored risk reduction plans that are discussed and modified over time. He also holds support groups that the clients run allowing them to have more open dialogue about safe sex and to feel greater ownership of the group process.
- Secondary prevention with substance abusers was not well described. Outreach workers have tremendous difficulty finding IDUs and tend to see more crack use. They counsel drug users not to share crack pipes and distribute bleach kits but recognize that the greatest risk factor crack users face is sex for drug exchanges. They reported that when drug users relapse, they *“just disappear”* and avoid all services and outreach efforts.
- One outreach worker said that service providers need to have a better understanding of the symbolic meaning of shared risk behaviors in the MSM community. Barebacking was described as a *“sign of trust” “I have your life in my hand you have my life in your hand.”* Others suggested that barebacking often occurs because the side effects of HIV medications make it hard for PLWHA to maintain an erection.
- Myths about safe sex are pervasive in both the heterosexual and homosexual HIV/AIDS communities including: oral sex is safe; it’s okay to have unprotected sex with a positive partner because there’s no such thing as reinfection; and if your viral load is zero you can’t spread HIV to others.
- Burn-out was described as particularly common among indigenous workers, because they are unable to escape the stress of their work. However they believe that their firsthand knowledge of at risk communities makes them more effective at what they do. *“You almost have to live in that person’s shoes in order to do this work.”*
- Several outreach workers were frustrated by their inability to gain access to venues where risk behaviors are taking place including, straight clubs, strip clubs and truck stops.
- Overall outreach workers feel much supported by the State Department of Public Health and their supervisors and feel that the trainings are generally thorough and applicable to their work.
- Outreach workers said more training is needed in the following areas: working with both the Hispanic community and substance abusers. Others felt that more graduated, trainings



tailored to the skill level, knowledge and experience of the worker made more sense than placing both new and experienced workers in the same session.

- Outreach workers recommended that medical doctors discuss secondary prevention with their patients provided they are better trained in counseling and in the HIV behaviors and lifestyles of at risk communities. They reported that when doctors deliver news about low viral loads they need to caution clients about risks of transmission and re-infection.
- Outreach workers were skeptical of care coordinators discussing secondary prevention because of their inherent power and control over client resources and access to services.



Executive Summary of Qualitative Findings Specific to People living with HIV and AIDS

- Few discussed safe sex with their care coordinators or medical providers.
- Most could not recall interacting with an outreach worker much less discussing sexual risk behaviors and risk reduction with them.
- Most do not discuss secondary prevention issues with service providers and tend not to talk to anyone about these issues. Conversations with friends and family members tend to be more cautionary in nature, instructing others about the importance of using condoms.
- Two of the 8 prevention case management clients interviewed provided a more explicit description of secondary prevention, one said he was taught how to *“put on a condom sexually to keep the other person aroused.”* The other client described having access to dental dams and female condoms.
- All clients had tremendously positive things to say about care coordinators and infectious disease doctors in terms of services they offered. Despite these positive relationships, clients were reluctant to discuss safe sex issues with these individuals.
- Condom negotiation fell into three categories: those determined to remain abstinent (usually recently diagnosed); those who demand condoms at every occasion; and those who describe greater internalized struggles about condom use, *“I know its wrong but it just got the better of me.”* Others have more *“harm reductive”* approaches to condom use, using condoms during anal sex but not oral sex.
- HIV disclosure – some tell potential partner right away, others postpone disclosure in new relationships due to fears of rejection, and still others have a more *“universal precautions”* approach assuming that if they use condoms they don’t need to bring it up.
- In many cases after diagnosis, PLWHA will return to past relationships which offer intimacy without the risk of rejection, quell fears of infecting someone they don’t know and provide needed emotional support.
- Among seroconcordant couples, condom use rarely occurs.
- Among serodiscordant couples, condom negotiation is less uniformly described. In new relationships condom use can be insisted upon, and in long term relationships it becomes far more difficult to remain vigilant at every sexual encounter. The stress of potentially infecting one’s partner is always in the foreground.
- Relationship to the infector – within HIV concordant couples, respondents frequently brought up who infected the other (in cases where transmission occurred). Feelings of anger and resentment and the stress of worrying about the health of your partner was described as at times overwhelming.
- Many of those interviewed described needing mental health services to deal with depression and the stress of living with HIV and AIDS. One participant commented, *“...if I don’t want to live, I ain’t worried about no groceries.”*



- Participants were frustrated with the high turn over rate of care coordinators. Clients described establishing close, trusting relationships with their care coordinators only to have them leave. Each time they start over with new care coordinators they invest less of themselves into these relationships.
- Others added that support groups need to have less of a focus on gay culture and homosexual risk in order to prevent alienation of heterosexuals from support systems.

Recommendations (Based on findings from interviews with outreach workers and people living with HIV and AIDS). (The DPH response is listed after each recommendation)

1. Strategies for coping with the emotional stress of outreach work need to be developed system-wide and especially for indigenous workers. Providing opportunities to discuss and process the stresses of the work and offering sufficient comp. time to emotionally distance oneself from the work were suggestions made by outreach workers.
 - One session per year within a quarterly training will address stress and burnout. The DPH will contact UK to obtain a grad level student to conduct the training.
2. Outreach worker training should include strategies for working with Hispanics (especially bisexual males) and substance abusers. Substance abuse training should include both IDUs and crack users, discussing how to locate active users when they go underground, and how to effectively counsel those who engage in sex for drug exchanges.
 - The Border Health Foundation will be contacted to conduct training for strategies to reach Hispanics and bisexual males. Dan Newman will be contacted to conduct substance training.
3. The State Department for Public Health should broker discussions with rest areas, truck stops and straight bars to allow for condom distribution and education.
 - Attempts and offers have been made at these locations to conduct prevention efforts and all offers have been denied. As one of these areas indicate willingness to work with us, services will be provided. Attempts will continue to encourage participation.
4. More Prevention Case Managers (PCMs) are needed throughout Kentucky. CDC defines PCM as intended for “persons having or likely to have difficulty initiating or sustaining practices that reduce or prevent HIV transmission or acquisition,” we recommend that PCM should have a designated caseload of only people living with HIV or AIDS. An existing PCM should facilitate training to provide concrete examples of how PCM functions.
 - CDC recommends PCM not only for people infected with HIV or AIDS, but also people at high-risk on infection. To only provide PCM to people living with HIV or AIDS is against our prevention mission to prevent HIV infection.
5. Because we recommend that PCM should only have a designated case load of persons living with HIV or AIDS, it is unrealistic to expect outreach workers to perform these functions while doing street outreach due to issues of anonymity and privacy.



- Steps have been taken to accommodate the needs of outreach workers conducting PCM. Their caseload is small and there has been a reduction of other responsibilities. Prevention Specialists have received training on the fundamentals of Maslachs' high archy.



Process Evaluation – Prevention Specialists 2004

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Overview

The research team at the University of Kentucky interviewed Prevention Specialists in Lexington, Paducah, Bowling Green, Louisville and Northern Kentucky to gain their perspectives of Prevention Case Management (PCM). This component of the evaluation was a process evaluation focusing on Prevention Case Managers' views on the development and implementation of PCM, the challenges of conducting PCM, and recommendations for modifying the program as it is being implemented throughout the State.

The State Department for Public Health was also interested in assessing “burnout” among Prevention Specialists. Burnout has been defined in the literature as a syndrome of increased emotional exhaustion, increased depersonalization and reduced personal accomplishment (Maslach et al, 1996). Burnout is a common result of increased demands and overwork and may appear as persistent physical and emotional exhaustion, unrelieved feelings of fatigue, marked irritability, and a decrease in the individual's desire and ability to work effectively. Failure to cope can result in low morale, high turn over, and absenteeism (Maslach et al, 1996).

The role of Prevention Specialist is tremendously taxing and emotionally exhausting. Like many in the “helping professions,” Prevention Specialists are vulnerable to burnout. The nature of this work often attracts people who are empathetic, sensitive, and who come from the communities at risk (indigenous workers), making it difficult to separate themselves from the needs of their clients.

Critical to the study of burnout are the linkages among stress, job satisfaction, and the work environment. When looking for possible reasons for burnout, Maslach and colleagues comment, “One is better off not to try to identify the bad people in an organization, but the characteristics of bad situations where good people function.” (1996). Listed below are the components of burnout as presented by Maslach and Jackson (Table 1).

Burnout = Increased Emotional Exhaustion + Increased Depersonalization + Decreased Personal Achievement

Table 1: Components of Worker Burnout

Emotional Exhaustion	Feelings of being emotionally overextended and exhausted by one’s work
Depersonalization	An unfeeling and impersonal response toward recipients of one’s service, care, treatment or instruction.
Reduced Personal Accomplishment	Feelings of incompetence and lack of successful achievement in one’s work.

Source: Maslach, C., Jackson, S. E. & Leiter, M.P. (1996). Maslach Burnout Inventory: Manual, 3rd ed. Palo Alto, CA: Consulting Psychologists Press.



Study Design

The process evaluation included a cross sectional (one point in time) survey and interview. Workers completed a short questionnaire and then participated in an interview conducted by a UK research team member. Workers were interviewed at agency offices. Completion of the interview and survey took approximately 40 minutes.

Prevention Specialist Recruitment

The State Department for Public Health provided a list of Prevention Specialists to the UK Research Team. This list was reviewed to identify workers who had recently left their jobs and workers who were newly hired and were not yet in the field working as Prevention Specialists. Twenty-one workers were identified who were currently employed and working in the field and therefore could be interviewed. Of these twenty-one, most (86%) had been trained in PCM and eighteen had been instructed to begin to build their PCM caseloads. Prevention Specialist interviews occurred between February 2004 and April 2004.

Survey Instrument

The purpose of this component of the evaluation was to look at the process of developing the PCM program from the perspective of the Prevention Specialist. The interview included a quantitative component with closed-ended questions about demographic characteristics, job responsibilities, caseloads and level of burnout. The interview also included a qualitative component that asked how PCM was going, obstacles workers faced and recommendations (See Appendix A). A separate interview guide was developed for Prevention Specialists who were not currently involved in Prevention Case Management (n=3) to ascertain their perspectives on the program (See Appendix A).

Measurement of Burnout

Employee burnout was assessed among Prevention Specialists using the Maslach Burnout Inventory (MBI). This tool measures burnout as it manifests itself in workers (1996) (see Appendix A). The 24 question inventory was broken down into the following subscales: emotional exhaustion (1), depersonalization (2); and reduced personal achievement (3) (Table 2).

Table 2: Subscales of the Maslach Burnout Inventory (MBI)

Emotional Exhaustion Subscale
I feel emotionally drained from my work.
I feel used up at the end of the day.
I feel fatigued when I get up in the morning and have to face another day on the job.
I feel very energetic.
Working with people directly puts too much stress on me.
I can easily create a relaxed atmosphere with people at work.
I feel exhilarated after working with people closely on my job.
I feel like I am at the end of my rope.
Depersonalization Subscale
I feel burned out from my work.
I can easily understand how people I work with feel about things.
I feel I treat some people in an impersonal manner.



Working with people all day is a strain for me.
I have become more callous toward people since I took this job.
I worry that this job is hardening me emotionally.
I really don't care what happens to some people I encounter at work.
I tire of seeing the same groups (as clients).
Reduced Personal Achievement Subscale
I feel frustrated by my job.
I deal effectively with problems people bring me at work.
I feel I am making a difference in other people's lives through my work.
I feel I am working too hard on my job.
I have accomplished many worthwhile things in this job.
In my work, I deal with emotional problems very calmly.
I feel others at work blame me for some of their problems.
Concerning HIV prevention, I feel qualified to deal with all types of people.

The survey instrument instructed participants to indicate whether they experienced each of these feelings: “Never” (1); “Some of the time” (2); “About half of the time” (3); “A little more than half of the time” (4); or “Always” (5). These survey response items were rescaled to indicate that the higher the value, the greater the level of emotional exhaustion, the greater the level of depersonalization, and the lower the level of personal achievement.

Mean scores of the three subscales and a global scale of burnout were calculated to assess whether there were significant differences in level of burnout by gender, race, education and whether the worker was indigenous or not.

Measurement of Indigenous Worker

Indigenous workers were defined as those who described themselves as being previously a member of a high-risk population, such as injection drug users. Indigenous workers were also defined as those who were members of the MSM community. We ascertained this information by asking workers, during the qualitative component of the interview, what made them get involved in HIV prevention. If a worker described coming from an at risk community and explained that this experience motivated him or her to get involved in HIV prevention, that worker was categorized as indigenous. Based on these qualitative and subjective assessments, 11 indigenous workers and 10 non-indigenous workers were identified among the 21 Prevention Specialists.

Data Analysis

Qualitative and quantitative data from the survey were entered into *Excel* and analyzed using coding and thematic analysis. Responses specific to the Maslach Burnout Inventory were downloaded into SPSS. Mean scores of burnout were calculated for each of three subscales, emotional exhaustion, depersonalization and personal accomplishment when stratified by gender, race, education level and indigenous versus non indigenous worker. Significant differences in mean level of burnout were estimated using the t test for independent samples and the F test for multiple categories. Three separate members of the UK research team analyzed the qualitative data to allow for triangulation of ideas and to arrive at themes that emerged from the data.



Quantitative Findings

Demographic Characteristics

As can be seen in Table 3, 44% of Prevention Specialists report having some college and 39% had a bachelor's degree. The majority of workers were White (66%) and a third were African American. The majority of Prevention Specialists involved in PCM were based in the larger metropolitan areas of Louisville and Lexington (33% and 33% respectively) and only one worker was involved in PCM in Northern Kentucky (Table 3).

Table 3: Characteristics of Prevention Specialists (n=21)

	% (n)
Education Level (n=18) ^a	
Some College	44 (8)
Bachelor's Degree	39 (7)
Graduate/Professional Degree	17 (3)
Race	
African-American	28 (6)
White	66 (14)
Asian	6 (1)
Region	
Lexington	33 (7)
Louisville	33 (7)
Paducah	14 (3)
Bowling Green	14 (3)
Northern Kentucky	6 (1)

^a Missing responses on education (n=3)

Roles and Responsibilities

Most workers (86%) reported being trained in PCM and 18 of the 21 respondents were in the process of conducting PCM (Table 4), although three had not been able to recruit a caseload at the time of the interview (Table 5).

Workers were asked to estimate the number of hours spent on various work activities. On average, Prevention Specialists spent 43% of their time conducting outreach activities, 25% on Prevention Case Management, 20% on administrative tasks and formal supervision, and 12% running support groups, conducting workshops and other activities (Table 4). More hours are spent conducting outreach in bars and parks (7 hours and 4.5 hours, respectively) and fewer hours in environments such as methadone maintenance centers and shooting galleries (0.75 and 0.5, respectively) (Table 4).

Table 4: Prevention Specialist Training and Responsibilities (n=21)

	% (n)
Trained in PCM	
Yes	86 (18)
No	14 (3)
Conducting PCM	
Yes	86 (18)



No	14 (3)
Hours of PCM training (n=18)	% Mean hours per worker 30 (12)
Prevention Specialist Activities:	% Mean hours per worker
Outreach	43 (17)
PCM	25 (10)
Administrative Tasks	10 (4)
Formal Supervision	10 (4)
Organizing/Running Support Groups	2 (1)
Other (including workshops)	10 (4)
Total	100 (40)
No. of hours per week spent doing outreach:	Mean hours per worker
Bars	7.0
Parks/Public Spaces	4.5
Bookstores	2.0
Shooting Galleries	0.5
Methadone Clinics	0.75
Other locations	1.75
Mean nos. of total outreach hours per week	17

PCM Caseloads

Limiting the analysis to Prevention Specialists designated to conduct PCM (n=18), 15 of the 18 workers (85%) had recruited PCM caseloads at the time of the interview. Caseloads ranged from seven to twenty-seven people, with a total of 170 clients reported to be in PCM (Table 5). It is important to note that this total number is based on those clients the workers enrolled, as opposed to clients who were actively seeing their Prevention Case Manager on an ongoing basis.

Prevention Specialists were asked to estimate the number of clients they talked to about PCM, and the number they actually enrolled in PCM, in order to calculate an average recruitment rate. Across the 18 workers, an average of 25% of clients who were approached about PCM agreed to enroll (Table 5). Of those enrolled in the program, 45% were reported to be HIV positive. When Prevention Specialists were asked how often they met with their PCM clients, 53% reported once a month, 20% said twice a month and 13% said on an “as needed basis.” When asked how often the Prevention Case Manager reviews Individual Prevention Plans (IPP) with clients, 47% reported that they review plans at each visit, 26% reported “as needed” and 20% reported that they had not reviewed IPPs with their clients. Over half (60%) of the Prevention Specialists reported that their PCM clients are attending support groups (Table 5).

Table 5: Characteristics of PCM Caseloads (Among PCM workers)

	% (n)
Prevention Specialist targeted population (n=18)	
HRH	11 (2)
MSM	27 (5)



MSM/HRH	6 (1)
IDUs	17 (3)
MSM/IDU	6 (1)
HIV+	6 (1)
African American	6 (1)
Provided No designation	21 (4)
Total	100 (18)
Do you have a Current PCM caseload (n=18)	
Yes	83 (15)
No	17 (3)
Size of Caseload (n=15)	Mean=10 Range (7-27)
No. enrolled in PCM at the time of the interview	170
HIV Status of Clients	
HIV Positive	45 (76)
HIV Negative	55 (94)
Total	100 (170)
Frequency of Meeting with PCM Clients (n=15)	
As needed basis/Varies	13 (2)
Every 2 months	7 (1)
1 per month	53 (8)
2 per month	20 (3)
Once a week	7 (1)
Frequency of Reviewing IPP with clients (n=15)	
Have not reviewed IPPs with client	20 (3)
At each visit (once a month)	47 (7)
3 to 6 months	7 (1)
As needed	26 (4)
Do your PCM clients attend support groups (n=15)	
Yes	60 (9)
No	40 (6)
Mean Percentage of clients invited to enroll in PCM and agreed to participate	25

Prevention Specialist Burnout

Burnout among Prevention Specialists was assessed by estimating mean scores for each of the three subscales of burnout and the global scale to see whether there were significant differences in levels of burnout by gender, race, education and whether the worker was indigenous or not. We found no significant difference in the 3 subscales of burnout or the global scale when comparing males to females (Table 6). When comparing African Americans to Whites, we found that African Americans scored significantly higher on the depersonalization score ($p=0.01$), meaning that they had significantly higher levels of depersonalization (4.5 vs.



4.1). African Americans also had slightly, though not significantly higher levels of emotional exhaustion (2.4 vs. 1.9, $p=0.1$) and slightly higher levels of feeling that they are not personally accomplishing things at work (4.2 vs. 4.1, $p=0.4$) when compared to Whites. The overall score for burnout was significantly higher for Blacks compared to Whites (3.7 vs. 3.4, $p=0.05$).

Prevention Specialists who reported higher levels of education (Bachelor's or Graduate school training) scored significantly lower on the emotional exhaustion scale (1.8 vs. 2.5, $p=0.08$) and scored significantly lower on the global scale of burnout (3.3 vs. 3.7, $p=0.07$) than those with only some college. This suggests that those with higher education were less likely to experience burnout than those with less education.

When comparing indigenous workers to non-indigenous workers, we found that indigenous workers had significantly higher levels of depersonalization than non-indigenous workers (4.4 vs. 4.1, $p=0.02$). They also had slightly, though not significantly higher scores on emotional exhaustion (2.2 vs. 1.9) and slightly higher levels of not experiencing personal accomplishment (4.2 vs. 4.1). Overall, their global burnout score was slightly, though not significantly, higher than non-indigenous workers (3.6 vs. 3.3).

The analysis by region showed consistent findings across all regions. The depersonalization subscale ranked the highest of the three dimensions of burnout and emotional exhaustion ranked the lowest across all regions. The global burnout indicator showed that regions ranged from 3.0 to 3.7 (data not shown to protect worker confidentiality).

Table 6: Level of Burnout among Prevention Specialists (n=21) *

	Accomplishment		Depersonalization		Emotional Exhaustion		Global Scale	
	Mean	sign. ^a	Mean	sign.	Mean	sign.	Mean	sign.
Females	4.2	0.2	4.2	0.7	2.1	0.9	3.5	0.9
Males	4.1		4.3		2.0		3.5	
Black ^a	4.2	0.4	4.5	0.01	2.4	0.1	3.7	0.05
White	4.1		4.1		1.9		3.4	
Some Col.	4.2	0.2	4.4	0.3	2.5	0.08	3.7	0.07
Bachelors/ Grad.Sch.	3.9		4.1		1.8		3.3	
Indig	4.2	0.3	4.4	0.02	2.2	0.3	3.6	0.1
Non.Indig	4.1		4.1		1.9		3.3	
All Responde nts	4.1		4.3		2.1		3.4	

*Higher scores mean higher level of burnout (range 1-5)

^a Significance based on t test, unequal variance assumed.



Qualitative Findings: Prevention Specialist Interview

This section of the evaluation presents findings from the qualitative component of the interviews with Prevention Specialists. Prevention Specialists were asked in open-ended questions about how PCM was going, obstacles workers faced and recommendations (See Appendix A). Data were inputted in Excel and analyzed using coding and thematic analysis.

PCM - Added Responsibility

Prevention Specialists were asked how their roles and responsibilities have changed with the advent of PCM. Many explained that their workload has increased with PCM. One worker described the change in role as a “major adjustment.” Workers expressed that they had not lost any of their previous responsibilities in order “to make room for PCM.” Workers reported that there is not enough time, too much to do, and that they are “spread too thin.”

A Prevention Specialist reported that at his agency, workers are required to be in the field throughout the week and in the office one day a week. He explained that this policy does not allow enough time to properly perform Prevention Case Management duties and presents difficulties in scheduling appointments with clients.

Client Recruitment

Prevention Specialists were asked where they recruit clients. Those working with IDUs recruit in parks, crack houses, shooting galleries and “bootleg joints.” Others said that a major method of recruitment was through the twenty-five dollar incentive that the UK research team provided to complete the baseline survey. Others placed flyers with outside agencies asking for referrals. New hires reported that they inherited their caseloads from previous employees.

PLWH recruitment

In many instances, Prevention Specialists reported that if they have a HIV positive client, he/she is referred to the Prevention Specialist designated to work with PLWHA. As a result, most workers do not carry HIV positive clients in their caseload. Prevention Specialists working with PLWHA receive referrals from other Prevention Specialists, from Care Coordination, and from infectious disease clinics such as the Wings Clinic.

Reasons Clients Resist Participating in PCM

Workers were asked why some clients do not want to participate in PCM.

1) Already know the talk

Prevention Specialists suggested that clients “already know the talk.” Some clients, especially those infected, only want to know about “new breakthroughs that arise in treatment and are well aware of HIV prevention.”

2) View themselves as low risk



The majority of clients who were unwilling to participate in PCM provided one of the following responses: 1) “don’t have time;” 2) “don’t need it;” 3) “aren’t at risk;” or 4) “not having sex.” Prevention Specialists commented that clients often viewed themselves as low risk.

In other instances, Prevention Specialists cautioned that “not everyone needs PCM.” Some workers expressed concern that there is a rush to build caseloads when some people do not necessarily need PCM.

3) *Invasion of Privacy*

Several Prevention Specialists suggested that potential clients resist participating in PCM because of “trust” issues. One worker reported that clients ask “what are you going to do with the information?” Almost all workers commented during the course of the interview that building trust was critical to having an honest dialogue about risk behaviors.

4) *Transportation Difficulties*

Prevention Specialists said one of the most common reasons clients gave for not participating in PCM was lack of transportation. Several workers suggested that a designated van should be made available to meet clients in their neighborhoods. The van could include testing and provide a secure place for PCM counseling.

Positive Aspects of PCM

1) *Building Trust, Rapport and Establishing Goals*

Most Prevention Case Managers, though skeptical of their ability to perform PCM in addition to their other work responsibilities, felt very positive about the newly established rapport they have developed with clients. They said they have gotten to know their clients at a deeper level and enjoy “the connection” they have made with clients. Overall Prevention Specialists enjoyed the opportunity to see clients one-on-one and over time.

2) *Establishing Individualized Prevention Plans (IPPs)*

Almost all workers (80%) reviewed IPPs during PCM sessions. One Prevention Specialist commented “I don’t write anything down in front of a client.” He reported that clients are very anxious if they think there are “Case files” on them. He purposely waits until they leave to update files.

Overall, Prevention Specialists felt very positive about developing IPPs. They expressed that IPPs instill in them and their clients a sense of progress and accomplishment. One worker commented, “It’s advantageous for anyone to work on goals and to strive toward meeting those goals.”

Challenges of PCM

1) *Balancing a Low Threshold Approach with Active Recruitment*

Overall, prevention specialists feel pressure to increase their caseload. One Prevention Specialist explained if you “push too hard, clients run away...The next time you see them at a PSE (public sex environment) they avoid you.” Another worker commented, “Many are not



ready to be that open.” One Prevention Specialist said, “Clients tell you they are too busy today, but that they’ll get back to you - and they never do. Then they avoid you.” Workers suggested that there is a balance between creating the opportunity for dialogue and pushing recruitment too aggressively.

Some Prevention Specialists reported that they are in the process of “building” their caseload. One worker recalled that clients will come to get prevention supplies. At that point, the worker will try to establish more of a dialogue about risk behaviors. The general feeling among Prevention Specialists was that the program is new and they are only just getting started. One worker commented, “even though I have been a Prevention Specialist for 14 months I am still new. The PCM concept is wonderful but every new program has to be tweaked a few times.”

2) Frequency of Contact with Clients Varies

One of the challenges for PCM workers is maintaining an ongoing relationship with clients over time. Most workers do not proscribe specific meeting times and let the client set up the time to meet. One worker said, “I don’t force them to see me.” Another worker commented “too much interaction and they shut down.” Prevention Specialists report that they meet with some clients weekly and meet with others once a month, depending on the client’s circumstances. When clients have sustained behavior change and are no longer engaging in high risk behaviors they become “inactive” but not terminated. Prevention Specialists reiterated that “not everyone needs PCM all the time.”

3) Lack of Therapeutic Skills

Many Prevention Specialists felt that they do not have the expertise and clinical training to work with clients at the level that is needed. One worker commented, “I feel like I am just touching the surface.” Several workers described feeling uncomfortable doing “therapy” without proper qualifications and degrees. One worker commented, “We don’t have social work degrees and aren’t qualified to be therapists.”

4) When Clients relapse they withdraw from PCM

One worker mentioned that in some cases clients disappear, making it difficult to maintain a caseload. When clients relapse, one worker explained, such as re-starting drug use or engaging in other self destructive behaviors, they feel they have “messed up and let me down” and they “don’t want to face me.”

5) Stigma Associated with Agency Offices

Prevention Specialists said that PCM has been difficult because some clients do not want to meet at agency offices. Closeted MSMs don’t want to participate, “They don’t want others finding out – if they come in - there’s more chance of that happening.” Workers suggested that PCM should be conducted in more anonymous or confidential settings or in the home to preserve client confidentiality.

6) Developing and Maintaining Successful Support Groups

Prevention Specialists clearly articulated a need for support groups but described the difficulty of establishing successful ones, specifically for HIV negative clients. Prevention Specialists



noted the enormous amount of time it takes to establish support groups, the difficulty of coming up with topics and maintaining the structure when “only two people show up.”

Suggestions of Prevention Specialists

1) Care Coordinators Conduct PCM

Workers were asked how they would redesign Prevention Case Management and whether it should remain with the Prevention Specialists. Five of the 21 workers interviewed suggested that Prevention Case Management should not be the responsibility of Prevention Specialists but should rest with Care Coordination.

An important point brought up was that trust needs to be established in order for Prevention Case Management to be successful. It is difficult to establish goals with a client if the Prevention Specialist does not have that trust. Some Prevention Specialists suggested that Care Coordinators already meet with clients one-on-one, have incentives that they can offer, and in most cases, have already established trust. “They are in their office everyday and meet with them all the time anyway. We aren’t in the office but one day a week.”

Others suggested that indigenous workers are key to building rapport and trust. They reiterated that the person conducting the Prevention Case Management sessions needs to have the same cultural background to allow for honest dialogue and goal setting.

2) Designating One PCM Worker at Each Site

Three Prevention Specialists in different regions suggested that one person should be designated to do Prevention Case Management at each agency. This person would be in charge of scheduling appointments, meeting all the PCM clients one-on-one, as well as being in the office full-time. The Prevention Case Management duties would be placed solely on this person and the rest of the outreach workers would be stripped of their Prevention Case Management duties. This would alleviate the heavy workload placed on the outreach workers to be both in the office and also out in the community.

3) Developing an Incentive Structure

Several Prevention Specialists also stated that clients could work toward an incentive, like a complementary hotel stay. They would receive some kind of graduated incentive that increases over time after they have reached specific goals and attended a specific number of counseling sessions.

4) Designated a van to be used for outreach, testing and counseling

One suggestion for addressing the stigma associated with agency offices was to have a designated van available to Prevention Specialists. The van could be used for counseling sessions and HIV testing, providing a confidential space for clients who would otherwise resist PCM.



5) Peer Recruitment

Some Prevention Specialists suggested that one way to recruit PLWHA was through peer networks. They reported that peer recruitment was the best way to get people into PCM who would otherwise think that they don't need PCM.

6) Networking with Other Agencies

One Prevention Specialist suggested that local agencies and institutions including "churches, jails, homeless shelters, drug rehab programs, etc..." should get together to brainstorm to figure out what can we do to change people's behaviors."

7) Working closely with Care Coordination

Several Prevention Specialists discussed the importance of working closely with Care Coordination to share information on clients. Many said they have good working relationships with Care Coordinators and that it is critically important to have that link when issues come up about medications, housing, and other issues related to managing HIV disease. One Prevention Specialist suggested that there should be one central file on each client and one central system.

8) Interventions in Chatrooms

Some prevention workers suggested that more attention should be paid to internet chat rooms and the sexual exchanges that occur through the internet. They reported getting on line in the evening, in the capacity of an outreach worker, but that much more needs to be done.



Evaluation of Prevention Case Management: Findings from Client Surveys

Overview

The University of Kentucky Research Team interviewed clients eligible for Prevention Case Management services. The purpose of this outcome evaluation was to assess the effect of Prevention Case Management on HIV-risk behaviors and intentions and to assess participation in and attitudes towards PCM services.

Client Recruitment

Prevention Specialists from five regions of Kentucky identified clients who were in the process of being recruited for PCM and those who were already enrolled in PCM. Clients were told about the survey by the Prevention Specialists and asked if they would like to participate. Clients who expressed interest signed a consent form agreeing to release their name and contact information to the University of Kentucky. The UK Research Team contacted the client or worked with the Prevention Specialist to schedule a time for the interview. The client signed a consent form, approved by the University of Kentucky Institutional Review Board, agreeing to participate in a baseline and follow-up survey (Appendix B). At each survey administration, the client received twenty-five dollars.

Participants completed baseline surveys between November and December 2003 and the follow-up interviews between February and March 2004. The purpose of the baseline and follow-up interviews was to assess levels of participation in PCM, changes in behavioral intentions and high risk sexual and injection related behaviors, and the degree to which clients described personalized prevention plans and articulated progress in changing behaviors. The number of clients interviewed at baseline was 161. The number of clients participating in the follow-up interviews was 114, representing a 71% response rate at follow-up. Clients were recruited for the follow-up survey by the UK research team with the assistance of Prevention Specialists. Clients were phoned at their home and invited to participate. If the UK team was unable to reach the client after repeated attempts, the client was mailed a reminder mailing. Participants were interviewed in agency offices or in public areas, and those unable to meet with the UK staff were interviewed over the phone (n=9, 8% of follow-up sample of 114).

Instrument

The baseline and follow-up surveys included closed-ended questions about client demographics, HIV status, access to prevention services, and sexual and injection-related risk behaviors. The follow-up survey included additional open-ended questions about experiences with PCM, what these interactions were like, goals and behaviors clients were attempting to change, and perspectives on their progress in meeting these goals. (See Appendix A for baseline and follow-up instruments.) The UK research team administered the interviews for the following reasons: 1) to avoid issues of low literacy; 2) to help elucidate the definition and meaning of "Prevention Case Management" services; and 3) to prevent confusing PCM with other services, such as care coordination.



Overview of Data Analysis

Quantitative data from the baseline and follow-up surveys were entered into *SPSS* statistical software. The baseline and follow-up data were matched by a confidential code, allowing for an analysis of change in behaviors and intentions among the same individuals at two points in time as well as group level changes. Basic descriptive statistics, paired t tests, and repeated measures of variance analysis were conducted to assess changes in behaviors and intentions at baseline when compared to follow-up, comparing level of PCM participation among males and females, and among HIV positive and HIV negative clients. Because of the limited number of individuals who reported injection drug use (n=3), we were unable to assess statistically significant changes in injection-related behaviors.

Qualitative data were entered into *Excel* and analyzed using coding and thematic analysis. Three separate members of the UK research team analyzed the qualitative data to allow for triangulation of ideas and themes.

Demographic Characteristics of Baseline Population

As can be seen in Table 7, the majority of clients interviewed were male (66%) with an even distribution identifying as gay, bisexual or heterosexual (32%, 33%, and 35%, respectively). Women represented 34% of the sample and identified overwhelmingly as heterosexual (77%). Approximately half of respondents were White, 40% were African American and 12% were Hispanic, Bi-racial or Other. Forty-nine percent of the sample had less than high school education, high school degree or GED, 38% had some college or an associate's degree and 13% had a bachelor's degree or higher. Of the 160 clients interviewed at baseline, 43% reported that they were HIV positive or had AIDS (Table 7).

Table 7: Demographic Characteristics of Clients Interviewed at Baseline

	Baseline Sample (n=160)	
	%	(n)
Males:	66	(105) ^a
Gay	32	(33)
Bisexual	33	(35)
Heterosexual	35	(37)
Females:	34	(53)
Gay	2	(1)
Bisexual	21	(11)
Heterosexual	77	(41)
Race:		
White	48	(75) ^b
African American	40	(63)
Hispanic	4	(6)
Bi-racial	4	(6)
Other	4	(6)
Education:		



High School/ GED	49 (78)
Some College/Assoc Deg.	38 (61)
Bachelors	8 (13)
Grad/Prof Degree	5 (8)
Agency/Region Interviewed:	
Lexington –AVOL	28 (44)
Lexington Hlth Dept.	9 (14)
Louisville Hth Dept & VOA	31 (50)
Paducah (Heartland Cares)	26 (42)
Northern Kentucky Hlth Dept.	6 (10)
HIV Positive:	43 (71)
Yrs. Since Diagnosis:	
≤1	12 (9)
1-2	17 (12)
3-5	15 (11)
6-8	15 (11)
9 +	41 (28)
HIV Negative	57 (89)
Average Age	38 (18-63)

^a Missing responses to gender question (n=2); ^b Missing responses to ethnicity (n=4).

Sexual Risk Behaviors of Clients At Baseline

To assess the sexual risk behaviors of respondents, questions were asked about condom use during anal or vaginal sex with “main” and “other” partners. For example, one of the survey questions asked “In the last month how often would you say that you used a condom during vaginal sex with you main partner?” Responses included: “Never” (1); “Less than ½ the time” (2); “About half the time”(3); “More than half the time”(4); Always”(5); or “No partner in the last month”(6). This question was also asked separately for anal sex with “main” and “other” partners. For descriptive purposes, we examined the highest risk category, “never” using a condom in the last month, when comparing main vs. other partners, stratified by gender.

Among both men and women, respondents tended to be more likely to have unprotected sex with their “main” versus “other” partner. For example among men, 59% reported “never” using a condom during vaginal sex with their “main” partner, compared to 32% with “others”, and 45% reported “never” using condoms during anal sex with their “main” partner compared to 33% with “others” (Table 8). Women were also less likely to use a condom during vaginal sex with their “main” compared to “other” partners (50% vs. 36%). With regard to injection behaviors, few (n=3) of the 160 respondents interviewed at baseline indicated that they were active injection drug users or had injected in the last year (Table 8).



Table 8: Sexual and Injection Behaviors at Baseline (n=159) ^a

	Males (n=105)	Females (n=54)
	% (n)	% (n)
Have a Main Sex Partner:	44 (45)	62 (33)
Gender of Main Partner:		
Male	58 (26)	100 (33)
Female	42 (19)	
Have "Other" Sex Partner	36 (38)	24 (13)
"Never" use condom during Vaginal Sex with: ^b		
Main partner	59	50
Other partner	32	36
"Never" use condom during Anal Sex with: ^b		
Main partner	45	50
Other partner	33	50
Injected drugs in the last year	3 (3)	0 (0)
Injected drugs in the last 2 months	3 (3)	0 (0)

^a Missing responses on gender (n=1); ^b Sample size not shown due to variation with each sexual behavior question.

PCM Recruitment

As can be seen in Table 9, we limited our analysis to those who were interviewed at baseline and follow-up and answered closed-ended questions on both surveys about the region in which they were interviewed and whether they were in PCM at baseline and whether they were in the program at follow-up (n=99, missing data n=15). In this analysis we found that 42% reported that they had enrolled in PCM at baseline compared to 62% at follow-up, suggesting a 20% increase in enrolled between November 2003 and March 2004.

When examining what percentage of clients from each region who were invited to participate agreed to participate, we found that 73% of participants at AVOL in Lexington agreed to participate (30 of the 41) and 73% of clients at the Lexington Health Department (8 of 11 that we interviewed). Paducah enrolled 65% of those approached (13 out of 20), Louisville enrolled 44% of those approached (11 of 25) and Northern Kentucky was unable to enroll any of those approached (Table 9). (In this case clients interviewed by the UK research team were residents of a substance abuse program and only 2 of the 10 interviewed at baseline were located at follow-up.) It is important to note that these numbers reflect who we interviewed at baseline and follow-up, and does not represent the total possible number approached or the total number who agreed to participate at each agency during the course of the study.



Table 9: Percentage within Each Region Who Enrolled in Prevention Case Management at Follow-up (n=99)

	Clients from Each Region at Follow-up (n=99) n ^a	Clients from Each Region Participating in PCM at Follow-up (n=62) % (n)
Lexington AVOL	41	73 (30)
Lexington Hlth Dept.	11	73 (8)
Louisville Hlth. Dept/VOA	25	44 (11)
Paducah	20	65 (13)
Northern Kentucky	2	0 (0)
	Nos. of Clients in PCM at baseline % (n)	No. of clients in PCM at follow-up % (n)
Total Enrolled in PCM at baseline	42 (42)	62 (62)

^a Missing responses (n=15)

Differences in Sexual Risk Behaviors at Baseline: PCM versus Non-PCM

We next assessed whether there were significant differences in the sexual risk behaviors at baseline when comparing those in PCM to those not in PCM. In other words, were clients who were involved in PCM at higher risk for HIV at the time of enrollment? When limiting our analysis to those who were interviewed at baseline and follow-up and answered questions on both surveys about their sexual behaviors and whether they were in PCM (n=99, missing data n=15), we found few significant differences in sexual risk behaviors. In other words, at baseline, there were few differences in the sexual risk behaviors of those who agreed to be in PCM when compared to those who declined to be in PCM. As can be seen in Table 10, there were no significant differences in the percentages who reported having “main” or “other” partners. There were also no significant differences in the frequency of unprotected anal sex with “main” or “other” partners. However, there was a slightly significant difference in the percentage who “never” used condoms during vaginal sex with their main partner when comparing PCM to non-PCM clients at baseline (56% vs. 33%, p=0.06) and a significant difference with regard to “never” using condoms during vaginal sex with “other” partners (44% vs. 36%, p=0.02) (Table 10). These findings suggest that at baseline, PCM clients were more likely to engage in unprotected vaginal sex than non-PCM clients. However we found no significant differences in the frequency of unprotected anal sex between the two groups at baseline.



Table 10: Characteristics of those enrolled in PCM at follow-up compared to those who did not enroll (n=99) ^a

	PCM (n=62) % (n)	Not in PCM (n=37) % (n)	Sign ^b
Males	63 (39)	69 (26)	0.5
Females	37 (23)	31 (11)	
Have a Main Sex Partner	49 (31)	41 (15)	0.4
Have "Other" Sex Partner	41 (26)	30 (11)	0.6
"Never" use condom during Vaginal Sex with:			
Main Partner ^c	56	33	0.06
Other	44	36	0.02
"Never" use condom during Anal Sex with:			
Main ^c	50	60	0.6
Other	16	25	0.7

^a Missing responses (n=15); ^b Pearson's Chi- Square test; ^c Sample size not shown due to variation with each sexual behavior question.

Characteristics of PLWHA and HIV Negative Respondents

We next assessed the demographic and sexual risk behaviors of those who reported living with HIV or AIDS (PLWHA) and those who reported being HIV negative or whose HIV status was unknown (referred to as HIV negative). As can be seen in Table 11, the majority of people in both the PLWHA and HIV negative groups were male (74% and 60%, respectively). Among the PLWHA group, 77% of males considered themselves gay or bisexual compared to 54% in the HIV negative group

Close to half of the PLWHA group were interviewed in Louisville (48%) including the Louisville Department of Health and Volunteers of America (VOA), 26% in Paducah and 26% in Lexington including AIDS Volunteers (AVOL) and the Lexington Fayette County Health Department. None of the PLWHA came from Northern Kentucky. Among the HIV Negative (or unknown serostatus) group, the majority were interviewed in Lexington (45%), followed by Paducah (26%), Louisville (18%) and Northern Kentucky (11%) (Table 11).

As can be seen in Table 11, 45% of the PLWHA group were involved in PCM at follow-up compared to 76% of HIV negative participants (p=0.001). This suggests that significantly fewer people living with HIV or AIDS took advantage of PCM, perhaps because PLWHA feel less of a need to work on a personalized prevention plan when they are already infected.

Only 1% of PLWHA group and 3% of the HIV negative group reported injecting in the last year, suggesting that either respondents were unwilling to admit this behavior or their HIV risk behavior was related to unprotected anal or vaginal intercourse (Table 11). Forty-nine percent of PLWHA and half of the HIV negative group reported having a "main" sex partner. A significantly greater percentage of the HIV negative group reported having "other" sex partners compared to PLWHA group (32% vs. 15%, p=0.03) (Table 11).



Comparing sexual risk behaviors of the PLWHA group to the HIV negative group, the HIV negative group reported engaging in significantly higher risk sexual behaviors. For example, a significantly larger proportion of the HIV negative group, when compared to the PLWHA group, reported “never” using condoms during vaginal sex in the last month (62% vs. 36%, $p=0.01$) (Table 11). Similarly, a larger proportion of the HIV negative group reported “never” using a condom during anal sex in the last month with “other” sex partners when compared to the PLWHA group, although this finding only approached significance (66% vs. 21%, $p=0.07$) (Table 11). These findings, however, should be interpreted with caution. Although questions about serostatus were placed at the end of the survey, it is possible that PLWHA were less likely to admit engaging in high-risk sexual practices due to the stigma associated with HIV and risky sexual behavior.

Table 11: Descriptive Analysis of PLWHA and HIV Negative Participants

	PLWHA (n=71)	HIV Neg. (n=89)
	% (n)	% (n)
Male	74 (53)	60 (53)
Females	26 (18)	40 (36)
Sexual Identification		
Males		
Gay	43 (22)	20 (11)
Bisexual	34 (18)	34 (17)
Straight	23 (13)	46 (25)
Total	100 (53)	100 (53)
Sexual Identification		
Females		
Bisexual	17 (3)	23 (8)
Straight	83 (15)	77 (28)
Total	100 (18)	100 (36)
Region where interviewed		
Lexington –AVOL	17 (12)	36 (32)
Lexington Health Dept.	9 (6)	9 (8)
Northern Kentucky H.D	0 (0)	11 (10)
Louisville Health Dept. or VOA	48 (34)	18 (16)
Paducah (Heartland Cares)	26 (19)	26 (23)
Injected in the last year	1 (1)	3 (2)
Main sex partner (baseline)	49 (35)	51 (46)
Gender of Main sex partner:		
Among Males		
Male	65 (15)	50 (12)
Female	25 (8)	50 (12)
Total	100 (23)	100 (24)
Among Females		
Male	100 (12)	100 (22)
Female	0 (0)	0 (0)
Total	100 (12)	100 (22)
Other sex partner (baseline)	15 (11)	32 (37) ^a



"Never" use condom during Vaginal sex with:		
Main	36	62 ^b
Other	6	18
"Never" use condom during Anal Sex with:		
Main partner	21	66 ^c
Other partner	18	42
Enrolled in PCM at follow-up ^e	45 (20)	76 (45) ^d

^a p=0.03 (Pearson's Chi Square); ^b p=0.01 (Pearson's Chi Square); ^c p=0.07 (Pearson Chi Square); ^e (limiting analysis to follow-up n=103; HIV+ =44; HIV-=59); ^d p<0.001 (Fisher's exact test);

Changes in Risk Behaviors (Baseline compared to Follow-up)

Data Analysis

Clients were asked, through closed-ended questions, about their sexual and injection risk behaviors at baseline and again at follow-up, eight to twelve weeks later. The purpose was to assess whether clients were attending PCM and whether they reported changes in risk behaviors or intentions, comparing responses at baseline to responses at follow-up. At follow-up, 62% of respondents reported working with a Prevention Case Manager over the last two months. We were thus able to compare survey responses of those involved in PCM (PCM attendees) to those who were not involved in PCM (PCM eligible but did not attend), to assess whether behavior changes were significantly different in the PCM group when compared to the Non-PCM group. We made these comparisons among different subgroups including: 1) males and females; and 2) PLWHA and persons who were HIV negative (or had unknown serostatus). Due to limited sample size, we were unable to make these comparisons among injection and non-injection drug users (n= 3).

The primary sexual behavior questions included in the survey were whether the participant used a condom during anal or vaginal sex with their "main" or "other" partner in the last month. The survey question asked, "In the last month how often would you say that you used a condom during vaginal sex with you main partner?" Responses included: "Never" (1); "Less than ½ the time" (2); "About half the time" (3); "More than half the time"(4); "Always"(5); or "No partner in the last month"(6). This question was asked separately for anal (both top and bottom) and vaginal sex, and for "main" and "other" partners. Respondents who reported that they did not have a partner in the last month were eliminated from the analysis.

To assess changes in condom use, a mean score was calculated for each question (ranging from 1 to 5). Mean scores at baseline were compared to mean scores at follow-up using a *paired t test*. Scores were calculated separately for those in PCM and those not attending PCM. The *paired t test* allows the investigator to compare mean scores for the same individual at two points in time (baseline and follow-up) and to test whether the follow-up mean score is significantly higher or lower than the baseline score. In addition, *Repeated Measures Analysis of Variance* using the *F test* was conducted to assess whether these differences in mean scores were significantly affected by participation in PCM. In other words, did Prevention Case Management significantly affect whether respondents changed their frequency of condom use? This method assesses changes in behavior among matched pairs of responses (baseline and



follow-up) for the same individual, taking into account whether that individual participated in PCM or not, and looks at the interactive effects of PCM involvement on behavior change. All statistical methods assessed significance at the $p < 0.05$ level. Significant findings are bolded in Tables 12-13.

Changes in Sexual Risk Behaviors

When stratifying the analysis by gender, we found that among men, the mean frequency of condom use during anal sex with a “main” partner increased though not significantly among those attending PCM, from a mean of 1.9 (less than half the time) to 4.0 (more than half the time) ($p=0.08$) and increased slightly, though not significantly in the non-PCM group from 2.6 to 3.3 ($p=0.3$) (Table 12). The mean frequency of condom use during anal sex with “other” partners was already relatively high at baseline in both groups (mean=3.7) and did not change at follow-up for either the PCM or Non-PCM groups (Table 12). Because of the limited sample size, we did not find a significant affect for PCM involvement on behavior change among men (F test=ns). However, change in the frequency of unprotected anal sex with “main” partners was greater in the PCM group than the Non-PCM group (mean difference 2.1 versus 0.7) suggesting that with a larger sample we would have had sufficient statistical power to demonstrate an effect of PCM on unprotected anal sex with main partners.

Among women, the mean frequency of condom use during vaginal sex with a “main” partner increased slightly, but not significantly, in the PCM group (2.1 to 2.9, $p=0.2$) and decreased slightly in the Non-PCM group (2.0 to 1.0, $p=0.3$) (Table 12). Again, due to the non-significant changes in condom use during vaginal sex in the PCM and Non-PCM group, the repeated analysis assessment using the F test was also not significant. This suggests that involvement in PCM did not affect whether women increased their frequency of condom use during vaginal sex with their “main” partner. However at the descriptive level, the mean difference in condom use was greater for women in PCM, than women not in PCM (+0.8 vs. -1.0), suggesting that with greater statistical power we may have detected a significant effect of the PCM program (Table 12). Because few women reported having vaginal sex with “other” partners or reported having anal intercourse, we were unable to assess changes in condom use in these instances.

We next assessed changes in sexual behaviors among those reporting to be living with HIV or AIDS (PLWHA). We saw no change in frequency of condom use during vaginal sex with a “main” partner among those in PCM (3.0 at both intervals) and a slight decrease in the frequency of condom use during vaginal sex among those not in PCM (2.0 to 1.0) (Table 12). With regard to anal sex with a “main” or “other” partner, we found slight increases in both the PCM and Non-PCM groups, but no significant differences comparing one group to another, suggesting that PCM involvement did not result in significant changes in risk behaviors for PLWHA.

Among people who reported to be HIV negative or whose HIV status was unknown at the time of the baseline interview, condom use during vaginal sex decreased slightly in the PCM group and increased slightly in the Non-PCM group resulting in a slight interactive effect of PCM participation ($p=0.07$). Surprisingly, those in PCM increased their risk behavior in this analysis. Among those who were HIV negative, condom use during anal sex with a “main” partner increased slightly though not significantly for those in PCM (1.2 to 3.0, $p=0.2$) and among those not in PCM, it stayed relatively unchanged (1.3 to 1.4) (Table 12). These findings suggest that PCM is having an affect on changing condom use frequency during anal sex with main partners. However due to small sample sizes, we were unable to have sufficient statistical power to confirm these descriptive findings.



By looking at the change in mean, the difference between the means at baseline and follow-up, we are able to assess, at the descriptive level, whether the magnitude of the change in the PCM group is bigger or smaller than the Non-PCM groups (Table 12). We found the following differences for each subgroup comparing PCM attendees to Non-PCM attendees:

- 1) Males:
 - PCM - Greater change in condom use during anal sex with main partner
- 2) Females:
 - PCM – Greater change in condom use during vaginal sex with main partner
- 3) PLWHA:
 - PCM- Greater change in condom use during anal sex with other partner.
- 4) HIV Negative:
 - PCM- Greater change in condom use during anal sex with main partner.

Table 12: Change in risk behaviors stratified by PCM involvement (n=114)

	Baseline (Mean)	Follow-up (Mean)	Change in Mean	Sig. (2 tailed) ^a	F test ^b
Condom Use During Anal Sex with Main Partner					
PCM	1.9	4.0	2.1	0.08	ns
Not in PCM	2.6	3.3	0.7	0.3	
Condom Use During Anal Sex with Other					
PCM	3.7	3.6	-0.1	0.9	
Not in PCM	3.7	3.7	0.0	0.5	ns
Condom using during Vaginal Sex with Main Partner					
PCM	2.1	2.9	0.8	0.2	ns
Not in PCM	2.0	1.0	-1.0	0.3	
Condom use during Vag. Sex with Main Partner					
PCM	3.0	3.0	0.0	1.0	ns
Not in PCM	3.0	2.0	-1.0	0.2	
Condom use during Anal Sex with Main Partner					
PCM	4.0	5.0	1.0	0.4	ns
Not in PCM	3.5	4.5	1.0	0.4	
Condom use during Anal Sex with Other					
PCM	3.3	4.5	1.2	0.3	ns
Not in PCM	3.7	4.5	0.8	0.4	
HIV Negative					



Condom use during Vag. Sex with Main Partner					
PCM	3.0	2.0	-1.0	0.2	0.07
Not in PCM	1.7	2.3	0.6	0.2	
Condom use during Anal Sex with Main Partner					
In PCM	1.2	3.0	1.8	0.2	ns
Not in PCM	1.3	1.4	0.1	0.4	

^a paired t test

^b Repeated measures analysis - assesses whether the change in frequency of condom use for those in PCM is significantly different than the change in frequency of condom use among those not in PCM.

Changes in Intentions

The HIV prevention literature finds that cohort studies with a short follow-up period tend to have a greater impact on the “intention” to change behavior than “behavior change” itself. Intention is a key mediating variable to behavior change in most theories of behavior change and can provide promising results for programs early in their implementation. In this evaluation, we assessed changes in intentions to use condoms at baseline and follow-up among the subgroups described in the previous section. Questions about intention to change behavior included the following at baseline and follow-up: “In the next 3 months how likely are you to use a condom every time you have...?” The sexual behavior questions included “vaginal sex,” “oral sex,” “anal sex when you are on top,” and “anal sex when you are on bottom.” Response items included “Definitely not” (1); “Probably not” (2); “Maybe” (3); “Probably, yes” (4); “Definitely, yes” (5); and “No plans in the next 3 months” (6). Those who reported no plans to have sex in the next 3 months were eliminated from these analyses. Intention questions for anal sex when “on top” or “bottom” were collapsed into a single measure of anal sex. Mean scores were calculated for each question at baseline and follow-up. Using the paired t test and repeated measures analysis of variance using the F test, we assessed whether there were significant changes in the baseline and follow-up responses comparing those in PCM to those not in PCM.

As can be seen in Table 13, we found significant changes in intentions to use condoms during vaginal and/or anal sex among the PCM groups but not the Non-PCM groups among men, women, and HIV negatives. For example among men, intention to use condoms during anal sex increased from 4.1 to 4.8 ($p=0.03$) in the PCM group and changed from 4.1 to 4.3 ($p=0.2$) in the Non-PCM group. For women, intention to use condom during vaginal sex increased from 2.9 to 3.8 in the PCM group ($p=0.003$) and changed only marginally in the Non-PCM group (3.7 to 4.1, $p=0.2$) (Table 13). We did not, however, find the same effect among PLWHA. Among PLWHA, there was little change in intentions to use condoms during vaginal or anal sex among the PCM and Non-PCM groups. Among the HIV negative group, we found a significant increase in intention to use condoms during vaginal and anal sex in the PCM group (2.8 to 3.8, $p=0.007$; 4.1 to 4.5, $p=0.02$, respectively) (Table 13). Despite the significant differences in mean scores among men, women and HIV negatives, repeated measures analysis (F test) did not reveal a significant impact of PCM on intention due to limited statistical power.



Table 13: Changes in Intentions comparing responses at baseline and follow-up, stratified by gender and HIV status.

	Baseline	Follow-up	t test (2 tailed) a	F test, Sig. b
Males				
Intention to use condom during				
Anal sex, next 3 months				
PCM	4.1	4.8	0.03	ns
Not in PCM	4.1	4.3	0.2	
Females				
Intention to use condom during				
Vaginal sex next 3 months				
PCM	2.9	3.8	0.003	ns
Not in PCM	3.7	4.1	0.2	
PLWHA				
Intention to use condom during				
Vaginal sex next 3 months				
PCM	4.3	4.7	0.4	ns
Not in PCM	4.3	4.4	0.3	
PLWHA				
Intention to use condom during				
Anal sex next 3 months				
PCM	3.2	3.7	0.7	ns
Not in PCM	4.6	4.9	0.2	
HIV -				
Intention to use condom during				
Vaginal sex next 3 months				
PCM	2.8	3.8	0.007	ns
Not in PCM	3.8	4.0	0.8	
HIV -				
Intention to use condom during				
Anal sex next 3 months				
PCM	4.1	4.5	0.015	ns
Not in PCM	c	c	c	

^c Insufficient cell size to conduct this analysis

PCM Interactions - Qualitative and Quantitative Analysis

We next assessed the more qualitative aspects of Prevention Case Management interactions. To do so, the follow-up survey included both closed and open-ended questions about the content of these interactions and how clients felt about the program. This qualitative and quantitative data were entered into Excel to allow for basic descriptive analysis of the closed-ended questions (see Table 14) and qualitative analysis of the open-ended questions. Findings were integrated together in the following section to allow the qualitative comments to expand upon and add depth to the quantitative findings.

Findings of PCM interactions

As can be seen in Table 14, all respondents during the follow-up interviews were asked whether they had participated in PCM in the last 2 months, and if so, how many times they met with their



case manager. Sixty-two percent (n=71) of the 114 interviewed at follow-up said they had met with a Prevention Case Manager. Of those who had not met with a PCM (n=43), half said they have not been asked to participate. Frequently cited reasons for non-participation included lack of transportation and not being aware of the services. One participant commented, "I know all that I need to know," another said, "What's the rush?" The majority of non-attendees said they were not interested. One client commented, "I am already practicing monogamy." Others stated that they did not want to go to agency offices due to AIDS related stigma and the lack of privacy.

Non-PCM participants were asked in open-ended questions if they had suggestions about how to increase participation. Almost all participants suggested some form of financial incentive or gift certificates. Others brought up that PCM should include a social component to attract new clients. Others suggested greater outreach to neglected populations including "18-26 year olds," "over 50 year olds" and those in high-risk environments like substance abuse programs.

Of those participating in Prevention Case Management (n=71), interactions with case managers were quite frequent; 81% of those enrolled reported that they had met with their PCM worker 1 to 4 times in the last two months (Table 14). This percentage should be viewed with caution, however. It is possible that clients included other HIV related appointments such as counseling and testing in these estimates. When clients were asked what they talked about during visits with their PCM worker in open-ended questions, many were hesitant to describe these interactions. Most described "HIV prevention" more broadly, 17% of respondents talked about "personal matters", three individuals (4%) discussed issues regarding their sexual performance, three others (4%) discussed OraSure testing and four mentioned their personal financial issues. When clients were questioned further about the quality of the interactions, the majority responded positively. Thirteen respondents (18%) said they liked the one-on-one atmosphere and the personalized nature of the program as well as the casual environment. Only two respondents described PCM interactions as negative. One client, who had been infected less than a year, called the meeting "awkward." Another commented, "I had a bad impression of the Prevention Case Manager. We need HIV positive people doing this work. I've been positive since before these people were in grade school. I don't feel like they have anything to offer me."

Participants were asked if they had regularly scheduled meetings with their PCM worker. Sixty-two percent said "no" (Table 14). Many reported that the meetings were informal and they saw their PCM "whenever." Most seemed to appreciate this less regimented and low threshold approach.

PCM participants were asked more broadly about the goals they set for themselves, as well as specific things they have been working on during their sessions with their worker. Forty percent described reducing their risk behaviors, while other participants discussed broader issues such as family and personal relationships, maintaining their spirituality, working on their self-esteem and mental health.

When asked specifically to name two or three things they have been working on during their PCM sessions, responses tended to be more narrowly focused on risk reduction. Comments included, "staying sober," "having condoms with you at all times to not break the mood," "preventing re-infection," and "getting the word out to others." One respondent commented, "avoiding self-pity and staying in a good circle of friends."

When clients were asked if they had made any changes to their prevention plan since their first meeting with their PCM worker, 31% (n=22) said they had (Table 14). Changes included "fewer anonymous encounters," "no drinking, no drugging and staying away from sex." Others



suggested more harm reductive approaches. One respondent commented, "I am breaking them down into smaller goals," another said, "If I'm going to drink or do drugs, stay home, don't go out!" Others described "being more choosy about sexual partners." and "You can't trust anyone, even if they say they love you." Other comments included, "fewer anonymous partners," and "asking questions of partners."

Respondents were asked in open-ended questions how they felt about their progress. Most responded positively, linking feelings of success to goal setting. One respondent said, "I feel good since I developed goals." Others commented, "good progress, I would like to see my prevention person every 90 days, it helps me know he cares about me." Another said, "very good, making progress with my partner's condom use."

The survey also inquired whether the Prevention Case Manager encouraged clients to attend support groups. Sixty percent (n=42) said their PCM had brought it up. Of those encouraged to attend (n=42), 59% actually went to a support group (Table 14). Most reported that they found the support group helpful, citing the social and emotional support they received from others. Comments included, "I found a lot of girls like me," "I talk with my friends and they support me." Others appreciated the open nature of the dialogue, allowing them to receive help without having to ask for it. One participant discussed the challenges of interacting in large group settings, "It was ridiculous, unfocused. Large groups are not conducive to doing real PCM."

The survey asked clients if PCM was helping them and in what ways. Ninety percent of those involved in PCM said it was helpful (n=64). Several clients commented, "PCM provides focus and structure through the meetings." Others commented, "it helps me focus on my goals," "it keeps it fresh on the brain," "it keeps me sober, right on track," "it's personalized prevention." One client reported, "My PCM doesn't pass judgment on me." Another said, "Someone is interested in your well being and it reminds you that someone does care."

Respondents were also asked about the strengths and weaknesses of the program. Respondents overwhelmingly appreciated the lack of condescension, the non-judgmental approach and the confidential nature of the sessions. One client commented, "education, openness, honesty, privacy, there is nothing not to like." Other comments included, "they are non-judgmental and encouraging," "(he's) straight forward, keeps it real, not condescending." Another commented, "I like the information being accessible at the drop of a hat."

When clients were asked about the weaknesses of the program, criticisms were primarily focused on the lack of publicity. One respondent commented, "It needs to be more visible." An individual living with HIV or AIDS described being overly case managed, "I don't like the bureaucratic overlap, too many counselors for one client." Others thought that more efforts should be directed to youth.

Table 14: Characteristics of the Prevention Case Management interactions (Participants at follow-up, n=114)

	% (n)
Met with Prevention Case Manager in last 2 months: (n=114)	
Yes	62 (71)
No	38 (43)
If no, asked to participate? (n=43)	
Yes	48 (21)
No	52 (22)
No. of times met with PCM	



Last 2 months? (n=71)	
1-2	40 (28)
3-4	41 (29)
5+	19 (14)
Had reg. scheduled meetings: (n=71)	
Yes	38 (27)
No	62 (44)
Made changes to your personalized prevention plan since your first meeting with your PCM? (n=71)	
Yes	31 (22)
No	69 (49)
Made changes to your risk behavior in the past month? (n=71)	
Yes	53 (38)
No	47 (33)
PCM encouraged attending support group (n=71)	
Yes	59 (42)
No	41 (29)
If yes, did you go? (n=42)	
Yes	60 (25)
No	40 (17)
Do you feel PCM is helping you? (n=71)	
Yes	90 (64)
No	10 (7)



Process Evaluation of Prevention Case Managers

Summary of Main Findings

Summary of Quantitative Findings

- Of the 21 Prevention Specialists interviewed, 18 were trained in PCM (86%). Of those PCM trained, 15 (83%) have active caseloads with an average size of 10 (range 7-27).
- PCM seems to be concentrated in the larger metropolitan areas (Louisville, n=7 & Lexington, n=7) with limited coverage in Northern Kentucky (n=1)
- Prevention Case Managers report spending the greatest percentage of their time per week doing outreach. On average, 43% of their time is spent on outreach, most commonly in bars, parks and other public places. Case managers spend 25% of their time conducting PCM, 20% on supervision or performing administrative tasks, and 12% conducting support groups, empowerment workshops and other activities.
- Prevention Case Managers report enrolling a total of 170 total clients into PCM, with 45% identified as HIV positive and 55% HIV negative. This number, however, should be interpreted with caution. Clients may be in a caseload but have little or no contact with a worker after enrolling.
- Most (73%) Prevention Case Managers meet with their clients once or twice a month, and 47% review the IPP with the client at each visit. Three Case Managers (20%) have not reviewed IPPs with their clients.
- Prevention Case Managers estimated that 25% of clients they approach about PCM agree to enroll.
- Forty percent of workers reported that their clients do not attend support groups. Qualitative findings also highlight the difficulty of establishing and maintaining successful support groups.
- There was no significant difference in Worker Burnout among Men and Women. However, African Americans when compared to Whites, those less educated compared to those with higher education, and indigenous when compared to non-indigenous workers, experienced slightly higher levels of burnout than their counterparts. In general, workers scored highest on experiencing depersonalization, second highest on feeling like they are unsuccessful at their work and third highest on emotional exhaustion.



Process Evaluation of Prevention Case Managers

Summary of Main Findings

Summary of Qualitative Findings

Overall Prevention Case Managers feel positive about the Prevention Case Management program. They describe liking the “connection” they make with clients and gain satisfaction from establishing IPPs because it instills in them and their clients a sense of progress and accomplishment.

- Despite the positive appraisal of PCM, Prevention Case Managers find that their workload has only increased. They report losing none of their previous responsibilities and describe being “spread too thin.”

Recommendations for Restructuring PCM

- Eight of the 18 Prevention Case Managers (44%), agreed with the concept of PCM, however, they had two proposals for restructuring:
 - **One Designated PCM at Each Site** - Three Prevention Case Managers (17%) suggested establishing one Prevention Case Manager per site. This individual would be responsible for meeting with all PCM clients one-on-one, allowing the remaining Prevention Specialist staff to focus on outreach.
 - **Care Coordination Conduct PCM** - Five Prevention Case Managers (28%) suggested that PCM should be the responsibility of Care Coordinators. They felt that Care Coordination is better equipped because they already meet with clients, have established rapport and trust, and have incentives to offer clients.

III. Challenges of PCM

Pressure to Increase Caseloads

- Many Prevention Specialists commented that they are under pressure to increase their caseload. Yet they have found that if they “push too hard, clients run away.” Workers suggested that one needs to strike a balance between recruiting too aggressively and having a more low-threshold approach, where the opportunity for dialogue is there when the client is ready to open up. Others acknowledged that not everyone needs PCM.



Process Evaluation of Prevention Case Managers

Summary of Main Findings

Lack of Therapeutic Skills

- A consistent theme throughout the interviews was that Prevention Specialists do not feel they have the necessary clinical training to conduct “therapy” with clients. One worker commented, “We don’t have social work degrees and we aren’t qualified to be therapists.” Another commented, “I feel like I am just touching the surface.”

When Clients Relapse They Disappear

- Prevention Specialists commented that when clients make mistakes and relapse into high risk sexual and injection behaviors, they don’t want to face their case manager. It was suggested that clients and workers need to accept and understand that relapse is frequently part of the process of establishing sustained behavior change.

Frequency of Contact – based on Client Needs

- One of the challenges of PCM is maintaining an ongoing relationship with clients, while tailoring the frequency of interaction to a level suited to the client. One worker commented, “too much interaction and they shut down.” Prevention Specialists meet with some clients weekly and others less frequently, depending on their circumstances and needs. Once a client becomes inactive, the appropriate amount of interaction becomes less clear.

Stigma Associated with Agency Offices

- Workers suggested that there is a certain amount of stigma associated with agency offices. For example, closeted gay men may be resistant to meet with their Prevention Case Manager at an office “because they don’t want others finding out.” Workers recommended that PCM could be conducted in public settings or clients’ homes as a way to protect client confidentiality. Others suggested that a van should be made available that could be used in the community as a place for counseling while also addressing transportation difficulties that clients experience.

Developing and Sustaining Support Groups

- Prevention Specialists recognized a need for successful and sustainable support groups, specifically for HIV negatives at risk, but many seemed to lack the time and perhaps skill to develop and run such groups.



Process Evaluation of Prevention Case Managers Summary of Main Findings

IV. Reasons Why Clients Resist Participating in PCM

Prevention Specialists proposed the following reasons for why clients resist participating in PCM:

1. "Already know the talk" - Clients feel they are already well informed about HIV prevention and don't see the need for PCM.
2. View themselves as low risk.
3. Concerned about sharing private information about risk behaviors.
4. Transportation Difficulties.

V. Overall Suggestions of Prevention Specialists

1. Incentive Structure - Develop an incentive structure to increase client adherence to sessions and to motivate behavior change.
2. Peer Recruitment – use peers to recruit at-risk clients.
3. Network with other agencies to increase recruitment.
4. Work more closely with Care Coordination to share information regarding clients.
5. Greater focus on internet chat rooms.



Outcome Evaluation of Prevention Case Management: Client Surveys Summary of Main Findings

Summary of Quantitative Findings of Client Surveys

Demographic Characteristics of Respondents at Baseline

- The clients interviewed at baseline included those in the process of being recruited into PCM (n=91) and those who reported already enrolled in PCM (n=70). The average age of respondents was 38, with most identifying as White (48%) or African American (40%) and 12% identifying as Hispanic, Bi-racial or Other. Sixty-six percent of respondents were male with an even distribution of males identifying as gay, bisexual or straight (32%, 33% and 35%, respectively). Among women, the majority were heterosexual (78%).
- Greater percentages of respondents came from Louisville (31%) and from AVOL in Lexington (28%), followed by Paducah (26%). Substantially fewer came from the Lexington Fayette County Health Department (9%) and Northern Kentucky (6%).
- Of those interviewed at baseline, 43% reported being HIV positive. The majority of PLWHA have been diagnosed for six years or more (56%) and 12% less than a year.

Enrollment into PCM

- When limiting the analysis to those who answered questions about PCM participation at baseline and follow-up (n=99), we found that 42% reported that they had enrolled in PCM at baseline compared to 62% at follow-up, suggesting a 20% increase in enrollment between November 2003 and March 2004.
- Among those interviewed at both time points (n=99), the following percentages of respondents from each agency were enrolled in PCM by the follow-up interview:

	Percentage	Nos. at baseline
➤ AVOL	73% (30)	41
➤ Lexington Health Department	73% (8)	11
➤ Northern Kentucky	0% (0)	2
➤ Louisville Health Dept/VOA	44% (11)	25
➤ Paducah	65% (13)	20
➤ Total		99



Outcome Evaluation of Prevention Case Management: Client Surveys

Summary of Main Findings

Summary of Quantitative Findings of Client Surveys (Cont.)

HIV Risk Behaviors of Baseline Population

With regard to HIV-risk behaviors, few respondents reported injecting drugs in the last year ($n=3$). When assessing sexual risk behaviors separately for men and women at baseline, we found that 44% of men and 62% of women reported having a “main” partner, while approximately a third of men and a quarter of women reported having “other” sex partners. Consistent with the HIV prevention literature, greater percentages of men and women reported engaging in unprotected vaginal and anal sex with their “main” partner when compared to “other” partners.

Characteristic of PLWHA and HIV Negative Groups

- 77% of males living with HIV or AIDS reported being Gay or Bisexual compared to 54% those who were HIV negative or whose HIV status was unknown. PLWHA were less likely to report having unprotected anal or vaginal sex than people who were HIV negative.
- A significantly smaller proportion of PLWHA compared to HIV negative clients enrolled in PCM by the follow-up interview (45% vs. 76%, $p=0.001$), suggesting that it may be more difficult to successfully recruit PLWHA into PCM.

Changes in Frequency of Condom Use

- Comparing those involved in PCM to those not involved in PCM, men in the PCM group reported a weakly significant increase ($p=0.07$) in the frequency of condom use during anal sex with their “main” partner.
- We found slightly greater, though not significantly greater, changes in frequency of condom use among those in PCM compared to those not in PCM for the following subgroups:
 - Females during vaginal sex with their “main” partner;
 - PLWHA during anal sex with “other” partners;
 - HIV negatives during anal sex with their “main” partner.



Outcome Evaluation of Prevention Case Management: Client Surveys

Summary of Main Findings

Summary of Quantitative Findings of Client Surveys (Cont.)

Changes In Intention to Use Condoms

- Males in the PCM group reported significant changes in intention to use condoms during anal sex ($p=0.03$)
- Females in the PCM group reported significant changes in intention to use condoms during vaginal sex ($p=0.003$).
- HIV negatives in the PCM group reported significant changes in intention to use condoms during vaginal and anal sex ($p=0.007$ and $p=0.015$, respectively).
- No significant changes in intentions among PLWHA
- No significant changes in intention among the Non-PCM subgroups.

Summary of Qualitative Findings – Client Surveys

Positive Appraisal of PCM

- Among those participating in PCM ($n=71$), counseling sessions were quite frequent with 81% reporting seeing their case manager 1 to 4 times in the last 2 months. During these sessions, workers were described as trying to address many of the broader dimensions of the client's life and trying to uncover the underlying issues that prevent clients from changing risk behaviors.
- Those involved in PCM described very positive experiences. Clients could clearly articulate what PCM was and what goals they were working on. They reported that PCM was having an impact on their behavior.
- When asked about the strengths of the program, qualitative responses reflect the importance of goal setting, frequent contact and a non-judgmental atmosphere during counseling sessions. One client commented, "PCM provides focus and structure through the meetings." Another reported, "It helps me focus on my goals."

Negative Reactions Among PLWHA

There were two negative comments about PCM sessions from persons living with HIV or AIDS. One commented that the meeting was "awkward" and the other felt that he would be better served if the worker was HIV positive.



Outcome Evaluation of Prevention Case Management: Client Surveys

Summary of Main Findings

Summary of Qualitative Findings (Cont.)

Some PLWHA described feeling overly case managed. They did not feel the need to work on prevention goals when they were already infected. Some described themselves as not having sex. Others reported being too busy seeing clinicians and working with care coordination to manage their disease.

Reasons Clients Resist Participating in PCM

- When clients were asked why they did not participate in PCM (n=43, 38%), the reasons provided reinforce comments made by workers. Some commented, "I know all I need to know," others said they were "already practicing monogamy" or "not having sex." Similar to the Prevention Specialist interviews, clients were hesitant to participate because of the AIDS stigma associated with agency offices and because of fears of disclosing risk behaviors to others.



Conclusions

Overall, the process and outcome evaluations suggest that Prevention Case Management has made an impressive start. Prevention Specialists, although overwhelmed by the numerous roles they still maintain, communicate that Prevention Case Management is going well. Most workers have been trained, demonstrate a clear understanding of the purposes, goals and nuances of PCM and describe feeling positive about developing Individualized Prevention Plans with clients. They enjoy connecting to clients on a deeper level but feel they are handicapped by the lack of more therapeutic training.

Most workers experienced high levels of burnout, specifically in the area of depersonalization and lack of personal accomplishment. These trends are most clear for African Americans, those with lower education levels and indigenous workers. Literature on worker burnout has suggested implementing stress management techniques, helping workers recognize signs of burnout, establishing realistic work objectives, and assigning each worker a stress management counselor, outside his or her chain of command (Maslach et al, 1996).

Prevention Specialists communicated a need for reducing their work load so that they could better focus on PCM. Others suggested restructuring PCM to rest with a single individual at each site or shifting the role to Care Coordination. Many workers are looking for therapeutic training to more effectively work with clients and to develop and guide support groups. Most described feeling pressure to increase their case loads and yet struggle with the need to have a more hands-off approach, recognizing that not all clients need PCM.

Findings from the client surveys generally reiterate and highlight findings from the PCM interviews. Comparing matched responses at baseline and follow-up, the program increased enrollment from 42% to 62% at follow-up. Males participating in the program reported a slightly higher frequency of condom use during anal sex with main partners. There were also slight, but non significant, increases in condom use among female participants, HIV negatives and HIV positive participants. The program also demonstrated significant increases in intention to use condoms among men, women and those who were HIV negative, but the program did not have that same impact on PLWHA.

PCM clients could clearly describe their interactions with Prevention Specialists. They articulated the goals and behaviors they were trying to change and pointed to goal setting, frequent contact and a non-judgmental atmosphere as critical aspects of PCM.

Those who were resistant to participating in PCM described themselves as low risk, reported that they were too busy, lacked transportation or were hesitant to enter agency offices because of fears of being recognized. Those living with HIV or AIDS report that they feel overly case managed. Others have decided not to have sex and don't see a need for PCM. The main recommendation among PCM clients was publicizing the program.

Based on these early findings, we suggest the following:

- Reduction in the Non-PCM related responsibilities of Prevention Case Managers.
- Establish realistic goals and objectives for Prevention Case Managers.
- Implement trainings on stress reduction and recognizing the signs of burnout.



- Develop a curriculum focused on therapeutic and counseling skills.
- Establish an inventory of support groups and evaluate their efficacy.
- Work with peer networks to reach PLWHA and injection drug users.
- Increase staffing in more rural areas.
- Reduce pressure to increase caseloads and instead focus on building relationships with current enrollees.

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SECTION
4
 STRATEGIES

STRATEGIES

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SECTION
4a
STRATEGIES

INTERVENTION TYPES USED IN CDC’S EVALUATION GUIDANCE

The CDC, National Center for HIV, STD, & TB Prevention, DHAP-IRS provided a series of training sessions for health department staff on Evaluating CDC-Funded Health Department HIV Prevention Programs (commonly referred to as the “Evaluation Guidance”) in February and March 2000. Kentucky sent three representatives to this training (the HIV/AIDS Branch Manager, the HIV Prevention Coordinator, and the former CPG State Co-Chair).

Upon return, the training on the Evaluation Guidance was provided to appropriate DPH personnel, the CPG, and the PSs. In compliance with the new Evaluation Guidance, the former CPG incorporated the use of CDC’s intervention classifications.

A.	Individual-level Interventions (ILI)	Health education and risk-reduction counseling provided to one individual at a time. ILIs assist clients in making plans for individual behavior change and ongoing appraisals of their own behavior. These interventions also facilitate linkages to services in both clinic and community settings (e.g., substance abuse treatment settings) in support of behaviors and practices that prevent transmission of HIV, and they help clients make plans to obtain these services. Note: According to a strict categorization, outreach and prevention case management also are individual-level interventions. However, for the purposes of this reporting, ILI does not include outreach or prevention case management, which each constitute their own intervention categories.
B.	Group-level Interventions (GLI)	Health education and risk-reduction counseling (see above) that shifts the delivery of service from the individual to groups of varying sizes. GLIs use peer and non-peer models involving a wide range of skills, information, education, and support. Note: Many providers may consider general education activities to be group-level interventions. However, for the purposes of this reporting, GLI does <i>not</i> include “one-shot” educational presentations or lectures (that lack a skill component). Those types of activities should be included in the Health Communication/Public Information category.
C.	Outreach	HIV/AIDS educational interventions generally conducted by peer or paraprofessional educators face-to-face with high-risk individuals in the clients’ neighborhoods or other areas where clients’ typically congregate. Outreach usually includes distribution of condoms, bleach, sexual responsibility kits, and educational materials. Includes peer opinion leader models.
D.	Comprehensive Risk Counseling and Services (CRCS)	Client-centered HIV prevention activity with the fundamental goal of promoting the adoption of HIV risk-reduction behaviors by clients with multiple, complex problems and risk-reduction needs; a hybrid of HIV risk-reduction counseling and traditional case management that provides intensive, ongoing, and individualized prevention counseling, support, and service brokerage.
E.	Partner Counseling and Referral Services (PCRS)	A systematic approach to notifying sex and needle-sharing partners of HIV-infected persons of their possible exposure to HIV so they can avoid infection or, if already infected, can prevent transmission to others. PCRS helps partners gain earlier access to individualized counseling, HIV testing, medical evaluation, treatment, and other prevention services.
F.	Health Communications/ Public	The delivery of planned HIV/AIDS prevention messages through one or more channels to target audiences to build general support for safe behavior, support personal risk-reduction efforts, and/or inform persons at risk for infection how to obtain specific services. Electronic Media: Means by which information is electronically conveyed to



	Information (HC/PI)	large groups of people; includes radio, television, public service announcements, news broadcasts, infomercials, etc., which reach a large-scale (e.g., city-, region-, or statewide) audience. Print Media: These formats also reach a large-scale or nationwide audience; includes any printed material, such as newspapers, magazines, pamphlets, and “environmental media” such as billboards and transportation signage. Hotline: Telephone service (local or toll-free) offering up-to-date information and referral to local services, e.g., counseling/testing and support groups. Clearinghouse: Interactive electronic outreach systems using telephones, mail, and the Internet/Worldwide Web to provide a responsive information service to the general public as well as high-risk populations. Presentations/Lectures: These are information-only activities conducted in-group settings; often called “one-shot” education interventions.
G.	Other Interventions	Category to be used for those interventions funded with CDC Announcement 99004 funds that cannot be described by the definitions provided for the other six types of interventions. This category includes community-level interventions (CLI). CLI are interventions that seek to improve the risk conditions and behaviors in a community through a focus on the community as a whole, rather than by intervening with individuals or small groups. This is often done by attempting to alter social norms, policies, or characteristics of the environment. Examples of CLI include community mobilizations, social marketing campaigns, community-wide events, policy interventions, and structural interventions.



SECTION
4b
STRATEGIES

STRATEGIC OVERVIEW OF SELECTED INTERVENTIONS

POPULAR OPINION LEADERS

This intervention involves the identification of popular "opinion leaders" among the targeted community to serve as endorsers of the need for behavior change to their own circle of friends and acquaintances. This intervention involves conducting an extensive pre-intervention survey to bar patrons, training bar staff to identify "opinion leaders," recruitment and six week training of "opinion leaders," contracting with "opinion leaders" to educate and encourage their friends to practice safer sex, regularly scheduled contacts with "opinion leaders", and post-intervention survey for bar patrons.

MSM/POL is a Community Level Intervention (CLI) due to its' use of local bars and clubs of potential clientele. It is also labeled as an Individual Level Intervention (ILI) due to one on one personal contact with bar and club patrons. Even though there is an obvious barrier to targeting HIV positives in this forum, the opinion leader should concentrate on those that are thought to be involved in high-risk behavior.

- A. **POTENTIAL IMPACT OF STRATEGY TO PREVENT INFECTIONS:** Rated as high, due to proactive nature of one-to-one communication and peer support from a friend talking to a friend approach.
- B. **COST EFFECTIVENESS OF STRATEGY:** Initially high to moderately high cost due to expense of evaluation of surveys, payment of stipends to "opinion leaders", training expenses, and staff time to maintain contact. Cost decreases after evaluations of the first implementation occurs.
- C. **THEORETICAL BASIS OF STRATEGY:** Diffusion of Innovation (Rogers, 1983; Kelly, et al., 1991). Social Cognitive Theory (Bandura, 1986). Theory of Reasoned Action (Fishbein & Middlestadt, 1989). Multi-component State Model (Prochaska et al., 1994).
- D. **RESPONSIVENESS TO TARGET POPULATION'S VALUES, NORMS, AND PREFERENCES:** High due to indigenous nature of intervention.
- E. **AVAILABILITY OF OTHER RELATED RESOURCES:** DEBIs.

Diffusion of Effective Behavioral Interventions (DEBIs)

These interventions recognize that psychosocial factors are often triggers for engaging in unprotected behaviors. These multi-session workshops do not focus on "instructing" participants on the mechanics of safer sex. Instead, the focus is on providing a supportive setting for experiential learning (co-lead by a trained mental health professional, when possible,



and the appropriate HIV prevention team member) designed to improve interpersonal relationship skills, increase self-esteem, remove social-isolation and cognitive-isolation, increase coping skill for handling stress, and increase self-awareness of behaviors. These interventions recognize the need to bridge mental health services with HIV prevention efforts.

These interventions represent one of the longest periods of time that a client or at risk individual may be in a teachable platform designed solely to reach their population. This will open opportunities for the outreach team to instill a sense of responsibility among those that are positive. With the understanding that there is a limit to the long term effectiveness of the risk reduction approach, these interventions target HIV positives, their sex partner(s) and at risk associates. The intervention emphasis must be on Harm Reduction when participants choose to engage in risky sexual practices or judgment impairing activities.

DEBIs are group level interventions (GLI). DEBIs have been selected targeting five risk groups. They are: HIV+, MSM, IDU, MSM/IDU, and High-Risk Heterosexual. The number of workshops for each population will be determined by prioritized populations. The planning should also place the most emphasis on HIV positives, African-Americans and Hispanic. Even though the Transgender population is not specifically mentioned in the above populations, they remain an entity of all priority populations. A specific Transgender workshop should be included in the MSM/IDU and High-Risk Heterosexual workshop series. All workshop participants should be evaluated for enrolment in Comprehensive Risk Counseling and Services (CRCS) (formerly known as Prevention Case Management).

- A. POTENTIAL IMPACT OF STRATEGY TO PREVENT NEW INFECTIONS: High. On going contacts with participants increase potential impact. Impact also increases when groups with disproportionate rates of infection are targeted or when the intervention targets HIV positive persons.
- B. COST EFFECTIVENESS OF STRATEGY: Low to moderate. Cost associated with contracting with regional HIV prevention team worker (HIV+, MSM, MSM/IDU, IDU and Heterosexual).
- C. THEORETICAL BASIS OF STRATEGY: Information-Motivation-Behavioral Skills Model (Fisher and Fisher, 1992). Theory of Gender and Power (DiClemente and Wingood, 1995).
- D. RESPONSIVENESS TO TARGET POPULATION'S VALUES, NORMS, AND PREFERENCES: High, issues are built in due to indigenous nature of intervention.
- E. AVAILABILITY OF OTHER RELATED RESOURCES: "Key Peer Opinion Leader" intervention for MSM patronizing gay bars.

PUBLIC SEX ENVIRONMENTS (PSE) OUTREACH INTERVENTION

This intervention's primary purpose is to connect via one-to-one communications with individuals who may not be reached by more traditional interventions. The principle here is to meet people on their "turf." This intervention involves training individuals to safely go to PSEs in teams and provide information, support, and referrals. Extensive preparations are required for this intervention, including the consent and cooperation of various agencies, institutions, and local governments.

- A. POTENTIAL IMPACT OF STRATEGY TO PREVENT NEW INFECTIONS: Moderately high due to connecting a low impact approach (brief public encounters) with very high prevalence target groups (Sex for trade/sale workers and non-gay identified MSMs).



- B. COST EFFECTIVENESS OF STRATEGY: Moderate. Expense of training, traveling, tracking persons reached, and stipends.
- C. THEORETICAL BASIS OF STRATEGY: Theory of Planned Behavior, (Ajzen, 1988).
- D. RESPONSIVENESS TO TARGET POPULATION'S VALUES, NORMS AND PREFERENCES: Clear understanding that workers are not to approach, but be approached and are not to condemn sexual behavior of target group. Workers are there to increase awareness of risks (HIV/AIDS, legal, physical, social, and family) and provide information, condoms, and referrals.
- E. AVAILABILITY OF OTHER RELATED RESOURCES: N/A, many from target PSE group cannot be reached by other means.

COMMUNITY AWARENESS/MOBILIZATION INTERVENTION

This intervention (targeting (MSM, MSM/IDU, IDU, Heterosexual)) recognizes the need to take into account the targeted community's culture, social, and behavioral norms in HIV prevention planning. This intervention involves contracting with an establishment, most likely a bar or community center, to provide a safe gathering place for the target population. Peer leaders from the target community will be identified, trained, and paid a stipend to serve as safer sex information "diffusion agents", to host the social event for their community and provide needed support, referrals, condoms and information. A core group will be maintained to continue the intervention activities and events.

- A. POTENTIAL IMPACT OF STRATEGY TO PREVENT INFECTIONS: High due to proactive nature of one-to-one communication and peer support. Also high due to "grass root" creation of the intervention via direct input from targeted community.
- B. COST EFFECTIVENESS OF STRATEGY: Moderate to high. Additional expense of renting facility, given current environment, a necessary expense.
- C. THEORETICAL BASIS OF STRATEGY: Diffusion of Innovation, (Rogers, 1983; Kelly et al., 1991). Social Cognitive Theory, (Bandura, 1986). Theory of Reasoned Action, (Fishbein & Middlestadt, 1989). Multi-component Stage Model, (Prochaska et al., 1994). Multi-component Stage Model, (Prochaska et al., 1994).
- D. RESPONSIVENESS TO TARGET POPULATION'S VALUES, NORMS AND PREFERENCES: High, intervention is directly based on input from the targeted community.
- E. AVAILABILITY OF OTHER RELATED RESOURCES: Empowerment workshops.

STREET OUTREACH

The Prevention Specialists providing outreach do one-to-one counseling, referrals, encourage and arrange counseling and testing, distribute bleach kits and latex condoms. All street outreach will include harm reduction information for IDU.

- A. POTENTIAL IMPACT OF STRATEGY TO PREVENT NEW INFECTIONS: High due to connecting a low impact approach (brief public encounters) with very high prevalence target groups (IDUs and persons with a history of substance abuse/addiction, MSM, MSM/IDU, and Heterosexual). Street outreach provides the most reliable gateway to prevention case management.



- B. COST EFFECTIVENESS OF STRATEGY: Moderate, expense of funding for outreach workers.
- C. THEORETICAL BASIS OF STRATEGY: Theory of Planned Behavior (Ajzen, 1988).
- D. RESPONSIVENESS TO TARGET POPULATION'S VALUES, NORMS AND PREFERENCES: Non-judgmental approach is essential to accessing difficult-to-reach populations. Increased contact contributes to awareness and effective referrals.
- E. AVAILABILITY OF OTHER RELATED RESOURCES: N/A, many from the targeted populations cannot be reached by other means.

HIV+ CRCS

In order to maximize resources for Comprehensive Risk Counseling and Services (CRCS) for HIV+ individuals, the former CPG recommended in the 2002 plan, a pilot program to identify those individuals most likely to engage in unsafe behaviors. Development of the intervention at one (1) counseling and testing site, (preferably a high volume site), would involve a triage approach using markers to identify candidates for CRCS at the time of post-test counseling. (See "The Unsafe Behaviors of Persons Living With HIV/AIDS: An Empirical Approach to Developing New HIV Prevention Interventions Targeting HIV-Positive Persons, Rosser, Gobby & Carr, Journal of Sex Education and Therapy Vol. 24, no.1 & 2.)

Recent public information has been presented from numerous studies regarding the percentage of HIV positives that have failed numerous AIDS drug therapies, giving new credence to the necessity for proactive CRCS approach for HIV+ individuals.

Since 2002, CRCS has been expanded so that every Prevention Specialist carries a small case load within their target population. These individuals will either be HIV positive or determined to be high risk HIV negative. In addition, the CRCS for HIV positives pilot project has been expanded to all three regions with one full time CRCS Provider in the East and West region, and two in the North Central Region.

At all times PSs doing CRCS should keep a record of the level of development that the client has reached or the level at which the client elected to discontinue the program. The levels are known as the "Stage of Change Rating". They are:

- Pre-contemplation
- Contemplation
- Preparation
- Action
- Maintenance

Prevention Specialists must be cautioned when being trained that their position involves management of the client only. When there are other needs that the client may have, the PS should direct the client to the proper Care Provider that is capable of administering the specific need of the client.



SECTION
4d
STRATEGIES

HIV TESTING AND PARTNER COUNSELING AND REFERRAL SERVICES (PCRS)

PCRS Goals, Objectives, Methods and Activities 2007

Objective 1 - Throughout 2007, maintain an accessible network of HIV Counseling and Testing Sites (CTS), which provide quality service to clients.

Methods - At present, there are 209 CTS sponsored by the Kentucky Department for Public Health (DPH). Sites include local health departments and satellite clinics, community health centers, high schools, community based organizations, Planned Parenthood and hospitals that serve substance abusers. Non-invasive testing is also presently available at off-site facilities who provide services to populations most adversely affected by HIV/AIDS. Specimens at these sites are tested by the OraSure and OraQuick test kits. The intent of these off-site test centers is to encourage high-risk populations to learn their serostatus and to adopt safer sex and needle sharing practices. Clients who test positive are also provided with the knowledge that they need to quickly access health care. The OraSure and OraQuick sites are proving to be an effective way to provide counseling and testing services to men who have sex with men, injection drug users and other high-risk populations who are often reluctant to present to local health departments to receive health services. Funds sufficient for the testing of approximately 3000 OraSure/OraQuick clients are presently available.

In 2007, all 120 counties in Kentucky will have at least one public health clinic where persons may voluntarily present for HIV counseling and testing. All counselors at these sites will have been trained in a two-day course entitled HIV Counseling and Partner Notification conducted by certified trainers who are staff members of the Kentucky STD Program or the HIV Prevention Program. Clients who seek services at a CTS will usually have to call the site and make an appointment. Some sites, however, have sufficient staff to provide service on a walk-in basis. CTS will be urged to ensure that the delay between date of request and date of service receipt is kept to a minimum of two or three work days. Delays exceeding one week will be unacceptable. All clients will be advised that services can be provided on either a confidential or anonymous basis and given the right to decide which they prefer. Health department counselors will, however, stress to clients to seriously consider confidential testing because the confidentially tested HIV infected client who fails to return voluntarily for post-test counseling will be assigned for follow-up by a Disease Intervention Specialist (DIS) to ensure that post-test counseling is achieved, arrange for partner notification and referral for counseling and testing for HIV and other STDs, referral for other medical services including tuberculosis skin testing,



contraceptive and/or prenatal care, if needed or indicated, and referral to health care providers for further HIV/AIDS diagnostic testing including CD4 and viral load testing. HIV infected patients will be routinely provided with the name, address and telephone number of an AIDS Care Coordinator who can assist the patient with a variety of needs (medical, financial, social, housing, legal) if the client contacts the coordinator and requests help.

Local health departments have expanded HIV services to include patients assessed to be at-risk for HIV infection who attend family planning, prenatal, tuberculosis and sexually transmitted disease clinics. HIV counseling and testing at jails and juvenile detention centers has been undertaken by some health departments. Although most health departments do not provide prenatal services, those that do routinely offer HIV testing as part of their initial examination. Pregnant women served at these sites have the right to refuse HIV testing but very few actually do. Regardless of where a client receives HIV counseling and testing services in a DPH sponsored CTS, the following basic rules apply:

*Every client will receive face-to-face counseling from a counselor who has been trained in the HIV Counseling and Testing and Partner Notification course taught by a certified instructor.

*Clients have the right to refuse testing and, if tested, have the right to choose whether the test will be confidential or anonymous.

*All post-test counseling will be done face-to-face after the client has been properly identified as being the person tested. No post-test counseling or notification of a test result will be done by telephone or mail.

CTS operation brings with it the responsibility to assure that patients receive quality services delivered in a professional manner and setting by well-trained and competent staff. Service delivery at each CTS will be closely monitored and personal visits will be made by STD Program administrators and supervisors to a site when it is observed that deficiencies exist or if complaints are received from clients about the quality and/or sensitivity of service delivery at a site.

Evaluation - supervisors and administrators of the STD and HIV prevention programs will monitor all activities performed at each CTS. Specific outcome indicators that will be measured and reported in progress reports include:

- 1) Updated listing for all CTS,
- 2) New sites added during a quarter,
- 3) Number of new personnel trained in HIV Counseling and Testing and Partner Notification courses
- 4) Statewide and individual site reports of all CTS, including OraSure and OraQuick test sites, compiled from data collected from an optical scan HIV Counseling and Testing Form completed for every client receiving services. These data will also be collected in the PEMS data system.

Objective 2 - Throughout 2007, promote and assess the availability of comprehensive counseling and testing services by maintaining a level of health care providers (public, private, and military) who have received training in courses approved by the Kentucky Department for Public Health. Emphasis will be placed on expanding services to include additional agencies who serve clients who use and /or abuse narcotics.



Method - As courses are planned, area hospitals, drug treatment centers, university student health centers, and correctional facilities located near course sites will be offered the opportunity to have staff members attend. Facilities who have trained staff may remain an independent counseling and testing service or become an official Kentucky DPH CTS. Those who elect to be an official CTS must agree to pretest counsel all clients prior to testing, offer the client the option of being tested anonymously or confidentially, test only when the patient elects to be tested, attempt to post-test counsel all clients tested, and to set up or arrange an interview with a DIS and an infected patient so that partner notification can be done. They must also agree to use the optical scan form for collecting data and to submit them in a timely manner to the Kentucky STD Prevention Program for data compilation and review. Non public health facilities who elect to become a CTS must submit all specimens to the Division of Laboratory Services (DLS) for processing and properly identify specimens on an official DLS form for HIV specimen testing. DLS will process specimens free of charge.

Selected non-public health facilities trained in HIV counseling will be encouraged to become an official CTS but those who remain independent will have received the same training as counselors in a CTS. They will also have better understanding of patient care and services available through public health programs for infected patients who have limited or no access to health care

Evaluation - Progress toward achieving this objective will be measured as follows:

- 1) Documentation of new non-public health facilities added as an official CTS
- 2) Documentation as to the number of employees at new sites who were provided training.
- 3) Monthly, quarterly, semi annual, and annual reports from individual sites and a statewide basis showing the number of clients served ,demographics of clients served, risk assessment of clients ,and test outcome.

Objective 3 - In 2007, maintain a test acceptance rate of at least 95% for all patients pre-test counseled in health department sponsored STD clinics.

Method - DIS and nurses serving patients with an STD or suspected exposure to an STD will emphasize to the patient that by virtue of being infected with an STD they are at increased risk of being infected with other STDs including HIV/AIDS infection. Patients will receive pre-test counseling for HIV and encouraged to be tested for HIV infection. Counselors in STD clinics will refer to the HIV test as the AIDS virus test because it is felt that many STD patients do not know that the HIV test is the test used to detect the virus that causes AIDS. STD patients will first be provided appropriate care for the STD infection they have and then referred to a counselor where they will receive basic information and educational materials about HIV and AIDS. They will then be offered and encouraged to be tested for HIV but assured that refusal to accept testing will not negatively impact or prevent their ability to receive health care services at the facility or any other clinic operated by a local health department. Patients who elect testing will be tested confidentially and advised that it will be necessary for them to return to the clinic in two weeks to learn their results and receive additional (post-test) counseling. In order to assure that a greater number of STD patients receive HIV/AIDS information, CTS services, when possible, will be provided while the patient is waiting to receive their STD examination.

Evaluation - Quarterly, semiannual and annual assessments will be made of the number of STD patients at public clinics provided HIV/AIDS information, pre-test counseling, testing and post-test counseling services. The specific documents used for data collection will be the HIV



Counseling and Testing Report (optical scan form) developed by the CDC and the PEMS form. These forms will be initiated on every STD patient approached and will enable us to accurately measure activity at each specific site as well as aggregate data on a state-wide basis. Data will be collected and tabulated by staff assigned to the STD Program.

Objective 4 - In 2007, confidentially or anonymously test at least 95% of CTS clients who receive pre-test counseling. Estimated number of pre-test counsels each year will be 19000 with 18000 tests performed.

Method - Brochures, handouts and pamphlets listing CTS locations will be distributed at public clinics statewide. Private, public and military care providers will be updated as to CTS locations by accessing information from the DPH Website and by periodic articles in EPI Notes and Reports, a DPH publication sent to over 8200 health care providers monthly. Newspapers and radio stations will be alerted about public awareness campaigns and asked to broadcast or print CTS locations in areas where awareness initiatives are being conducted. In order to achieve a high test acceptance rate, clients attending a CTS will have the option of receiving either confidential or anonymous services. Confidential services will be emphasized by counselors, as will procedures in place for the protection of privacy. During pre-test counseling the following will be stressed:

- 1) Educate the patient about HIV/AIDS infection including risk factors and modes of transmission.
- 2) Assess the patients' risk of infection.
- 3) Assist the patient with developing a plan to adopt safer sex/ needle use practices.
- 4) Explain what a negative, positive and indeterminate test result means and does not mean.
- 5) Let the patient decide whether to be tested. Care will be taken to ensure that the counselor neither talks a client into or out of being tested.
- 6) Emphasize to the patient the need to voluntarily return for his/her test result and post-test counseling and of the importance, if the test is positive, that all sex/needle sharing partners within the previous two years, and spousal partners within the previous ten years, be informed of possible exposure. All CTS services will be monitored to ensure that counseling is non-judgmental and sensitive to the needs of patients.

Evaluation - Data will be compiled and presented as part of quarterly, semiannual, and annual reports which will be sent to each CTS and which will be reviewed by the administrative staff of the Kentucky Sexually Transmitted Disease Program and HIV Prevention Program. These reports will also be forwarded to the CDC. Specific documents from which data will be compiled are:

- 1) The HIV Counseling and Testing Report Form initiated on every client served in a CTS. The form will provide information as to the clients age, sex, race, risk factors, reason for seeking services, county of residence, identification of the CTS site where service was sought, date of test and result if tested and date of post-test counseling if the client returns.
- 2) HIV CTS logs maintained at each CTS.
- 3) The Division for Laboratory Services Human Immunodeficiency Virus Serology (DLS form 197) completed on all persons tested in a CTS.

Objective 5 - In 2007 achieve at least a 70% return rate for post-test counseling for all persons tested (confidentially or anonymously) in a CTS and at least a 50% return rate for STD clinic patients.



Method - At the time of pretest counseling, counselors will emphasize to clients that there is nothing to be gained from testing and deciding not to return to learn their test result. Clients will be informed that the result, whether negative or positive, serves as a guide as to how to alter life styles and adapt safer sex and needle use practices. Clients tested by OraQuick procedure are virtually assured to receive post-test counseling because the test result will be available within 20 minutes of collection. To ensure a higher rate of return for post-test counseling when blood draws are performed, counselors will emphasize the following to clients:

- 1) Prior to testing, each client will be asked to verbally consent to return for post-test counseling.
- 2) Each client tested will be given a specific date and time to return for post-test counseling. The date and time will be entered on a piece of paper and the client will be asked to put the paper in a place where it will not be lost or easily forgotten.
- 3) Clients will be advised to call the site to ascertain that the test has returned and to reschedule another date if the result is not available. Clients will also be instructed to call the CTS to reschedule an appointment if they are unable to attend on the date scheduled.

In addition to the measures described above, STD patients will receive the following messages:

- 1) Confidential testing will be strongly advocated for STD patients but anonymous testing will remain available to patients who will not accept confidential HIV testing. STD patients seen at the Specialty Clinic, Louisville, and at the Lexington-Fayette County Health Department Annex will be advised that a counselor will be available to provide post- test counseling without delay.
- 2) Staff time and other resources permitting, high risk STD patients who accept confidential service and test negative but fail to return for post-test counseling, may be mailed a second appointment within three days of the missed appointment.
- 3) All patients testing positive who are confidentially tested in a CTS or STD clinic who fail to meet their scheduled post-test counseling date, will be assigned follow-up by a DIS within three days of the missed appointment.
- 4) Post-test counseling in the field will be done when possible, but only when the setting is one in which complete privacy is assured.

Evaluation - Achievement toward measuring whether 70% of all clients tested in a CTS and whether 50% of clients tested in STD clinics are post-test counseled will be assessed from data collected from the following documents:

- 1) HIV Counseling and Testing Report form and the PEMS data document. These optical scan forms will be completed on every client attending a CTS and on those approached in STD clinics. Monthly, quarterly semi-annual, and annual reports will be prepared and submitted to the state and the CDC.
- 2) HIV Counseling and Testing logs maintained at CTSs which include dates of pre and post-test counseling, test results if testing was done, and information as to whether the client was seen by a member of the STD or HIV prevention staff or by local health personnel.

Objective 6 - In 2007, increase the number of positive patients tested in a CTS who receive post-test counseling to at least 90%. (Baseline 84% in 2005)



Method - Many of the methods described in objective 5 to return clients for post-test counseling also apply to this objective. However, since targeted clients in this objective are HIV positive, they are of special concern because:

- 1) They are infectious.
- 2) They need appropriate risk reduction counseling.
- 3) They need to work closely with counselors to insure that sex/needle sharing partners and spouses are notified of exposure.
- 4) They need prompt medical, dental, social and human health services available through a CTS or through referral to other care providers.
- 5) They need to be referred to an AIDS Care Coordinator who can assist them in obtaining medical, financial and other services that are not provided by the CTS.

Patients tested confidentially, (who provide truthful information about their identity) present less problems because if they fail to return for post-test counseling their name, address and other locating information are available for follow-up by a DIS staff member. Unfortunately, those tested anonymously and who fail to return voluntarily cannot be followed. To ensure a higher rate of return for post-test counseling when anonymous or confidential testing is done with client assessed to be at high risk for HIV, counselors will:

- 1) Inform the client that they are high risk because of sexual/ needle sharing practices
- 2) Determine if the client has already developed signs and symptoms of HIV disease (weight loss, night sweats, fever, lymphadenopathy, diarrhea, white spots or unusual blemishes in the mouth, etc.) and if so, arrange for an immediate medical assessment by a physician.
- 3) Reemphasize to the client that they must return to learn their results and that a positive result indicates need for additional testing, medical evaluation and possible treatment with medicines that have proven to be very effective in delaying the on-set of AIDS and associated opportunistic infections.
- 4) Assure the client that there is nothing to fear about the counseling and testing service they received or will receive and resolve any concerns the client has which could result in a decision of not voluntarily returning for results.

Evaluation - Area supervisors and administrators of the Kentucky STD Program central office and administrators with the HIV Prevention Program off-site testing facilities will keep constant vigil on CTSs to ensure that every effort is being made to provide post-test counseling to clients testing positive for HIV. Counselors who have difficulty in returning patients for post-test counseling will be provided remedial training (audit and /or demonstration counseling sessions by a supervisor) to identify weaknesses in counseling techniques and to recommend and demonstrate methods that could possibly improve performance. Data collected from optical scan forms will be the basis for measuring objective achievement. Reports will be produced for each site on a regular basis and composite reports will be forwarded to the CDC on a semi-annual and annual basis.

Objective 7 - In 2007, improve the quality of services provided to clients by Kentucky DPH sponsored CTSs by conducting the following activities:

- 1) Conducting HIV Counseling and testing classes at various locales throughout the state on an as needed/indicated basis.
- 2) Continue the practice of providing each DIS assigned to the STD Program stationed in Louisville, Lexington, Bowling Green and Florence with at least two



audit/demonstration counseling sessions by a supervisor each quarter.

- 3) Improve the quality of counseling and testing services at all sites by developing half day workshops which address issues related to the proper scheduling of appointments, intake sensitivity issues, assessing risks factors and assisting clients with developing a risk reduction plan, assisting patients with referrals for needed services and improving ability to inform partners of exposure and need for counseling and testing.

Methods -The STD Program and HIV Prevention Program will work jointly on setting up courses at various locations throughout the state. The courses will be targeted at new employees of health departments and off-site test center employees who will be serving clients. Re-training will be offered to counselors who have not received up-dated training for three or more years. To encourage attendance, every effort will be made to keep the number of attendees to 15 or less and to select locations that are accessible to attendees without need of overnight travel and per-diem costs. Re-training will be directed to sites where review of optical scan forms suggests services are not being offered or poorly provided. Any verbal or written complaint received by the STD Program or HIV Prevention Program will be immediately investigated and remedial training will be provided when deemed necessary. Re-training will also be achieved by videotapes prepared by the HIV Program that deal with basic issues related to privacy, sensitivity and quality service delivery. DIS employed by the STD Program will be audited at least once quarterly, more often if needed, by their supervisor during a pre-test or post-test counseling session with a client. DIS will receive a written appraisal of their performance by the supervisor within 24 hours of the audit. The written appraisal will highlight portions of the session that were performed well and those in need of improvement. Remedial training will be provided if performance is substandard.

Evaluation - Quarterly, semi-annual and annual assessment will be made to determine the number of new counselors trained and the number who receive remedial training. The assessments will also include the number of video tapes reviewed for training and the number of personal visits made to sites by STD or AIDS staff to correct deficiencies and to address issues with sites from which complaints were received.

Objective 8 - In 2007, regularly assess the impact of HIV partner notification and other follow-up services for HIV positive individuals through activities performed by a DIS and through referral made by infected clients.

Method - At the time of post-test counseling, HIV infected clients will be advised of the crucial need to have all sexual partners within the previous two years and all marital partners within the previous ten years informed of possible exposure to HIV disease. HIV positive clients will be advised that informing of exposure can be done directly by the client or by a DIS. Those electing to self-refer will be cautioned that doing self referral may compromise their right to privacy because the contact may divulge the information to other people who have no legitimate right to know about their HIV status. The DIS or counselor will then explain that the only way to assure that complete confidentiality is maintained is to let the DIS take full responsibility for informing contacts with the absolute guarantee that their name, or any other information, will not be revealed. Patients who prefer to self-refer will be provided with information that will be helpful to them when attempting the referral. Role plays will be conducted pointing out specific questions and reactions which the client may encounter and how to best answer and respond in a manner that satisfies curiosity and doubt and at the same time motivates the contact to seek counseling and testing. DIS assistance will also be offered when the client is unable to complete the referral or encounters difficulty in communicating with the contact. When DIS assistance is



requested for partner notification, counselors will sensitively seek exposure history and locating and identifying information that will enable a DIS to complete the referral. Notification and referral attempts undertaken by a DIS will always be done in a manner which fully protects the infected client's identity and which avoids placing the contact in an awkward, compromising, or embarrassing position. Specific rules for notification include:

- 1) All referrals will be done face-to-face between the contact and the DIS.
- 2) No other person will be present when the referral is made except an interpreter if one is needed or a trainee who is accompanying the DIS.
- 3) Under no circumstance will a letter be mailed to or an appointment slip left at the residence of a contact which indicates exposure to HIV or AIDS
- 4) Telephone usage will be restricted to only informing a contact that it is important to meet them and discuss an urgent health matter. Under no circumstance will the telephone be used to inform the contact of exposure.
- 5) DIS will not go to a contact's place of employment to complete a referral unless the contact has agreed to meet the DIS and has assured that complete privacy can be maintained.

Evaluation - Area supervisors and STD Program management staff will monitor the performance of DIS as they conduct counseling sessions and perform field follow-up of HIV contacts. Semiannual and annual progress reports will be made available to the CDC, which will provide the following data and information:

- Total number of HIV infected clients who are post-test counseled.
- Total number of resident contacts named with sufficient information to initiate follow-up by a DIS.
- Total number of contacts residing outside of Kentucky with sufficient information to initiate follow-up.
- Total number of resident contacts located and informed of exposure and the number who elected to be tested for HIV.
- Total number of contacts located who were newly tested and found to be HIV positive, newly tested and found to be HIV negative, had previously tested positive for HIV, and the number who, after notification of exposure, refused to accept an HIV test.
- Total number of spousal notifications attempted and the results of those attempts.



SECTION
4e
STRATEGIES

OVERVIEW OF SPECIFIC TARGET GROUPS

MSM, Including AAMSM and MSMOC

The largest unmet issue in the area of MSMs and MSMOCs is the lack of community organizations and therefore the lack of "hands-on" community based efforts. Of the limited number of gay and lesbian organizations few are doing any HIV prevention or education besides providing brochures. The bulk of HIV prevention efforts for the gay community is provided by AIDS Service Organizations (ASO). There are also needs relating to MSMs who do not identify as "gay" who engage in high-risk activities such as sex with strangers. Gay youth are another area where little is being or can be done with the MSM community. There are limited interventions being conducted, especially with gay youth, which focus on the development or enhancement of skills to initiate or maintain safer sex practices and support maintenance of safer behaviors. Likewise, very few interventions that are directed at establishing or modifying community norms or values to promote behavior change exist outside those currently funded under the CDC Cooperative Agreement.

While there are numerous areas where services are not being provided for MSMs, there are areas where services are being provided. In the North Central region (Louisville) there may be duplication of efforts with regard to reaching gay and bisexual men through condom distribution and there is a great need to provide these products in an efficient, timely manner with better coordination among agencies. All county health departments provide anonymous and/or confidential counseling and testing, although there is a disparity in the quality of services among counties. Several health departments (Lexington-Fayette County, Jefferson County, and Northern Kentucky Independent Health Department) encourage testing for all populations and target MSMs specifically by posting information in adult bookstores, detention centers, and bars that are frequented by MSMs. On-site testing is also provided in all the gay bars in Lexington. Persons testing positive are referred to the Care Coordinator for their region. Many health departments, urban CBOs and other agencies are working together to improve infrastructure and to support HIV prevention/assessment.

IDU

As with other high-risk populations, there are few interventions targeting IDUs. A few local health departments distribute bleach kits and latex. All Health Departments provide anonymous and/or confidential testing. Individuals who test positive are referred to the Care Coordinator Program. Louisville, Lexington, and Paducah now provide CRCS for IDUs. There is a tremendous need for legislation that would decriminalize possession of sterile injection equipment and residue. This legislation would create a platform for harm reduction practices. This would additionally develop and promote social norms and values that



would offer support and decrease the stigma associated with substance abusers and IDUs. Several KHPAC members have independently lobbied for harm reduction legislation that would decriminalize efforts that are designed to reach IDUs. These measures began in the 2000 Legislature and have continued in subsequent legislative sessions without passage so far.

MSM/IDU

MSM/IDU are men who have sex with men and who also use intravenous drugs. While interventions have certainly targeted MSM and IDU, to date none have specifically targeted MSM who inject drugs. The issue relates to recognition of this community and finding MSM/IDU's that remain largely unrecognized in the North Central region. KHPAC recommends that the present emphasis should be on HIV positive MSM/IDUs and identifying candidates for CRCS. Interventions must also consider harm reduction techniques for this population. The continuing approach of prevention for positives for members of this community through CRCS may be the best approach for this population.

HETEROSEXUAL CONTACT with PWHIV, MSM, MSM/IDU, IDU

Kentucky has targeted African Americans, Hispanics, youth and women at risk for several years. Trends indicate that the HIV rates are on the rise in the heterosexual populations, particularly among women and youth. This risk group is often largely ignored in HIV prevention. Oftentimes, many African Americans, Hispanics, youth and women are at high risk of infection due to injecting drug use and/or their sexual interactions with IDU and MSM. However, interventions targeted towards heterosexuals as defined by CDC fail to address these relationships with MSM and IDU.

AFRICAN AMERICAN

There remain very few organizations that primarily serve the African-American population. The Louisville Jefferson County Minority AIDS Program that served this population exclusively with HIV prevention cancelled their contract in 2003. Many of the other organizations serving large numbers of African-Americans are tied to perceived societal "negatives", e.g., correctional facilities, drug treatment centers, homelessness, etc. This creates a void in the HIV prevention services to African-Americans and also allows for some dangerous myths and stereotyping. The impression is created that all African-Americans are drug abusers or criminals or that only African-Americans who are criminals or drug abusers are at risk for HIV. There is a great need for organizations based in the African American community to do work from an African-American perspective. Additionally, there remains a great need for services targeted to African-American youth and MSMOC.

All county health departments provide anonymous and/or confidential testing. There is a great deal of disparity in the quality of services offered among counties. Persons testing positive for HIV are referred to the Care Coordinator in their region. The distribution of latex condoms is done by local health departments, but many at risk individuals would not or do not feel comfortable coming to the health departments to obtain condoms. Efforts should be focused on developing additional sites where people of color feel free to obtain prevention supplies. On a community level, there are few interventions for at-risk populations who seek to reduce risk behaviors by changing attitudes, norms and practices through health communications, community mobilization and community wide events. Intervention specific activities for African-Americans include Soul Fest events, Roots and Heritage Festival, Jubilee, Balm in Gilead, and the African American and Hispanic Leadership Conference on AIDS.



HISPANIC

Every county health department now has access to interpreters. The Lexington-Fayette County Health Department provides two interpreters and several volunteers. Matthew 25 and Heartland Cares each have one interpreter. There are still issues of distrust, as many of the Hispanic/Migrant worker population are "illegal".

From a former Hispanic CPG Member: "In the Hispanic community it is common, even for a married man with children, to go out and have sex with other men. They usually stay within their own community to seek out other men. Although it is known it is never talked about. I would say over 50% of married men go out on their wives with other men and alcohol and drugs does play a role. 75% to 80% of single Hispanic men will seek out some form of sex from other men. Hispanics have a macho problem and will seek MSM secretly within the Hispanic community. It is socially accepted but not talked about. Hispanic men would rather get a free blow job from a man than pay twenty dollars to a prostitute."

MOTHERS WITH/AT RISK OF HIV

As with other risk groups, there are too few interventions that target mothers with/ at risk of HIV. The local health departments provide CTRPN.

The greatest concern for this risk group is the identification and access to women who are IDUs, sex trade workers, and/or partners of MSMs, bisexual men, or other high risk or infected individuals. Another significant need is the provision of services at times that these at-risk women are able to access them. As with other at risk groups there is the need to provide interventions that target community norms or values that promote and support safer practices, communication skills and access to latex products and perinatal prophylaxes for infected women.

TRANSGENDER

The University of Kentucky Needs Assessment Report provides evidence of Transgendered and men on the DL also being un-reached. Additional anecdotal evidence from former CPG members underlines the need for pilot efforts to reach these populations.

From a Transgendered former CPG Member: "Men on the DL tend to want the illusion of the female, but because sometimes they choose to be penetrated and do not want this act to take place by another man, they go to transies. DL brothers should be included with the transies because they are the trade. A good term for people on the DL as well as transies could be Bridge Crossers, because they are living the life style of both worlds. Infection rates of transies are very high because most of them tend to make a living on the streets, because being accepted and hired on a normal job is not very easily achieved."



SECTION
4f
STRATEGIES

STRATEGIES COMMITTEE FINDINGS, RECOMMENDATIONS AND PRIORITIZATION

EVALUATION

KHPAC met over several meetings to prioritize interventions for the year 2007. Since the DEBI interventions first began in 2005, and an evaluation of the effectiveness of these DEBIs will be conducted at the end of 2006, KHPAC agreed to remain with the current DEBIs being implemented. DEBI trainings for Prevention Coordinators and Specialists were conducted from January to May of 2005. The first DEBI, Many Men Many Voices was implemented in April of 2005. All DEBIs were implemented by May of 2005.

The following report is guided by the HIV/AIDS epidemiology profile of Kentucky and the gaps analysis derived from the needs assessment. Accepted and proven evidence shows that all new HIV infections are a result of direct and indirect contact with an HIV positive individual. Therefore, in order to combat the spread of HIV, the concentrated effort of interventions must be directly aimed at those that are HIV positive and those most at risk of becoming infected with HIV.

KHPAC members chose to focus more on details of existing interventions and the introduction of new approaches than on a grading system using the prioritization tool. The committee decided the prioritized list from the 2006 Revised Prevention Plan would be used as a guide for the 2007 Plan. KHPAC believes it is important to spread the funding across the full range of interventions and pilot programs. The approach of funding every intervention and program to some extent may be the only way of evaluating as quickly as possible the practicality of any single project.

A large percentage of interventions are directed toward HIV positives. However, there is a limit to how much personal contact and guidance that the average client is willing to allow. There must be a concentrated effort among PSs to instill a sense of responsibility among those who are HIV positive.

Since there is an assumed limit on the effectiveness of risk reduction behaviors, KHPAC recommends that the focus of all interventions be based on harm reduction principles. When HIV positive or high-risk clients choose to engage in risky sexual, drug related, or judgment impairing activities, the principle of harm reduction allows clients to engage in these activities in a more responsible manner. The focus of this three-year planning cycle has been on expanding efforts in CRCS. A youth centered intervention continues to be a critical need. Youth are a major concern within the epidemic.



RECOMMENDATIONS

EASTERN AND NORTHERN REGION

Cultural and rural geographic barriers are the main deterrents to effective outreach in these regions of Kentucky. Recommendations are increased public media campaigns and increased PSE approaches that are now allowed during times of high activity. We believe a sector of the Hispanic population in this region can be reached through community mobilization. A higher concentration of CRCS specific to IDUs is also necessary in this region.

NORTH CENTRAL REGION

In Jefferson County, the groups that remain at highest risk with the greatest level of unmet need are biological and transgendered women. Prevention strategies, such as DEBIs should be designated to address these communities.

WESTERN REGION

Rural Western Kentucky continues to lack an effective number of CBOs. Capacity Building is needed immediately to serve this large area. Concentrated African American and Hispanic populations continue to be the most underserved and under represented. The most effective intervention seems to be with MSM PSs and PSE outreach as often as possible. Community Mobilization efforts are addressed for this region in this section under Community Mobilization requests. The time consuming travel of this geographic area is a great barrier. More cost effective interventions are being considered for this region.

CAPACITY BUILDING GUIDELINES

Capacity building efforts should be used to reach organizations that are interested in becoming contracted CBOs that will be addressing the concerns of emerging minority populations. It is assumed that in order to reach a specific population, a culturally sensitive CBO needs to be in place to first reach out to volunteers for assistance with this population and then to offer culturally inclusive Prevention Specialists, the needed contact with this population. The need for direct contact with capacity building efforts is seen in the Eastern and Western regions. The transgender and Hispanic communities are lacking interventions. Individuals should be recruited to work in their own communities, targeting all risk groups with special emphasis on transgendered and Hispanics, organizing outreach and peer-to-peer influence at a grass roots level.

COMMUNITY MOBILIZATION

Community Mobilization money needs to be made available for continuation of community awareness initiatives. These community mobilization events should address the needs of at risk communities. The successful local and statewide organizational efforts that need continued funding as well as new funding are:

- a. Come Together Kentucky Conference
- b. The African-American and Hispanic Leadership Conference
- c. The Kentucky HIV/AIDS Conference
- d. Owensboro/Henderson Dust Bowl



- e. National Black HIV/AIDS Awareness Day
- f. World AIDS Day
- g. Pride Fair of Louisville
- h. National HIV Testing Month
- i. Latino/Hispanic HIV/AIDS Community Awareness Activities

OUTREACH TO HISPANIC POPULATIONS

While existing epidemiological data lacks reliable figures of transmission rates among members of Kentucky's exploding Hispanic population, anecdotal evidence suggests a pressing need for effective outreach. The existence of seasonal migrant workers and a less mobile, more stable Hispanic community working in year-round industries indicates a two-pronged approach.

The DPH has established a very good working relationship with the Area Health Education Centers in Kentucky and the Bluegrass Farmworker Clinic who provide services to the Hispanic and Latino communities.

MINORITY AND INDIGENOUS PREVENTION SPECIALISTS

The Prevention Plan must not overlook the need for culturally specific and indigenous CBO's and PSs (formerly CHOWs) contracted for their targeted at risk populations. For instance, CBOs that work with IDUs should be staffed with former IDUs or people with highly specific education and credentials relative to that community. This applies as well to MSM, MSM/IDU, MSMOC, HIV + etc.

Support should be given to CBOs or individuals qualified to address a gap in prevention efforts. Shortfalls in prevention should be addressed by using Capacity Building funds to increase the ability of CBOs to qualify as a contracting organization as well as recruit, hire and retain indigenous PSs specific to their targeted at risk populations.

OTHER RECOMMENDATIONS AND CONCERNS

NEEDLE EXCHANGE

The number one recommendation of KHPAC is, as in the past, needle exchange programs. Kentucky paraphernalia laws prohibit the possession, sale or distribution of injection equipment preempting any plans for needle exchange programs. The introduction of harm reduction principles for IDU's has been an incremental process and particularly difficult in agencies traditionally based on abstinence only substance abuse programs.

While no official endorsement of needle exchange program has been forthcoming from DPH, the commissioner did, in an interview with a Lexington television station, state his "belief" that such programs work. A lack of political will by Kentucky lawmakers to revise statutes to decriminalize activities related to needle exchange programs remains the largest single barrier to HIV prevention statewide. DPH should provide leadership in this area.

CTS EVALUATION

KHPAC recognizes the importance of Counseling and Testing Services in the prevention process. In 2001 the University of Kentucky evaluated sites through out the state. The UK evaluation cited numerous problems with the protocols used by the testing sites. The evaluation cited problems beginning with appointment information and continuing with pre-test and post-



test counseling of clients. A plan to address these recommendations is listed in the gap analysis section.

MSM/IDU

For 2007, MSM/IDU has been prioritized as the number five at-risk population in Kentucky. Specific attention was given to this population in 2001. In 2002 training was provided regarding identification of appropriate interventions. PS assignments were directed to regional needs, (1) MSM/IDU PS for Western Kentucky, (2) PS's for North Central and (1) for Eastern Kentucky. Continued training and adjusting of approaches to this community are a necessity if significant results are to be expected in this population. In spite of these efforts, this population continues to be underserved and IDU PSs continue to be disconnected with this population. MSM/IDU indigenous workers are desperately needed in this community.

YOUTH

It should be stressed that while Youth at Risk (YAR) is not prioritized as a separate target population, it is highly prioritized as a component of all target populations. KHPAC believes that interventions targeting young MSM/IDU, MSMOC, MSM and all risk groups are of major concern. It is a recognized problem, that with the longevity of this disease, a generation gap exists in planning proper intervention strategies. Initiatives to properly convey the realities of this disease to future generations must not only be creative to be effective, but must derive its design from the at risk group. CBOs and outreach workers must develop component programs with the input of at risk youth as an ongoing part of their prevention efforts.

STREET OUTREACH, PSE OUTREACH AND OFF-SITE TESTING

Previous recommendations have stressed the importance of street outreach, effective PSE outreach and off-site testing.

Using OraSure and OraQuick and other technologies to increase testing in all high-risk populations, contracts must require interventions to take place at the corresponding time of day or night when high-risk behaviors occur. Contracts must require training for PSs in effective outreach strategies, counseling and testing protocols, harm reduction training/utilization.

These combined activities will serve to reduce HIV, STD, TB, and Hepatitis transmission.

PROGRAM OVERSIGHT

Intervention oversight and implementation is directed in two different ways, either by state oversight delegated by statutes and contract language, or by independent contractor evaluation. We recommend that the daily intervention work report should list the number of daily hours worked and the hours of the day that the work took place. Without a comparison of the time of day that the work took place, there is no way to determine if the intervention is taking place at peak hours of activity. Comparing the two timelines will allow for more efficient scheduling and coordination between PSs and Initiative Coordinators.

With implementation of PEMS and the purchase of PEMS hardware, more accurate monitoring and evaluation data will be available to assist in the assessment of the effectiveness of specific interventions.



SURVEILLANCE AND REPORTING

HIV case reporting data will be available by the end of 2007. HIV data will assist in more clearly identifying emerging at risk populations.

PRIORITIZATION

KHPAC used the prioritized target populations (based upon the epidemiological profile) to assist in the prioritization of strategies for the 2007 grant year. The prioritization of interventions was finalized on May 23, 2006.

Prioritized Strategies for Interventions
Intervention
CRCS for HIV+
Street Outreach for all Populations
Healthy Relationships
Community Mobilization Activities
Materials Distribution
CTS – Ora-Sure/Ora-Quick
CRCS for all other populations
SISTA
Popular Opinion Leader (POL)
Many Men Many Voices (3MV)
Safety Counts
Community Mobilization Population Order:
MSM Community
HRH Community
IDU
MSM/IDU Community
Specific Community Mobilization Activities:
Come Together Kentucky Conference
African American and Hispanic Leadership Conference
Kentucky HIV/AIDS Conference
Owensboro/Henderson Dust Bowl
National Black HIV/AIDS Awareness Day
World AIDS Day
Pride Fair of Louisville
National HIV Testing Month

There is no evaluation for Mothers with/or at Risk for HIV or General Population as defined risk categories by the CDC. This is because there are no prescribed interventions for Mothers with/or at Risk in Kentucky currently. While there are no specific interventions for General Populations, this is by design since most are not in high-risk categories. Most Community Mobilization public events and public information efforts also reach the general population.



SECTION
4g
STRATEGIES

PRIORITY STRATEGIES/INTERVENTIONS FOR DEFINED TARGET POPULATIONS

Category	ILI	GLI	Outreach	CRCS	PCRS	HC/PI	Other
1 CRCS for HIV+	■			■			
2 Street Outreach for all Populations			■				
3 Healthy Relationships		■					
4 Community Mobilization						■	
5 Materials Distribution			■				
6 CTS-Ora-Sure/Ora-Quick	■						
7 CRCS for all populations				■			
8 SISTA		■					
9 POL	■	■					
10 Many Men Many Voices		■					
11 Safety Counts		■				■	
Condoms, lubricants and harm reduction supplies are to be included with each intervention.							



SECTION
5
CONCLUSION

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CONCLUSIONS AND RECOMMENDATIONS FOR PROGRAM COORDINATION

LINKAGE OF PRIMARY AND SECONDARY SERVICES

Many of the linkages are accomplished through referrals. The state maintains referral lists for prevention and care services. Some of the HIV PSs and health educators providing prevention interventions distribute pocket cards with referral sources and phone numbers for CTRPN and HIV Care Coordinators. Any individual who is targeted for prevention is encouraged to seek HIV testing, often through the use of OraSure or OraQuick. Individuals who seek testing are given information on sources of prevention and treatment. Individuals are also referred to substance abuse treatment, physicians, social services organizations, and AIDS Service Organizations (ASO). Individuals who test positive are referred to the Care Coordinator Program where coordination of many services occurs, and they are entered into HIV reporting. The services coordinated include travel, assistance with activities of daily living, physician referrals, drug and insurance assistance programs, legal aid services, etc. Many of the services provided to HIV positive individuals are funded through both state dollars and Ryan White CARE dollars and HOPWA.

THE LINKAGE OF PRIMARY AND SECONDARY SERVICES GOALS FOR 2007:

GOAL 1: Develop a comprehensive checklist of activities prescribed in this plan.

Objective 1: DPH to ensure that the goals and objectives of this plan are outlined in a time frame, and that all items are assigned to specific parties.

Objective 2: KHPAC will collaborate with DPH in monitoring all items on the checklist. Progress reports on this goal will be made semi-annually to KHPAC. This report should include a comparison of the year-end activities report to the application.

GOAL 2: Provide primary and secondary prevention services and/or referrals to all individuals who present for testing in Kentucky.

Objective 1: Ensure that all clients who test positive for HIV whether through PSs or CTSs receive HIV Care Coordinator Program referral, appropriate medical referrals, and social services referrals if indicated, as well as partner notification.

Objective 2: HIV positive and high-risk negative individuals are to be exclusively targeted for primary and secondary prevention activities.

Objective 3: Ensure that Care Coordinator clients who continue to practice high-risk behaviors are referred for CRCS and PS interventions. Develop a system to track these referrals.

Continued, Revised, or New Objective? Continued from 2002 Plan.

Activities:

1. The state should monitor and evaluate existing referral systems currently in place.



2. Continue to provide training for prevention specialists and other staff on referrals and existing resources.
3. Continue to provide training for Care Coordinators and other staff on referrals and existing prevention resources.

GOAL 4: Enhance linkages between HIV/AIDS Branch and TB Branch.

Objective 1: The DPH branch should ensure that clients who test positive for HIV are referred for TB assessment. Ensure that clients who test positive for TB are referred for HIV counseling and testing.

Continued, Revised, or New Objective? Continued from 2002 Plan

Activities:

1. Monitor and evaluate existing referral systems of TB and HIV testing programs currently in place.
2. Evaluate documentation of initial referrals and determine method of verifying client utilization of referrals to services.

LINKAGES WITH OTHER HIV PREVENTION RELATED ACTIVITIES

The HIV/AIDS epidemiological surveillance data, CTRPN data, and youth and adult behavioral survey results are utilized for development of the epidemiology profile. The CTRPN activities are addressed in this Comprehensive HIV Prevention Plan. Behavioral surveillance (both adult and youth) basic data and trend analysis data are utilized in planning interventions.

Coordination with STD, TB, Substance Abuse, Mental Health Services: Many referrals for HIV CTRPN occur through or at STD, specialty clinics and HIV CTS in local health departments. In addition, substance abuse clinics refer clients to various programs like CTRPN. Counseling and testing training is provided to individuals who perform these services. The PSs who target IDU and other substance abusers encourage individuals to get counseling and testing and treatment for drug abuse. Representatives of STD and CTRPN programs participate as advisors for KHPAC. Many PSs offer HIV OraSure testing in the field to targeted populations.

The Comprehensive School Health Program provides training to individuals on STDs, substance abuse, mental health, and HIV prevention. STD prevention and education and drug abuse prevention education is provided to the schools as dictated by local jurisdiction.

Coordination between public and nongovernmental programs: The DPH, local health departments, other government agencies, and private organizations work cooperatively in HIV prevention through the community planning process and the delivery of interventions and services. (See 'Introduction and Overview of KHPAC Process' for additional information).

ASSISTANCE AND SUPPORT ACTIVITIES

Recommendations regarding epidemiologic and behavioral surveillance: Epidemiologic data needed to enhance assessment include more accurate assessment of the size of the at risk populations targeted and minority and migrant worker populations and assessment of their risk.



Migration data of individuals to and from areas with establishments that cater to at risk populations is needed as well. Migration data on individuals who travel out of counties and the state for counseling and testing, diagnosis, and treatment is needed.

KHPAC also requested data on methamphetamine use as a risk factor for HIV, as well as a comparison of rural and urban data be included in the Epidemiological Profile.

EVALUATION OF PLANNING PROCESS

This year has been the first year of working as the newly integrated Kentucky HIV/AIDS Planning and Advisory Council. KHPAC undertook the completion of the final update of this 3 year Prevention plan, the provision of a Year-End Report for the Cabinet for Health and Family Services (CHFS), as well as receiving training on what is entailed in HRSA related planning activities. Each KHPAC meeting was evaluated and the summary of these evaluations are provided to KHPAC members to assist in monitoring the planning process. KHPAC will conduct a process evaluation survey in August of 2006. KHPAC members report an overall sense of encouragement regarding the members of KHPAC working together to achieve the goals set out before them. PIR is ensured through recruitment and meeting facilitation. KHPAC members have worked hard together to learn the various components of KHPAC. Team building is emphasized to assist in recognizing and utilizing the similarities and differences among members.

KHPAC will work next year to integrate as many of the products as possible into cohesive documents, in order to fully integrate care, prevention and legislation and policy recommendations.

TECHNICAL ASSISTANCE ACTION PLAN FOR 2006 – 2007

Following the completion of this plan, KHPAC members will be meeting to determine how to meet the expectations of CDC, HRSA and KRS 214.640 most effectively in the coming years to further integrate prevention, care and legislative and policy recommendations as well as to collaborate more closely with DPH. Specific product related technical assistance will be used throughout the year to ensure that KHPAC members have an in depth knowledge and the appropriate tools to conduct the work before them.



Appendices

