

Special Projects of
National Significance

A Program of the Ryan White C.A.R.E. Act

SPNS

**GRANTEE
DIRECTORY**

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INTRODUCTION

PROGRAM AUTHORITY

The SPECIAL PROJECTS OF NATIONAL SIGNIFICANCE (SPNS) PROGRAM is authorized by Section 2691 of the Public Health Service Act, as amended by the Ryan White CARE Act Amendments of 1996, Public Law 104-146, dated May 20, 1996. The SPNS Program is administered by the Health Resources and Services Administration, Bureau of Health Resources Development.

PURPOSE

The primary purpose of the SPNS Program is to demonstrate and evaluate innovative and potentially replicable HIV service delivery models. The authorizing legislation specifies three SPNS Program objectives: (1) to assess the effectiveness of particular models of care; (2) to support innovative program design; and (3) to promote replication of effective models.

SPECIAL PROJECT CATEGORIES

In establishing Special Project Categories, consideration was given to the priority service areas identified in the concept paper, "Future Directions: Increasing Knowledge about Health and Support Service Delivery to People with HIV Infection." That document, commissioned by the SPNS Program, was developed through interviews and written comments from key HRSA staff and federal and non-federal experts in the field of HIV/AIDS.

Currently, the SPNS Program is supporting grants in the following project categories:

- **Adolescent Care Demonstration and Evaluation** -- This category was initiated in FY 1993 with 10 projects funded. This initiative targets adolescents (ranging in age from 10 to 24) at high risk of HIV infection or who are already infected. These projects are participating in a national, cross-cutting evaluation study.
- **Dissemination and Refinement of the Model** -- This category was initiated in FY 1994 with 9 projects funded. This initiative focuses on the dissemination, refinement, and replication of previously evaluated models of care.
- **HIV Service Delivery Models and Evaluation & Dissemination Center** -- This category was initiated in FY 1994 with 27 projects funded in four different subcategories that focus on-- 1) comprehensive primary care (including managed care); 2) reduction of cultural, linguistic, and organizational barriers of care; 3) provider training and education in rural, correctional, or mental health settings; and 4) a national, cross-cutting evaluation study and dissemination plan.

Adolescent Care Demonstration and Evaluation Grantees

Bay Area Young Positives, Inc.

518 Waller Street
San Francisco, CA 94117
OFC: (415) 487-1616
FAX: (415) 487-1617
eMail: N/A

Contact Person:

Antigone Hodgins

Project Period: 12/93-11/96

This project uses a staff of full-time, paid young people and volunteers to provide support services for youth with HIV who are under 26 years of age. These services include recreational and social activities, peer counseling, advocacy education, practical support services, and information on youth-sensitive care providers.

Children's Hospital, Boston

Boston Happens

Division of Adolescent/Young Adult
Medicine

Boston Adolescent HIV Network Program
300 Longwood Avenue
Boston, MA 02115

OFC: (617) 355-6495 or

Clinic: (617) 355-7181

FAX: (617) 730-0442

eMail: WOODS@a1.tch.harvard.edu or
HN5400@handsnet.org

Contact Person:

Elizabeth Woods, M.D., M.P.H.

Project Period: 12/93-11/96

This program provides outreach to HIV positive, high risk, homeless, and street youth through a diverse and comprehensive network of primary care service providers. Its network model facilitates an integrated service referral program among the principal adolescent service providers in the Boston area.

Children's Hospital, Los Angeles

Division of Adolescent Medicine

P.O. Box 54700, Mailstop #2

Los Angeles, CA 90054-0700

OFC: (213) 669-4604

FAX: (213) 664-8365

eMail: N/A

Contact Persons:

Michele Kipke, Ph.D.

Arlene Schneir

Project Period: 12/93-11/96

This project disseminates HIV prevention and early intervention information, provides risk reduction counseling, and initiates case management services for youth at high risk for HIV who are also runaway, homeless, and/or injecting drug users. A wide range of medical and psychosocial services is provided including HIV testing and counseling, mental health screening and crisis intervention, and substance abuse services.

**Greater Bridgeport Adolescent
Pregnancy Program/TOPS Project**

200 Mill Hill Avenue
Bridgeport, CT 06610
OFC: (203) 384-3629
FAX: (203) 384-4034
eMail: HN5490@handsnet.org

Contact Persons:

Rudy Feudo, Ph.D.
Sandra Vining-Bethea
Project Period: 12/93-11/96

This program provides outreach, HIV prevention and early intervention, case management, and referral services for underserved minority adolescents, ages 15 to 24, who are HIV+ or at high risk for HIV. Program staff provide intensive supervision and support for ten peer-youth street outreach educators.

Health Initiatives for Youth

Youth Services
1242 Market Street, 3rd floor
San Francisco, CA 94102
OFC: (415) 487-5777
FAX: (415) 487-5771
eMail: HYHI@HYHI.COM

Contact Persons:

Ron Henderson
Joanne Lothrop
Project Period: 12/93-11/96

This initiative is providing a comprehensive array of youth-centered services, self-help resources, and skills-training for young people with HIV, age 25 years and under.

Indiana State Department of Health

Division of HIV/STD Services
2 North Meridian Street, Suite 600
Indianapolis, IN 46202
OFC: (317) 233-7867
FAX: (317) 233-7663
eMail: N/A

Contact Persons:

Michael Wallace
Diane May
Project Period: 12/93-11/96

This is a peer-based model that addresses access to health and support services for underserved gay, lesbian, and bisexual adolescents who are HIV+ or at risk for HIV. The project focuses on peer counseling, risk reduction and assessment, health evaluations, street outreach, and an HIV prevention case management model in central Indiana.

Project Site:

Indiana Youth Access Project

Indiana Youth Group
P.O. Box 20716
Indianapolis, IN 46220
OFC: (317) 541-8726
FAX: (317) 545-8594
eMail: HN5849@handsnet.org

Contact Person:

Jeff Werner

University of Alabama at Birmingham
School of Medicine
Department of Pediatrics/Teenage Access Project (TAP)
1630 Sixth Avenue, South
CHOB-basement
Birmingham, AL 35233
OFC: (205) 934-5262 or 5252
FAX: (205) 975-7307
eMail: pedp044@uabdpo.dpo.uab.edu
Contact Persons:
Marsha S. Sturdevant, M.D.
Pernell Brown, R.N.C.
Project Period: 10/93-09/96

University of Minnesota Youth and AIDS Project
Adolescent Early Intervention Project
428 Oak Grove Street
Minneapolis, MN 55403
OFC: (612) 627-6824
FAX: (612) 627-6819
eMail: HN5416@handsnet.org
Contact Persons:
Gary Remafedi, M.D., M.P.H.
Kathleen Roach, M.P.H., M.B.A.
Project Period: 12/93-11/96

Walden House, Inc.
214 Haight Street
San Francisco, CA 94102
OFC: (415) 554-1480
FAX: (415) 241-5599
eMail: www.sfo.com/~walden/
Contact Persons:
Brian Greenberg, Ph.D.
Rob Burch, Ph.D.
Chris Sayer, M.S.W.
Project Period: 10/93-09/96

YouthCare
Project for Street Involved, Homeless and Sexual Minority Youth
P.O. Box 9130
Seattle, WA 98109
OFC: (206) 282-9907
FAX: (206) 282-6463
eMail: a10er@sswgate
Contact Person:
Adam Tenner
Project Period: 12/93-11/96

The TAP model provides HIV outreach, education, testing and counseling, and case management for disadvantaged, high risk females between the ages of 10 to 24 years. It seeks to improve access to medical and psychosocial services through family-centered case management and to identify HIV+ female youth through early intervention, outreach, and testing.

This project is developing and evaluating a model of outreach, early intervention, and service delivery for adolescents ages 13-23 living with HIV in Minnesota. It provides outreach and comprehensive, coordinated, and family-centered care to Minnesota youth who are HIV+.

Walden House provides a multi-disciplinary approach to the substance abuse treatment, psychiatric, and medical needs of dually diagnosed youth. The program combines long-term residential treatment with clinical and medical services specifically designed for adolescents living with HIV and those at risk.

This project combines HIV testing and counseling with early intervention and prevention case management services to develop a continuum of care for youth who are living with HIV.

Dissemination and Refinement of the Model Grantees

Children's Hospital of New Orleans

Pediatric AIDS Program
200 Henry Clay Avenue
New Orleans, LA 70118
OFC: (504) 524-4611
FAX: (504) 523-2084
eMail: HN5420@handsnet.org

Contact Persons:

Michael Kaiser, M.D.
DeAnn Gruber, B.C.S.W.
Project Period: 09/94-08/96

This program is focusing on assuring the availability of comprehensive, family-centered, community-based services for HIV-infected women, children, adolescents, and their families in Baton Rouge and Monroe, Louisiana. This is being accomplished by replicating the model of care utilized by the Pediatric AIDS Program (PAP) and the Resources for Adolescents Program (RAP) of the Children's Hospital of New Orleans through the provision of technical assistance and support to Friends For Life in Baton Rouge and GO CARE in Monroe. Both process and impact evaluation.

Children's National Medical Center

Project CHAMP
111 Michigan Avenue, N.W.
Washington, D.C. 20010-2970
OFC: (202) 884-4004 or 5451
FAX: (202) 884-3711
eMail: N/A

Contact Persons:

Robert H. Parrott, M.D.
Mary Rathlev, M.S.N.
Project Period: 09/94-08/96

The Children's National Medical Center's Project CHAMP (Children's HIV/AIDS Model Program) is collaborating with the Pediatric AIDS Health Care Demonstration Project and the Synergy Project to adapt its model community education program to target youth service providers. The youth service provider project will develop educational programs specific to the learning needs of a variety of community-based professional and alternative caregivers. This community educational program is being refined and replicated in another urban area.

Family Planning Council of SE Pennsylvania

260 South Broad Street, Suite 1000
Philadelphia, PA 19102-3865
OFC: (215) 985-2657
FAX: (215) 732-0916
eMail: N/A

Contact Persons:

Alicia Beatty
M. Delores Vera
Project Period: 09/94-08/96

This project will refine the homemaker position to meet some of the in-home medical as well as practical needs of medically fragile families as the HIV-infected member(s) becomes increasingly ill. The goal of this project is to reduce emergency room visits and hospitalizations, to increase the sense of well-being, and to help the families remain intact and in their homes for as long as possible. The project will be comparing the effectiveness of enhanced, skilled homeworkers (medically trained) vs. families without homeworkers or traditional homeworkers from the perspective of the family and the provider.

Fortune Society, Inc.

39 West 19th Street
New York, NY 10011
OFC: (212) 206-7070
FAX: (212) 366-6323
eMail: JPFORTUNE@aol.com

Contact Person:

JoAnne Page, J.D.

Project Period: 09/94-08/96

This project expanded the availability of effective counseling, case management and other services for HIV+ ex-prisoners by training other organizations to provide these services. They implemented the ETHICS (Empowerment Through HIV Information and Community Services) model of HIV intervention, which was developed by Fortune Society, Inc. This model utilizes a holistic approach to meet a broad range of needs critical to client stabilization and health preservation while supporting clients effectively to avoid relapse into substance abuse and high risk behaviors associated with substance abuse.

Indiana State Department of Health

Division of HIV/STD Services
2 North Meridian Street, Suite 600
Indianapolis, IN 46202
OFC: (317) 233-7867
FAX: (317) 233-7663
eMail: N/A

Contact Persons:

Michael Wallace

Diane May

Project Period: 09/94-08/96

This project's model is refining a statewide integration of well-informed and accessible community-based mental health services into the primary health care of those affected by HIV/AIDS. Timely intervention is designed to increase the capacity for informed decision making and self-management of the individual's well-being. Mental health services are further integrated into a statewide system of HIV care coordination. The primary mechanism for system integration is referral and care delivery network development and maintenance.

Project Site:

**Indiana Integration of Care
Project**

I. Michael Schuff, Ph.D.

OFC: (812) 237-3910

FAX: (812) 237-3613

eMail: N/A

Montefiore Medical Center

Albert Einstein College of Medicine
Belfer Building, Suite 906
1300 Morris Park Avenue
Bronx, NY 10461
OFC: (718) 430-2154
FAX: (718) 430-8645
eMail: Mulvihill@aecom.yu.edu

Contact Persons:

Michael Mulvihill, Dr.P.H. or
Mark Winiarski, Ph.D. at
OFC: (718) 405-4133
FAX: (718) 405-4148
eMail: HN5471@handsnet.org or
Sister Rosemary Moynihan, L.C.S.W. at
St. Joseph's Hospital and Medical Center
OFC: (201) 754-4767
FAX: (201) 754-4777
eMail: N/A

Project Period: 09/94-08/96

**Multnomah County Health
Department**

426 SW Stark Street, 4th-Floor
Portland, OR 97204
OFC: (503) 248-5020 x 2290
FAX: (503) 248-5022
eMail: HN5519@handsnet.org

Contact Person:

John Dougherty, Ph.D.

Project Period: 09/94-08/96

**National Native American AIDS
Prevention Center (NNAAPC)**

2100 Lakeshore Avenue, Suite A
Oakland, CA 94606
OFC: (510) 444-2051
FAX: (510) 444-1593
eMail: nnaapc@aol.com

Contact Person:

Ron Rowell, M.P.H.

Project Period: 09/94-08/96

Project Management Site:

Ahalaya Project--NNAAPC
5350 South Western, Suite 500
Oklahoma City, OK 73109

OFC: (405) 631-9988

FAX: (405) 631-9989

eMail: bettyd2702@aol.com

Contact Person:

Betty Duran, M.S.W.

This is a quasi-experimental evaluation project that is evaluating two refined models of integrating HIV/AIDS mental health services with primary care: a hospital-based HIV primary care model at St. Joseph's Hospital and Medical Center in Paterson, NJ and a community health center model with several sites at Montefiore Medical Center in Bronx, NY. This assessment will be used to determine whether this integration of mental health services has a positive effect on the providers working within the system as well as to determine if the increased use of mental health services improves the psychosocial well-being of the targeted patients.

This project is replicating the NOAH (No One Alone with HIV) model developed by Boston City Hospital. The primary goal of the project is to increase mental health and substance abuse assessment, intervention, and referral skills/resources of primary care staff, thereby increasing the number of clinic clients who receive these services.

This project is refining the Oklahoma-based, culturally relevant "Ahalaya Case Management" model to further improve the quality of life for HIV-infected Native Americans and to improve access to needed health and social services. The target population includes American Indians, Alaska Natives, and Native Hawaiians who are HIV infected. The essential components of the model are traditional healing, referral services, essentials of life, health-oriented case management, secondary prevention services, and social and psychological support. A rigorous evaluation is being conducted on data collected from all 10 sites nationwide.

**Protection and Advocacy System,
Inc.**

1720 Louisiana N.E., Suite 204
Albuquerque, NM 87110
OFC: (505) 256-3100
FAX: (505) 256-3184
eMail: HN5412@handsnet.org

Contact Persons:

James Jackson
Susan Boettger

Project Period: 09/94-08/96

The goals of this project are to replicate the previously developed New Mexico model of protection and advocacy programs for persons with HIV/AIDS in three western states through a combination of training, technical assistance, and support strategies. Through educational efforts, technical assistance, and related dissemination strategies, the project aims to build the service capacity of the national network of Protection and Advocacy Systems by encouraging these systems to adopt or adapt one or more key model elements. Program evaluation will consist of process and outcome measures.

HIV Service Delivery Model Grantees

Primary Care Service Delivery

Capitated Reimbursement System

AIDS Healthcare Foundation

6255 W. Sunset Blvd., 16th Floor
Los Angeles, CA 90028
OFC: (213) 462-2273 or 468-1353
FAX: (213) 962-8513
eMail: N/A

Contact Persons:

Michael Weinstein
Craig Thompson, J.D., M.B.A.
Peter Reis

Project Period: 10/94-09/99

The objective of this project is to test the feasibility of providing comprehensive HIV services under a capitated reimbursement system utilizing an established pilot project. This pilot project offers a comprehensive managed healthcare program to Medi-Cal-eligible AIDS patients in Los Angeles County and was established through the State of California's Department of Health Services. The AHF Clinic patients will have access to a full continuum of medical and social services. An intended outcome of this project is to demonstrate that an enhanced, capitated, managed healthcare approach to providing HIV/AIDS care will produce fewer opportunistic infections, fewer and shorter hospitalizations, better compliance with medical treatment, and an overall longer lifespan including a better quality of life for HIV/AIDS diagnosed populations.

East Boston Neighborhood Health Center

10 Gove Street
East Boston, MA 02128
OFC: (617) 568-4755 or 4452
FAX: (617) 539-5025
eMail: N/A
Contact Persons:
James Taylor, M.D.
Judy Steinberg, M.D.
Project Period: 10/94-09/99

This project is developing an expanded, capitated reimbursement system for providing a cost-efficient, community-based HIV/AIDS care plan. They will explore the feasibility of developing three separate, capitated reimbursement rates for patients who will be appropriately grouped according to clinical diagnosis--HIV+ asymptomatic, HIV+ symptomatic, and CDC AIDS. This system of care will provide appropriate and comprehensive services from the time of seroconversion through terminal care.

Johns Hopkins University School of Medicine

720 Rutland Avenue, Ross 1159
Baltimore, MD 21205
OFC: (410) 955-7634, (410) 614-3631
FAX: (410) 955-7889
eMail: jb@welchlink.welchijhu.edu
Contact Person:
John Bartlett, M.D.
Project Period: 10/94-09/99

This activity involves three major entities--Johns Hopkins Health Systems, the Hopkins HIV Care Program, and the Maryland Medicaid Program. The goal of this project is to reduce the financial barriers to adequate care for AIDS patients and to improve the comprehensiveness of their care while containing costs to the insurer and reducing uncompensated costs to the provider. The evaluation analysis will include: 1) cost-effectiveness, 2) rate of clinical progression, and 3) quality of life assessment.

New York State Department of Health/Health Research

Division of HIV Health Care/
AIDS Institute
Empire State Plaza
Corning Tower, Room 327
Albany, NY 12237
OFC: (518) 473-7781
FAX: (518) 474-0419
eMail: hxc01@health.state.ny.us
Contact Person:
Humberto Cruz
Project Period: 10/94-09/98

This project involves a dynamic data collection effort to generate information related to cost, utilization, and access to care as persons with HIV/AIDS transition from fee-for-service to a managed care environment. Cost and utilization data collected will be used to validate risk-adjusted payment rates for HIV/AIDS and to develop accurate cost estimates that will be used in structuring HIV Special Needs Plans. Access to care will be evaluated through a representative survey of the experiences of persons with HIV and AIDS as they seek and use services during the period of transition to Medicaid managed care. Financial, administrative, and organizational information necessary to develop managed care Special Needs Plans that ensure appropriate access to and quality of care will be collected from organizations awarded HIV Special Needs Plans planning grants.

**Visiting Nurses Association of
Los Angeles**

520 S. LaFayette Park Place, Suite 500

Los Angeles, CA 90057

OFC: (213) 386-7200

FAX: (213) 386-9072

eMail: cherin@chaph.usc.edu

Contact Persons:

David Cherin, M.S.W.

Kristine Hillary, M.S.N., R.N.

Project Period: 10/94-09/97

This project focuses on AIDS patients. A database program is being developed which will test the feasibility of providing a comprehensive, capitated reimbursement system. This system will compare service utilization, costs of care, quality of life, and patient outcomes of approximately 1,000 AIDS-infected clients under a fee-for-service Medicare/Medicaid reimbursement system and a condition-based Medicare/Medicaid capitated hospice. The project will also provide a fuller continuum of care and test the model on a broader population base. To accomplish this, an effort will be made to remove barriers to hospice utilization by AIDS patients through patient and physician education as well as broadening AIDS hospice eligibility requirements.

Coordinated Care System (Managed Care Plan)

Missouri Department of Health

Bureau of HIV/AIDS Care

930 Wildwood

Jefferson City, MO 65109

OFC: (573) 751-6107

FAX: (573) 751-6447

eMail: N/A

Contact Person:

James Dempsey, M.A., M.S.W.

Project Period: 10/94-09/97

The objective of this project is to develop and implement an "Integrated Model of Care" for patients with HIV that suffer from mental illness and/or have substance abuse problems in Kansas City, St. Louis, and outstate Missouri. An enhanced case management system (through collaborative efforts with the Department of Mental Health) is being developed which will simplify referral services for mental health and substance abuse treatment services.

**University of Nevada School of
Medicine**

Department of Pediatrics

411 W. Second Street

Reno, NV 89503

OFC: (702) 784-6170

FAX: (702) 784-4828

eMail: tal@med.unr.edu

Contact Persons:

Trudy Larson, M.D.

Barbara Scott, MPH, RD

Project Period: 10/94-09/98

The goal of this service delivery model is to provide comprehensive nutrition assessment and intervention services to relatively healthy individuals with HIV. Patients are from the Early Intervention Clinic of the Washoe County District Health Department and from private practitioners in the medical service area of Reno, Nevada. The program will-- 1) demonstrate the efficacy of nutritional services in preventing or delaying the onset of weight loss and wasting syndrome in individuals with HIV, 2) determine the most practical and cost effective system of incorporating nutrition screening and counseling in a clinic setting, and 3) develop an automated FAX-IN based system for recording, managing, and tracking data from physician and nursing interventions.

Intermediate Level of Care

Larkin Street Youth Center

1044 Larkin Street
San Francisco, CA 94109
OFC: (415) 673-0911
FAX: (415) 923-1378
eMail: N/A

Contact Persons:

Anne Stanton, M.S.W., C.S.W.
Michael Kennedy, M.S., M.F.C.C.
Project Period: 10/94-09/99

There are two primary objectives for this project. First, the Larkin Street Youth Center (LSYC) will expand their existing "Aftercare" program services which provide emergency housing, comprehensive primary medical care and psychosocial support services for homeless youth living with HIV, to serve CDC-defined HIV symptomatic disease, or AIDS diagnosed youth. Secondly, they are establishing an "Assisted Care Facility"; this will consist of a 12-unit assisted living and long-term care facility. The permanent housing program will be a focal point for providing a coordinated service delivery model which manages medical, substance abuse, and mental health treatment needs of these young people.

Rural Continuum of Care

University of Vermont & State Agricultural College

Medical Center Hospital of Vermont
Dept. Of Family Practice
235 Rowell Building
Burlington, VT 05405
OFC: (802) 656-4330
FAX: (802) 656-3353
eMail: cgrace@salus.uvm.edu,
ksoons@salvs.uvm.edu

Contact Person:

Christopher Grace, M.D.
Karen Richardson Soons, Ph.D
Project Period: 10/94-09/98

This activity involves the development of three rural community HIV satellite clinics in Vermont to supplement services currently being provided by the state's only comprehensive HIV clinic located in Burlington. These satellite clinics are housed in regional hospitals. The clinics provide state-of-the-art medical care for people with all stages of HIV/AIDS, psychosocial case management, and education for rural primary care providers in diagnosis and treatment of people with HIV/AIDS.

Service Delivery Models for Women

**Cook County Hospital/Hektoen
Institute for Medical Research**
CCSN-12th Floor
1900 West Polk Street
Chicago, IL 60612-3810
OFC: (312) 633-8675
FAX: (312) 633-4902
eMail: dris101W@wonder.em.cdc.gov
HN5391@handsnet.org

Contact Person:
Mary Driscoll, R.N., M.P.H.
Project Period: 10/94-09/99

Cook County Hospital HIV Primary Care Center, Women and Children's HIV Program is developing the Maternal and Child Health (MCH) HIV Integration Project. The purpose of this project is to insure HIV education, counseling and testing by consent in all family planning and perinatal sites in Cook County. Additionally, the project will link the MCH service delivery sites and the Ryan White funded primary care agencies to guarantee on-going care for identified women living with HIV and their families. The project is also following HIV + pregnant women and their infants. The evaluation will assess the change in practice of MCH providers in providing HIV education counseling and testing by consent as a routine part of MCH care and the offering of ZDV to pregnant women.

Research Foundation of SUNY
Health Sciences Center at Brooklyn
450 Clarkson Avenue, Box 1240
Brooklyn, NY 11203
OFC: (718) 270-2690
FAX: (718) 270-3386
eMail: jrrips@netmail.hscbklyn.edu
Contact Persons:
Howard Minkoff, M.D. or
Jill Rips, M.A., M.Phil
OFC: (718) 270-4737
FAX: (718) 270-3386
Project Period: 10/94-09/99

The major objectives of this initiative are to develop systems which-- 1) reduce the frequency of perinatal transmission of HIV through increased counseling and testing of pregnant women and increased use of perinatal AZT protocols, 2) enhance access to care for women with HIV through provision of combined HIV primary and gynecologic care, and 3) disseminate successful systems models to the greater community of providers. Models are being developed at three sites--SUNY Health Science Center at Brooklyn, a tertiary care center; Kings County Hospital Center, a municipal hospital; and Luthern Medical Center, a community hospital.

**Washington University School of
Medicine**
660 South Euclid Avenue
Campus Box 8051
St. Louis, MO 63110
OFC: (314) 747-1026 or 362-4413
FAX: (314) 362-5727
eMail: kmeredit@imgate.wustl.edu
Contact Persons:
Victoria Fraser, M.D.
Karen Meredith, M.P.H., R.N.
Project Period: 10/94-09/99

This project is developing a special care unit for women with HIV to integrate services for women in a 12 county area around St. Louis. Early intervention and treatment would be promoted to involve women in the area who are not presently seeking services. The integrated services will include pediatric services. Case management will be used to coordinate all services and appointments while attempting to assure compliance with medication and medical regimens. The intended results are to identify women with HIV at an earlier stage, increase access to service and clinical trials, opportunistic infections and vertical HIV transmission and improve quality of life.

Active Substance Abusers

Outreach, Inc.

3030 Campbellton Road, SW
Atlanta, GA 30311

OFC: (404) 346-3922

FAX: (404) 346-3036

eMail: N/A

Contact Person:

Sandra McDonald

Project Period: 10/94-09/99

Outreach's project, *SAFE PLACE*, utilizes a peer counselor and street team model for service delivery using indigenous staff. They will expand enrollment and enhance retention of substance abusers with HIV in primary care by opening a satellite facility within an African-American neighborhood near downtown Atlanta. Activities will include assisting 75 substance abusing, HIV-infected adults in obtaining medical and substance abuse treatments. The project also addresses barriers to care by developing a training program for primary care and other service providers.

PROTOTYPES

5601 W. Slauson Avenue, Suite 200
Culver City, CA 90230

OFC: (310) 641-7795

FAX: (310) 649-3096

eMail: sarw23a@prodigy.com

Contact Person:

Vivian Brown, Ph.D.

Project Period: 10/94-09/99

PROTOTYPES heads a consortium of Los Angeles County agencies designed to be a community-based, outpatient model for delivering a comprehensive continuum of services for women with HIV/AIDS. Women are recruited throughout Los Angeles County in order to-- 1) provide a range of quality services to substance abusing women with HIV designed to increase their use of health care services and treatment compliance; 2) change risk behaviors with an array of services; 3) increase compliance with medical treatment and enhance access to existing services outreach to high need women; 4) improve the quality of life for women living with HIV through comprehensive case management; 5) increase provider's knowledge, receptiveness and skill in treatment of women substance abusers living with HIV; 6) to develop and evaluate models for replication and integration into HIV/AIDS delivery systems for women; and 7) disseminate information about successful service models.

Well-Being Institute
216 South State Street, Suite 4
Ann Arbor, MI 48104
OFC: (313) 913-4300
FAX: (313) 913-4306
eMail: user6rm@mts.cc.wayne.edu
Contact Person:
Geoffrey Smereck, J.D.
Project Period: 10/94-09/99

The Well-Being Institute Women's Intervention Program is a comprehensive, nursing-based intervention program designed for HIV positive women substance abusers who are not accessing existing health delivery systems. The program is three-tiered and will serve 32 women at any one time. Tier one services assists women in overcoming access barriers to primary health care services. Tier two services assist women to become drug free and provide temporary housing for the women and their children. Tier three services provide an opportunity for participation in a revenue-generating activity for the women.

Ethnic Group Facing Both Linguistic and Cultural Barriers

**Center for Community Health,
Education, and Research**
(formerly Haitian Community AIDS
Outreach)
420 Washington Street
Dorchester, MA 02124
OFC: (617) 265-0628
FAX: (617) 265-4134
eMail: N/A
Contact Person:
Eustache Jean-Louis, M.D.
Project Period: 10/94-09/97

The project is seeking to enhance its current community and hospital-based case management system. The enhancement will add one-on-one intensive counseling sessions and educational training. The grantee will develop a Haitian culturally competent risk reduction curriculum. Clients will be selected from the Haitian population residing in the Greater Boston Area who are HIV + or have AIDS. The participants will sign a consent form and receive a stipend for complying with the guidelines and completing the program.

Special Populations Experiencing HIV-Based Discrimination

**Indiana Community AIDS Action
Network**
3951 North Meridian Street, Suite 200
Indianapolis, IN 46208
OFC: (317) 920-3190
FAX: (317) 920-3199
eMail: HN3745@handsnet.org
Contact Person:
Paul Chase, J.D.
Steve Johnson
Project Period: 10/94-09/96

This program targets African-Americans and men who have sex with men to increase their utilization of advocacy services and, therefore, reduce barriers to health care access and discriminatory practices encountered in health care settings, employment, housing, public accommodations, governmental services, criminal justice, social/domestic relations, and insurance. The model provides education to reduce HIV discrimination by employers and health care providers, coupled with skills building to increase the capacity of consumers and consumer advocates to redress HIV-related bias. Primary objectives are assistance in enforcing state and federal anti-discrimination laws and development of a grass roots coalition through which to influence public policy decision-making. Increased utilization of these advocacy services will reduce barriers to health care access and financing.

Michigan Protection and Advocacy Services

29200 Vassar Blvd., Suite 501
Livonia, MI 48152-2181
OFC: (810) 473-2990
FAX: (810) 473-4104
eMail: HN5293@handsnet.org or
HN5606@handsnet.org

Contact Persons:

Jay Kaplan, J.D.
Laura Anderson, J.D.
Project Period: 10/94-09/96

This project is expanding its HIV/AIDS Advocacy Program to increase access to legal services and information on rights to HIV+ African-Americans, Latinos, gay men and lesbians throughout Michigan. The program trains volunteer community advocates on HIV-related laws, who will in turn provide legally-based advocacy services to clients within their own community. The program is also training attorneys, expanding an attorney referral network, and pursuing some impact litigation.

Underserved Population Groups

Center for Women Policy Studies

1211 Connecticut Avenue, NW - Suite 312
Washington, D.C. 20036
OFC: (202) 872-1770
FAX: (202) 296-8962
eMail: HN4066@handsnet.org

Contact Persons:

Leslie Wolfe
Belinda Rochelle
Project Period: 10/94-09/99

The Center for Women Policy Studies project--the Metro DC Collaborative for Women with HIV--is designed to ameliorate organizational barriers to care for women with HIV through organizational collaboration and inclusion of women with HIV, their providers, and advocates in policy development. The project is conducted in collaboration with PROTOTYPES. The components of the model are-- 1) nurturing leadership among women with HIV in the policy arena and building a cadre of women with HIV who are policy advocates and influencers; 2) for educating policy makers about the needs of women with HIV; 3) capacity building through training, technical assistance, and organizational development; and 4) process and outcome evaluation consisting of a needs assessment instrument of service barriers, a longitudinal client-participation instrument, a training and technical assistance evaluation form, and a fax-in data system maintained by TMG, as well as qualitative data gathering.

Health Initiatives for Youth

1242 Market Street, 3rd Floor
San Francisco, CA 94102
OFC: (415) 487-5777
FAX: (415) 487-5771
eMail: HN5409@handsnet.org

Contact Persons:

Ron Henderson
Project Period: 10/94-09/99

This project helps health and human service providers offer developmentally and culturally appropriate care for HIV-affected youth and young adults ages 12 to 25. This project offers a variety of experiential trainings on health and psychosocial topics related to youth; informational resources including a quarterly newsletter, a directory of providers, and information on packets; and technical assistance through in-person, written,

Health Initiatives for Youth cont'd

**Interamerican College of Physicians
and Surgeons**

NYU School of Medicine
915 Broadway, Suite 1105
New York, NY 10010-7108
OFC: (212) 777-3642
FAX: (212) 505-7984
eMail: icps@iia.org

Contact Persons:

James P. Tierney
Larua Zizic

Project Period: 10/94-09/97

**University of Texas Health Science
Center at San Antonio**

Community Pediatrics Division
7703 Floyd Curl Drive
San Antonio, TX 78284-7818
OFC: (210) 567-7400
FAX: (210) 567-7443
eMail: german@uthscsa.edu

Contact Persons:

Victor German, M.D., Ph.D.
Selina Catala, M.S., L.C.D.C.

Project Period: 10/94-09/97

and telephone consultation. In addition, the project encourages networking and collaboration among providers so that youth receive better coordinated care for HIV and health-related concerns.

This project is a collaborative effort between the Interamerican College of Physicians and Surgeons (ICPS), Bellevue Hospital Medical Center, and the Department of Dermatology at NYU School of Medicine. ICPS is expanding access to health care services for HIV-infected Hispanic populations by increasing, through training, the number of Hispanic health care providers active in screening, testing, counseling, and managing their patients at risk or already HIV infected. Individualized training will be provided to each of the 90 physician trainees in their private offices and an in-hospital training session will be held at Bellevue Hospital Medical Center. Physicians will be assigned to intervention and control groups in a randomized research trial with a post-test intervention and a case study design involving 5% of randomly selected subjects.

The "Salud y Unidad en la Familia/Health and Unity in the Family" ("SALUD") project targets the health and human services delivery system for women, children, and their families with HIV in South Texas. Project "SALUD" is a collaborative effort involving the Texas Department of Protective and Regulatory Services (TDPRS) and four Ryan White service providers who have been seminal organizations in the development and delivery of HIV/AIDS services in San Antonio, Corpus Christi and the Lower Rio Grande Valley. This project is designed to provide a mechanism for urban and rural communities to build upon existing strengths and capacities for continued development of a comprehensive, family-centered continuum of care for HIV/AIDS women, children, and their families. Project "SALUD's" goal is to bring about system assessment and system change. System assessment objectives include: child and family-focused needs assessment and organizational and systems resource assessment. System change objectives include: dissemination activities at the local and state levels, cross-training of staff, caregiver training and curricula development.

**Provider Training and Educational Models in Rural, Correctional, or
Mental Health Settings**

Correctional

Emory University
Southeast AIDS Training and Education
Center
735 Gatewood Road, NE
Atlanta, GA 30322
OFC: (404) 727-2929
FAX: (404) 727-4562
eMail: rswift@emory.edu
Contact Persons:
Ira Schwartz, M.D.
Jacqueline Zalumas, Ph.D., R.N., FNP
Project Period: 10/94-09/97

This project is developing, testing, and evaluating educational models for increasing, improving, and updating knowledge about HIV infection and treatment for Georgia's correctional health care providers. Using a quasi-experimental design, Emory will compare the impact of three different levels/intensities of training and three different training strategies. The project is utilizing interviews and chart audits to examine the following variables: knowledge and attitudinal changes, trainees' assessments, and observed change over time.

The Fortune Society, Inc.
39 West 19th Street
New York, NY 10011
OFC: (212) 206-7070
FAX: (212) 366-6323
eMail: JPFORTUNE@aol.com
Contact Persons:
JoAnne Page, J.D.
Tracey Gallagher
Project Period: 10/94-09/99

The Fortune Society's Latino Discharge Planning (LDP) program delivers culturally and linguistically appropriate services to Hispanic women and men prisoners and releasees who are HIV+ and symptomatic in New York City jails and New York state prisons. This project focuses on discharge planning for prisoners, case management referrals with follow up, and intensive case management post release. This innovative approach entails identification of and consistent contact with clients prior to release.

Mental Health

University of Washington
AIDS Education and Training Center
1001 Broadway, Suite 217
Seattle, WA 98122
OFC: (206) 720-4250
FAX: (206) 720-4218
eMail: keegan@u.washington.edu
Contact Person:
Karina Uldall, M.D.
Project Period: 10/94-09/97

The University of Washington Center for AIDS and STDs is working with the School of Medicine, Department of Psychiatry and Behavioral Science to train primary care providers, mental health staff, and volunteers at four sites: Harborview Medical Center, Swedish Medical Center AIDS Unit, Bailey Boushay House and Rosehedge. The training and education model will develop, test, and evaluate strategies for increasing, improving, and updating

knowledge about HIV neuropsychiatric illness with specific emphasis on delirium and its treatment. Program goals include enhancing current service delivery and standardizing assessment and treatment across providers in the project.

Rural Areas

University of Colorado Health Sciences Center

4200 E. Ninth Avenue, Box A-089
Denver, CO 80262

OFC: (303) 315-2516

FAX: (303) 315-2514

eMail: andersod@essex.hsc.colorado.edu

Contact Persons:

Donna Anderson, Ph.D., M.P.H.

Sara Martin

Project Period: 10/94-09/97

This project is evaluating the impact and cost effectiveness of three educational methodologies designed to increase service delivery to individuals in rural areas. The methodologies are self-study modules, two-way interactive audio/visual teleconferencing, and experiential programs delivered by rural outreach teams. The project focuses on physicians, physician assistants, and nurses to examine whether improvements in knowledge, attitudes, and willingness translate into increased services for at-risk and seropositive individuals.

University of Mississippi Medical Center

Division of Infectious Diseases

2500 N. State Street

Jackson, MS 39216

OFC: (601) 984-5556

FAX: (601) 984-5565

eMail: harold@fiona.umsmed.edu

Contact Person:

Harold Henderson, M.D.

Project Period: 10/94-09/99

This project is enhancing the capacity of health care providers in rural clinics to diagnose and treat asymptomatic HIV disease. This occurs by expanding the Delta AIDS Education and Training Center's (DAETC) ability to provide clinical training for those providers with a computer-based distance learning system and building on the existing preceptorship provided by DAETC. Physicians, nurse practitioners, and dentists at targeted clinics are being provided with updated medical references, access to sources of additional HIV funding, and a means for interactive training supervised by HIV specialists at University of Mississippi Medical Center. Providers and community health centers in areas of highest HIV prevalence are being targeted.

Evaluation and Dissemination Center (EDC)

The Measurement Group/PROTOTYPES Consortium

c/o The Measurement Group
5811A Uplander Way
Culver City, CA 90230
OFC: (310) 216-1051

FAX: (310) 670-7735
eMail: ghuba@prodigy.com
lmelchior@prodigy.com

Contact Persons:

George Huba, Ph.D.

Lisa Melchior, Ph.D.

Project Period: 10/94-09/99

The Measurement Group/PROTOTYPES consortium provides consultation and technical support services to grantees which include components of centralized data entry/management, statistics and management information reports, and information dissemination functions. Some specific activities that the Center provides to HRSA as well as the HIV Service Delivery grantees include review and assess evaluation plans; provide technical assistance to refine and implement evaluations; conduct an evaluation workshop; provide on-going support for data collection and analysis of site-specific data; monitor the quality of data and provide feedback; establish and maintain a computerized data repository; provide writing and editing support; provide logistical support for meetings; and work with HRSA and grantees to produce journal articles and policy program reports. The EDC is a consortium headed by The Measurement Group and also includes PROTOTYPES. The Measurement Group provides overall management for the EDC and is responsible for the evaluation and some dissemination activities. PROTOTYPES is responsible for logistical support of the Steering Committee meetings and dissemination activities.

Special Projects of National Significance (SPNS) Program Grantees

<i>Adolescent Care Demonstration and Evaluation</i>	<i>Dissemination and Refinement of the Model</i>	<i>HIV Service Delivery Models</i>
<p>Bay Area Young Positives, Inc. Children's Hospital, Boston (Boston Happens) Children's Hospital, Los Angeles Greater Bridgeport Adolescent Pregnancy Program, TOPS Program Health Initiatives for Youth Indiana Youth Access Project (ISHD) University of Alabama at Birmingham University of Minnesota, Youth, and AIDS Project Walden House, Inc. YouthCare</p>	<p>Children's Hospital, New Orleans Children's National Medical Center Family Planning Council of SE Pennsylvania Fortune Society, Inc. Indiana Integration of Care Project (ISHD) Montefiore Medical Center Multnomah County Health Department National Native American AIDS Prevention Center (NNAAPC) Protection & Advocacy System, Inc. (New Mexico)</p>	<p>AIDS Healthcare Foundation Center for Community Health, Education, and Research Center for Women Policy Studies Cook County Hospital/Hektoen East Boston Neighborhood Health Center Emory University Fortune Society Health Initiatives for Youth Indiana Community AIDS Action Network Interamerican College of Physicians & Surgeons Johns Hopkins University School of Medicine Larkin Street Youth Center Michigan Protection & Advocacy Services Missouri Department of Health New York State Department of Health/Health Resources Outreach, Inc. PROTOTYPES (includes TMG/PROTOTYPES EDC) Research Foundation of SUNY University of Colorado Health Sciences Center University of Mississippi Medical Center University of Nevada at Reno University of Texas Health Science Center at San Antonio University of Vermont & State Agricultural College University of Washington Visiting Nurses Association of Los Angeles Washington University School of Medicine Well-Being Institute</p>

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AIDS Healthcare Foundation

Los Angeles, CA
OFC: (213) 462-2273
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Bay Area Young Positives, Inc.

San Francisco, CA
OFC: (415) 487-1616
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Center for Women's Policy Studies

Washington, D.C.
OFC: (202) 872-1770
Page: 15

Children's Hospital, Boston

Boston Happens

Boston, MA
OFC: (617) 355-6495 or 735-7131
Page: 2

Children's Hospital, Los Angeles

Los Angeles, CA
OFC: (213) 669-4604
Page: 2

Children's Hospital, New Orleans

New Orleans, LA
OFC: (504) 524-4611
Page: 5

Children's National Medical Center

Washington, D.C.
OFC: (202) 884-4004 or 5451
Page: 5

Cook County Hospital/Hektoen

Chicago, IL
OFC: (312) 633-8675
Page: 12

East Boston Neighborhood Health Center

Boston, MA
OFC: (617) 568-4755 or 4452
Page: 9

Emory University

Atlanta, GA

OFC: (404) 727-2929

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Family Planning Council of S.E. Pennsylvania

Philadelphia, PA
OFC: (215) 985-2657
Page: 5

Fortune Society, Inc.

New York, NY
OFC: (212) 206-7070
Pages: 6; 17

Greater Bridgeport Adolescent Pregnancy Program – TOPS Project

Bridgeport, CT
OFC: (203) 384-3629
Page: 3

Center for Community Health, Education, and Research (formerly Haitian Community AIDS Outreach)

Dorchester, MA
OFC: (617) 265-0628
Page: 14

Health Initiatives for Youth

San Francisco, CA
OFC: (415) 487-5777
Pages: 3; 15

Indiana Community AIDS Action Network

Indianapolis, IN
OFC: (317) 920-3190
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Indiana Integration of Care Project (ISHD)

Indianapolis, IN
OFC: (317) 233-7867
Page: 6

Indiana Youth Access Project (ISHD)

Indianapolis, IN

OFC: (317) 541-8726
Page: 3

Interamerican College of Physicians and Surgeons

New York, NY
OFC: (212) 777-3642
Page: 16

Johns Hopkins University School of Medicine

Baltimore, MD
OFC: (410) 955-7634
Page: 9

Larkin Street Youth Center

San Francisco, CA
OFC: (415) 673-0911
Page: 11

Michigan Protection and Advocacy Services

Livonia, MI
OFC: (810) 473-2990
Page: 15

Missouri Department of Health

Independence, MO
OFC: (816) 325-6140
Page: 10

Montefiore Medical Center

Bronx, NY
OFC: (718) 430-2154
Page: 7

Multnomah County Health Department

Portland, OR
OFC: (503) 248-5020 x 2290
Page: 7

National Native American AIDS Prevention Center (NNAAPC)

Oakland, CA/Oklahoma City, OK
OFC: (510) 444-2051/(405) 631-9988
Page: 7

New York State Department of Health/Health Resources

Albany, NY
OFC: (518) 473-7781

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Outreach, Inc.

Atlanta, GA
OFC: (404) 346-3922
Page: 13

Protection and Advocacy System, Inc.

Albuquerque, NM
OFC: (505) 256-3100
Page: 8

PROTOTYPES

Culver City, CA
OFC: (310) 641-7795
Page: 13

Research Foundation of SUNY

Brooklyn, NY
OFC: (718) 270-4737
Page: 12

The TMG/PROTOTYPES Consortium

Culver City, CA
OFC: (310) 216-1051
Page: 19

University of Alabama at Birmingham

Birmingham, AL
OFC: (205) 934-5262
Page: 4

University of Colorado Health Sciences Center

Denver, CO
OFC: (303) 355-1305
Page: 18

University of Minnesota, Youth, and AIDS Project

Minneapolis, MN
OFC: (612) 627-6824
Page: 4

University of Mississippi Medical Center

Jackson, MS
OFC: (601) 984-5556
Page: 18

University of Nevada School of Medicine

Reno, NV
OFC: (702) 784-6170
Page: 10

**University of Texas Health Science Center at
San Antonio**

San Antonio, TX
OFC: (210) 567-7400
Page: 16

**University of Vermont & State Agricultural
College**

Burlington, VT
OFC: (802) 656-4836
Page: 11

University of Washington

Seattle, WA
OFC: (206) 720-4250
Page: 17

Visiting Nurses Association of Los Angeles

Los Angeles, CA
OFC: (213) 386-7200
Page: 10

Walden House, Inc.

San Francisco, CA
OFC: (415) 554-1480
Page: 4

Washington University School of Medicine

St. Louis, MO
OFC: (314) 747-1026 or 362-4413
Page: 12

Well-Being Institute

Ann Arbor, MI
OFC: (313) 913-4300
Page: 14

YouthCare

Seattle, WA
OFC: (206) 282-9907
Page: 4

Special Projects of National Significance (SPNS) Program

A Program of the Ryan White CARE Act

**Partnership
Steering Committee Grant
Project Abstracts:**

**Demonstration Models for
HIV Infected Youth**

**Innovative HIV Service Models for
Native American Communities Grants**

**Integrated Service Delivery
Models Grants**

Multiple Diagnoses Initiative Grants

**National Evaluation
Technical Assistance Center Grant**

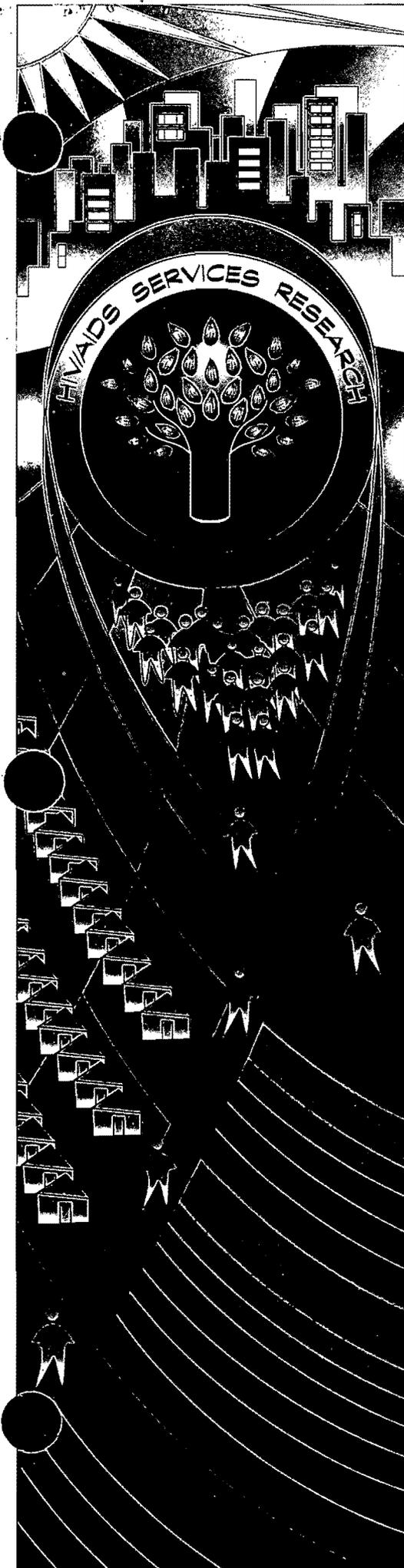
Partnership Steering Committee Projects are funded by:

**Special Projects of National Significance Program
Health Resources and Services Administration**

**Office of HIV/AIDS Housing
Housing Opportunities for Persons with AIDS Program**

U.S. Department of Health & Human Services

HRSA
Health Resources & Services Administration



**Special Projects of National Significance Program
Office of Science and Epidemiology
Bureau of Health Resources Development
Health Resources and Services Administration
U.S. Department of Health and Human Services**

**Office of HIV/AIDS Housing
Housing Opportunities for Persons with HIV/AIDS Program
U.S. Department of Housing and Urban Development**

Partnership Steering Committee Grant Project Abstracts

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Introduction to the SPNS Program

The Special Projects of National Significance (SPNS) Program is authorized by the Ryan White Comprehensive AIDS Resource Emergency (CARE) Act to support demonstrations and evaluations of innovative models of delivering health and support services to people with HIV. The goal of the SPNS Program is to advance knowledge about the care and treatment of people with HIV.

Awards are made to non-profit organizations wishing to evaluate a model of care. The SPNS Program uses a competitive grant award process which includes a peer review component to assure fair and equitable distribution of funds to the organizations that apply for support. Awards are made on the basis of: 1) a need to assess the effectiveness of a particular model of HIV care, 2) the innovative nature of the proposed activity, and 3) the potential for replication of the proposed activity. In order to meet program goals, applications must contain a strong program evaluation component and provide evidence of the potential replicability of the model.

SPNS Program Initiatives

The SPNS Program has endeavored to be responsive to the changing epidemiology of HIV in the United States by identifying categories for proposals. In the first two years of program operations, priority was given to categories of: 1) increasing access to care through the reduction of sociocultural, financial and transportation barriers among groups (e.g. rural residents, women, adolescents, correctional populations, Native Americans or Alaskan Natives); 2) legal advocacy models; 3) reduction of social isolation; and 4) integration of mental health and primary care services.

In 1993, adolescents were targeted as a separate category, and categories were added to focus on comprehensive primary care; coordinated delivery of health and support services to mobile populations; reduction of cultural and linguistic barriers to care; and training and education models. In 1994, projects were funded to disseminate, refine and replicate previously evaluated models of care. In addition, the SPNS Program began a collaborative project with the Center for Mental Health Services and the National Institute of mental health to initiate demonstration projects addressing mental health care for people with HIV. No new categories were added in 1995.

In 1996, the SPNS Program funded projects in two areas. The first focuses on adolescents with HIV or who are at high risk for HIV. The second focuses on the development of integrated service delivery models. As a component of the integrated service delivery models initiative, the SPNS Program began a collaboration with the Housing Opportunities for Persons with AIDS Program, U.S. Department of Housing and Urban Development. This collaboration, the Multiple Diagnoses Initiative, aims to integrate the full range of housing, health care, and support services needed by homeless people living with HIV/AIDS whose lives are further complicated by mental illness and/or substance abuse.

In 1997, the SPNS Program funded proposals focusing on the provision of culturally appropriate care to Native Americans.

Program Design

Each funded SPNS Program project is responsible for the implementation and evaluation of its proposed project. Evaluation must be conducted at both the local and national levels. Each project chooses its own evaluator for local evaluation purposes; for the national evaluation, the Columbia School of Public Health is funded to work with all Partnership Steering Committee grant projects. The national evaluation is based on a data set contributed to by each project, although not every project will contribute the same type of data since different projects have different scopes, focuses and outcomes.

Introduction to the HOPWA Program

The Housing Opportunities for Persons with AIDS Program (HOPWA) provides housing assistance and supportive services for low-income persons with HIV/AIDS and their families. Grants are provided: (1) by formula allocations to States and metropolitan areas with the largest number of cases and incidence of AIDS; and (2) by selection through a national competition of projects proposed by State and local governments and nonprofit organizations. Grantees are encouraged to develop community-wide comprehensive strategies and form partnerships with area nonprofit organizations to provide housing assistance and supportive services for eligible persons.

Consolidated Planning

HOPWA formula grants are available as part of the area's Consolidated Plan, which also includes the Community Development Block Grant, HOME, and Emergency Shelter Grants. Plans are developed through a public process that assesses area needs, creates a multiple-year strategy and proposes an action plan for use of Federal funds and other community resources in a coordinated and comprehensive manner.

Formula Awards

In order to receive funding, formula areas must have at least 1,500 cumulative reported cases of AIDS and metropolitan areas must have a population of at least 500,000.

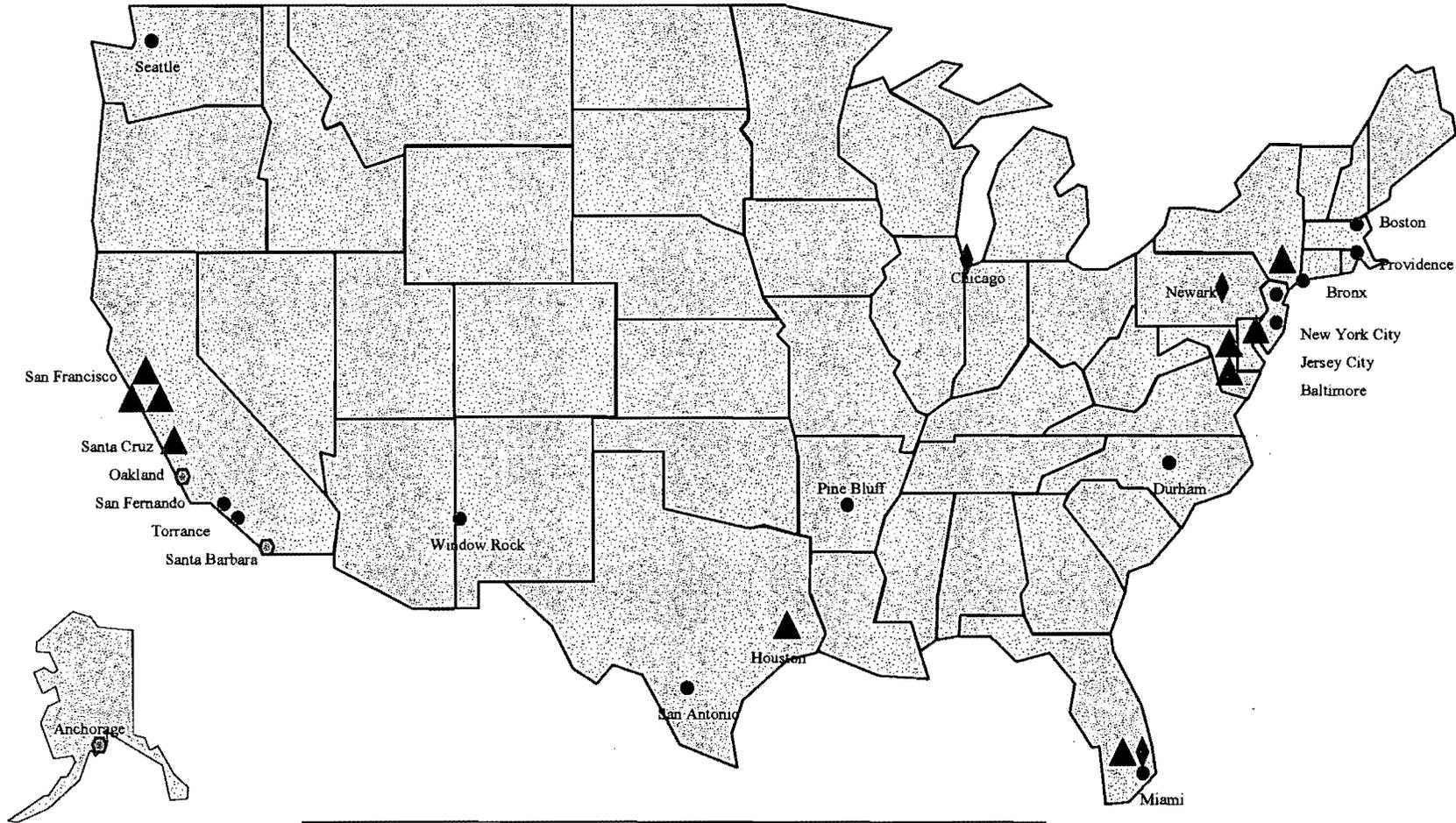
Competitive Grants

Special Projects of National Significance (SPNS) grants are competitive awards which, due to their innovative nature or their potential for replication, are likely to serve as effective models in addressing the needs of eligible persons. Under a collaborative initiative with the SPNS Program, Health Resources and Services Administration, U.S. Department of Health and Human Services, funds have been made available under HOPWA SPNS to support the HIV Multiple Diagnoses Initiative (MDI) which targets assistance to homeless persons living with HIV/AIDS who also have chronic alcohol and/or other drug abuse problems and/or serious mental illness.

Program Uses

HOPWA funds have helped communities establish strategic plans, better coordinate local and private efforts, fill gaps in local systems of care, and create model programs. HOPWA funds may be used for a wide array of housing, social services and program planning and development costs, including, but not limited to, the acquisition, rehabilitation or new construction of housing units, costs for the operation of facilities and community residences, rental assistance and short-term payments to prevent homelessness. HOPWA may also support services, such as health care and mental health services, chemical dependency treatment, nutritional services, case management, assistance with daily living, housing information and other services.

SPNS Program Projects



- Integrated Service Delivery Model for Persons with HIV Disease
- ▲ HIV Multiple Diagnosis Initiative
- ◆ Youth and Family
- ⦿ Native American Initiative

Partnership Steering Committee Grant Project Abstracts

Demonstration Models for HIV Infected Youth Grantees
Innovative HIV Service Delivery Models for Native American Communities Grantees
Integrated Service Delivery Models Grantees
Multiple Diagnoses Initiative Grantees
National Evaluation Technical Assistance Center

American Indian Health & Services "Red Ribbon Bridge"

4141 State Street, Suite B-6
Santa Barbara, CA 93110

Project Director: Seh Welch, J.D.
Contact Person: Nancy McNeil
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PARTNERS

AIDS Project Central Coast, Central Coast Congregate
Care, County Health Care Services

TARGET POPULATION

Native Americans infected with HIV and residing in
Santa Barbara County.

DESCRIPTION

Insensitivity and fragmentation of the current system of care for Native Americans infected with HIV causes demoralization of the afflicted and impedes care. The purpose of *Red Ribbon Bridge* is to set up a culturally appropriate model for the comprehensive, coordinated delivery of services. These include counseling (personal, social work/benefits), nurse case management, risk reduction, food pantry, legal assistance, and housing to Indians by Indians. All services will be responsive to the cultural, spiritual, and traditional medicine requests of Native Americans. *Red Ribbon Bridge* is an effort to foster a trust that is extremely necessary to ensure client utilization of services and compliance with treatment. By coordinating with existing local agencies to care for the whole person, *Red Ribbon Bridge* seals the cracks often associated with social service programs. The action plan includes dissemination of cultural outreach information to gateway sites and individuals in the target population that are at high risk; cross training of collaborative agency staff about Native American culture; and coordinating all health and social services for the target population via case management techniques.

Asian & Pacific Islander Coalition on HIV/AIDS, Inc.

"The Bridges Project"

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PARTNERS

Elmhurst Hospital Center, Wyckoff Heights Medical
Center, New York Hospital Medical Center of Queens,
Community health Project, Rivington House,
Chinatown Action for Progress

TARGET POPULATION

Asians and Pacific Islanders living with HIV/AIDS in
the New York City metropolitan area who speak little
or no English

DESCRIPTION

Asians and Pacific Islanders make up the fastest growing racial group in New York City. As of March 1996, 95 percent of the total adult AIDS cases for this racial group in the entire state were found in the city's Asian and Pacific Islander community. This represents 13 percent of the total AIDS cases for the same group in the United States as well. The city's Asians and Pacific Islanders have difficulty accessing HIV-related services that are culturally-competent, language appropriate, and HIV-sensitive due to a shortage of such services. Where services do exist, they are fragmented, and the delivery system is confusing. *The Bridges Project* improves access by 1) integrating a

range of HIV medical and social services through formal linkages and a Referral Services Network made up of bilingual providers; 2) providing training to overcome cultural program incompetence and HIV insensitivity; and 3) decreasing language barriers through interpretation by paid, on-call Bilingual Peer Advocates. Also, this model expands the range of HIV services without having to create new service sites.

**Baltimore City Office of Homeless Services
"Diamond Project"**

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PARTNERS

HERO, Project PLASE, Health Care for the Homeless, Housing Unlimited Group, AIDS Interfaith Residential Services, The League, Black Education AIDS Project, Chase-Brexton Health Services, Project Home AIDS Program, Movable Feast, Inc., Baltimore City Department of Housing and Community Development

TARGET POPULATION

Dual-diagnosed homeless persons with HIV in Baltimore City and County

DESCRIPTION

An estimated 80 percent of the 2,900 people with AIDS and the 38,000 infected with HIV in the Baltimore EMA, live in poverty. Most are single, black men. Service providers estimate that 60-75 percent of this population has a substance abuse history, 15 percent report suffering from mental illness, and 10 percent are dually diagnosed. The goal of the *Diamond Project* is the coordinated provision of housing counseling, case management, day center activities, medical and mental health care, and substance abuse treatment. There are two major program components. The Emergency Housing Facility for medically fragile individuals serves up to 75 persons per year in a supportive transition (ranging from one to three months) from crises to stable, secure, and appropriate living situations. The Community Resource Center provides primary health care, psychiatric evaluations

and referrals, case management, housing counseling, and a day respite facility with structured activities, vocational training, and a range of other related assistance for approximately 700 clients per year. These activities address unmet needs specified in the metropolitan area's ten-year strategic *HIV Housing Plan for Greater Baltimore*.

Bernal Heights Housing Corporation

*"Housing, Outreach, Transitional Strategies (HOTS)
Collaborative: Permanent Housing with Supportive
Services for HIV-Positive Women and Their
Children"*

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PARTNERS

Catholic Charities of the Archdiocese of San Francisco, Legal Services for Children, Edgewood Family Center, San Francisco Redevelopment Agency, San Francisco Dept. of Public Health-AIDS Office, Dept. of Social Services, Mayor's Office, Women's Health Advisory Council (Dept. of Public Health), Bayview Hunters Point Foundation

TARGET POPULATION

Homeless families with dependent children living with HIV/AIDS, and impacted directly by substance abuse and/or mental illness

DESCRIPTION

One-third of the 3,200 people with HIV/AIDS on a centralized housing wait list in San Francisco can expect to wait two years for housing subsidies. The shortage is acute for homeless women and children living with HIV as there has been only one nine-unit facility available. *HOTS* aids 45 families (about 95 adults and 120 children). The program allows acquisition of four units of permanent, supportive housing for service recipients. It also provides a one-stop, integrated case management service delivery system that includes mental health and substance abuse

services, AIDS care, and supportive and children's services. A child-centered approach focuses on the needs of the entire family prior to and after the death of a family member. A long-term plan for child placement after a guardian's death begins in advance of the crisis. The project runs an aftercare program for children and guardians, and conducts educational forums on health issues, skills development, domestic violence, and parenting. An additional 900 clients and 30 agencies receive related outreach and educational services.

Catholic Community Services
"Operation Link"

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PARTNERS

Let's Celebrate, Jersey City Medical Center, Francisca House Transitional Residence, St. Lucy's Homeless Shelter, Mount Carmel Guild Behavioral Healthcare System (Division of CCS), Jersey City Family Health Center (WISE Program), Christ Hospital (HRSA Home Health Care), St. Mary Hospital (Family Practice Center)

TARGET POPULATION

Homeless persons with HIV/AIDS and mental illness and/or substance abuse

DESCRIPTION

Although local homeless service providers have reported an increase in the need for health, housing, and social services by mentally ill and HIV positive homeless persons, there is no integrated health and housing model to provide these services. *Operation Link's* goal is to connect this traditionally underserved population with a broad range of housing services that meet their special need. Services are provided for up to 450 homeless persons, and direct housing placements are provided for 56 individuals. Up to 23 of these individuals are women and children who are provided with further specialized services. Operation Link is designed to move the target population from the streets to permanent housing through: 1) An Assertive Mobile Outreach Unit, 2) a No/Low Demand Drop-In Center, 3) St. Lucy's 10 Designated shelter beds; (4)

transitional housing at Francisca House, and (5) Permanent Housing advocacy and placement. Program staff involves experienced behavior, health, and social service professionals, and a staff of specially trained "Peers." The support helps clients navigate the social service system and achieve a more stable, healthy, and independent lifestyle. The drop-in center is the first in Jersey City.

Chugachmiut

"Alaska Native HIV/AIDS Case Management Project"

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PARTNERS

Yukon Kuskokwim Health Corporation, Kodiak Area Native Association

TARGET POPULATION

HIV positive Alaska Natives and those living with AIDS, their families and fellow villagers

DESCRIPTION

The *Alaska Native HIV/AIDS Case Management Project* is designed to meet the special needs of the target population by coordinating and integrating services so as to allow clients to stay in their villages or as close to home as possible. It accomplishes this by: 1) use of a comprehensive intake and client evaluation tool to determine the multiple needs of native village residents, development of individualized plans for meeting client/family/village needs, and the consistent monitoring of client health and well-being; 2) collaboration with other service providers within each region served by the health corporations, specifically strengthening relationships between out-of-village providers and village-based health care workers; and 3) use of project staff to provide training and work on developing protocols, linkage agreements, and supportive systems necessary to improve client service, and to facilitate the exchange of relevant information among involved client providers.

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"SPNS Program National Evaluation Technical Assistance Center"

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DESCRIPTION

The SPNS Program National Evaluation Technical Assistance Center (ETAC) provides overall evaluation coordination for the cross-cutting, multisite evaluations of the Partnership Steering Committee (PSC) grant projects. This effort includes: supporting the development of local evaluation capacity of PSC grant projects by providing targeted technical assistance; providing leadership in the development of a collaborative multisite evaluation strategy that addresses the replicability, efficiency, and effectiveness of innovative HIV service delivery models; developing data collection protocols; training PSC project directors, local project staff, and local project evaluators in common procedures; managing PSC data; conducting evaluation analyses; and using a variety of methods to disseminate the results of the multisite evaluations of the PSC.

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"Chicago HIV Risk Reduction Partnership for Youth"

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PARTNERS

Midnight Basketball League, Boys and Girls Club, Horizons, STOP AIDS, Prologue Alternative High School, Neon Street, Night Ministries, Chicago Adolescent HIV Network

TARGET POPULATION

Adolescents aged 12-19 who are in or have dropped out of school

DESCRIPTION

Chicago's Department of Public Health estimates that there are 714 HIV-infected youth aged 10-19. However, HIV testing sites identified fewer than 15 HIV-positive youth in 1995. This means many such youths are unidentified and not receiving health care. Youth cite barriers to testing, including structural problems with accessing present sites (hours of operation coincide with school hours, presence of gang turf boundaries which make access prohibitive) and personnel who are not "youth friendly" (little knowledge of the age group and insensitivity). *Partnership for Youth* provides HIV educational sessions (including testing and counseling) within community adolescent service agencies. The goals are to: 1) increase the number of youth receiving HIV counseling and testing; 2) use HIV testing as an intervention to reduce youth's risky behaviors; and 3) raise the number of HIV-positive youth entered into comprehensive medical and mental health care services. To facilitate HIV counseling and testing for another 720 youth, on-site HIV services are provided.

Duke University Medical Center
"Integrated HIV/AIDS Delivery System for Rural Eastern North Carolina"

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PARTNERS

University of North Carolina at Chapel Hill (School of Medicine), East Carolina University School of Medicine

TARGET POPULATION

Medicaid eligible HIV-infected adults living in Eastern North Carolina

DESCRIPTION

Traditionally, health care and social services have been fragmented for poor individuals with HIV/AIDS living in rural areas where AIDS is spreading at the fastest rate. The *Integrated Delivery System* project develops a model of care previously missing for the target population. Goals for the model are: 1) to improve access to health and social services; 2) create a modifiable standard of care that can be evaluated; 3) improve quality of life; 4) raise patient satisfaction with such services; and 5) reduce or maintain current health care and human services costs by reducing the use of inpatient, emergency room, and institutional care through more intensive, appropriate, and coordinated ambulatory care. The program's main features are a comprehensive range of services and an innovative payment system. Case coordinators track and facilitate integration and coordination of health and social services with the assistance of a computer network and clinical and ambulatory care mapping. Capitated payments from North Carolina Medicaid finance the model. The rate, which applies to all three project sites, includes all Medicaid services and elements of the integrated service delivery system.

East Boston Neighborhood Health Center
"Building Bridges from Primary Medical Care to Mental Health and Substance Abuse Services"

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PARTNERS

East Boston Health Center, North Suffolk Mental Health Association, Boston University Medical Center, Massachusetts General Hospital, AIDS Action Committee Cambridge Cases about AIDS, Positive Directions, RUAH (Breath of Life), Victory Programs, Trinity Mental Health

TARGET POPULATION

80 percent of East Boston Neighborhood Health Centers HIV Services population who are suffering from major mental illnesses, primary substance abuse problems, or have been dually diagnosed and, as a result, exceed primary medical care-driven, team-based model capability

DESCRIPTION

Care for the target population has been compromised by fragmented services, inconsistent service quality, and lack of immediate access to critically needed services. *Building Bridges* augments the existing, insufficient system of HIV care for multiply-diagnosed clients. It improves access to and quality of substance abuse and mental health services. It secures a more reliable service bridge between primary care and mental health and substance abuse services through a jointly employed coordinator--an M.S.W. with demonstrated expertise in dual diagnosis. Another essential component of this new model is the contractual relationships with facilities which offer the services the target population requires and include emphasis on quality and cultural/linguistic sensitivity. These relationships relieve access problems and facilitate the vital link back to primary care. If successful, this model will be supported in the future under capitated managed care.

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PARTNERS

Institute for Urban Family Health, Veteran's Leadership Program, GMHC, God's Love We Deliver

TARGET POPULATION

Prisoners, ex-offenders, and their family members

DESCRIPTION

The target population is an underserved group experiencing significant barriers to care. *Ethics 3* develops a much-needed model that engages and retains HIV positive ex-offenders and their families in primary and HIV-specific ambulatory medical care. It utilizes medical care, discharge planning, intensive case management, and a family focus to address the special issues that make the target population difficult to serve through traditional medical systems. The model expands on the ETHICS program (Empowerment Through HIV Information, Community and Services) by linking clients and families with an integrated system of medical care that is sensitive and responsive to their special needs and willing to work closely with clients' case managers in providing holistic services. It provides personalized, high-quality medical care teamed with case management to help clients stabilize their lives. ETHICS 3 also addresses such issues as homelessness, risk of relapse, transition from incarceration, and isolation which could possibly result in episodic or discontinued involvement in medical care.

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PARTNERS

Long Beach CHC HIV Program, UCLA School of Medicine, Goodwill Industries of Long Beach and South Bay, City of Long Beach Community Development Program, Long Beach Comprehensive Health Center's Tom Kay Clinic, Long Beach Division of HHS Early Intervention and HIV Case Manager Programs, Long Beach HIV Care Consortium, St. Mary Medical Center's Care Program, CSU Long Beach Center for Community Research and Services, Redgate Memorial Recovery Center, Substance Abuse Foundation's Sobriety House

TARGET POPULATION

Indigent, non-disabled persons with HIV

DESCRIPTION

Ninety-four percent of HIV patients who do not have AIDS and are served by community agencies report being unemployed. Joblessness places such individuals at risk for medical care drop out and continued or relapse into substance abuse. Unemployment is also a major contributor to psychiatric co-morbidity. *Rehabilitation Services* adds vocational rehabilitation and job placement aid to existing medical, mental health, and psychosocial services. Integration of such services aids coordination and provision of health-care assessments and follow-up care, as well as training in life and job-related skills. Specifically, the project provides medical, psychosocial, mental health, and vocational evaluation of unemployed, non-disabled HIV persons to help them plan for vocational rehabilitation. It implements such plans for non-disabled HIV clients who want to return to the workplace and provides job placement services.

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"Diamond Project"

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PARTNERS

John Hopkins Moore Clinic, Chase-Brexton Health Services, University of Maryland Adult HIV Clinic, John Hopkins Community Psychiatry Program, Housing Unlimited Group, Project PLASE, Baltimore City Health Department, Baltimore Mental Health Systems, Baltimore City DSS, Family and Children Services of Central Maryland, Helping Up Mission, Health Education Resources Organization, Housing Opportunities for People with AIDS, JHH Program for Alcoholism and Other Drug Dependencies, Maryland Society for Sight, Mercy Medical Center, University of Maryland Adult HIV Program, U of M Dental School, U of M Pediatric Ambulatory Care Clinic

TARGET POPULATION

Homeless individuals in Baltimore City with HIV and substance abuse and/or mental illness

DESCRIPTION

An estimated 25,000 homeless people, predominantly from cultural and ethnic minorities, seek shelter each year in Baltimore. About 1,800 of them are HIV positive and are also mentally ill and/or substance abusers. Due to their multiple problems, many of these individuals have difficulty accessing existing services. The *Diamond Project* concentrates on their needs. It augments existing services in order to facilitate access to comprehensive primary care, support services, and housing for 300 clients. It utilizes a multidisciplinary approach to care which begins on the streets and continues until a client is housed. Two outreach teams, consisting of a peer leader (a formerly homeless person), a registered nurse, and an addictions counselor engage homeless people living on the streets and facilitate their entry into on-site primary medical care; case management; substance abuse and mental health services; health education; and assistance with entitlements, transportation, and housing.

Housing and Services, Inc.
"SHARE Project"

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PARTNERS

Jackson Memorial Hospital, Camillus Health Concern

TARGET POPULATION

Homeless multiply-diagnosed people with HIV/AIDS in Dade County, Florida

DESCRIPTION

Dade County, Florida has about 6,000 homeless people, approximately 40 percent of whom are chronic substance abusers, 30 percent are chronically mentally ill, and 25 percent are HIV infected. The Miami area has the highest per capita growth rate of reported HIV infection in the country. The *SHARE Project* is the first coordinated, integrated, and comprehensive housing and service assistance program for multiply-diagnosed homeless men and women with AIDS/HIV in Dade County. It reduces and eliminates barriers to housing and services for 250 clients. *SHARE* helps resolve the housing, medical, and service needs of the target population by fostering increased collaboration among area agencies to maximize the use of available resources. Barriers are reduced through training, technical assistance, advocacy, and changing public policy.

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PARTNERS

Santa Cruz AIDS Project, Santa Cruz Health Services Agency (General Medical Clinic and AIDS Programs), Early Intervention Program, CARE, Homeless Persons Health Project, County Mental Health Department, Community Action Board, Food and Nutrition Services, Hospice Caring Project of Santa Cruz County, Triad Methadone Program, Janus Alcohol and Drug Treatment, Parent Center, Familia Center, Salud Para La Gente, Mercy Charities

TARGET POPULATION

Homeless persons with HIV/AIDS who are substance abusers and/or suffer from mental illness

DESCRIPTION

Primarily rural Santa Cruz County has the highest per capita rate of AIDS in central California. The *Santa Cruz Initiative* provides short-term emergency funds, long-term scattered-site housing assistance, and intensive supportive services and treatment for 200 persons with HIV/AIDS who are homeless and having difficulties with substance abuse and/or mental illness. It provides a continuum of care from street living to permanent housing that promotes independence and minimizes hospitalization for clients. Motel vouchers are offered as an alternative to county shelters. Peer independent living skills workers will assist clients with daily living tasks, skill building, and maintaining stable housing. Rental assistance and moving expense funds are available through the initiative. Intensive

case management and specialized psychiatric and drug treatment/harm reduction services will be provided to all clients.

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PARTNERS

Ryan White Planning Council, Houston HIV Care Consortium, Minority Caucus, Persons with AIDS Coalition, Thomas Street Baylor Psychiatric Services, Crisis Intervention, Bering Community Service Foundation, Montrose Counseling Center, UT Houston Recovery Campus, Ben Taub Hospital, Star of Hope Transitional Living Center, The Housing Corp for Greater Houston, MAC House, Milam House, Pollux House, River Oaks Health Alliance, WAM Foundation, The Housing Corporation, Houston Area Community Development Corporation

TARGET POPULATION

Homeless persons with HIV/AIDS who are also substance abusers or mentally ill

DESCRIPTION

In Houston, only 2 percent of the public housing units are designated for HIV/AIDS clients. Housing needs are critical for the target population, especially women and African Americans. The *MDI Housing Project* assists 500 homeless persons with HIV/AIDS who are also substance abusers or mentally ill and 125 family members in the metropolitan Houston area. An additional 500 clients receive housing referrals from this program. Three new services help fill gaps in a continuum of care for clients. These are: 1) housing coordination undertaken to provide clients with information on housing availability through a centralized database and make service referrals, periodically assess local housing needs, and coordinate the activities of area organizations; 2) short-term crisis

housing; and 3) a deposit pool which allows access to funds from the Bering Community Service Foundation for utilities and rental deposits for 214 individuals who are exiting transitional drug treatment programs. Enhanced pre-treatment and residential drug/alcohol treatment are provided at UT-Houston Recovery Campus.

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"Jefferson Comprehensive Care System"
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PARTNERS

Arkansas Department of Health, Center for Outcomes Research and Effectiveness (School of Medical Sciences, University of Arkansas)

TARGET POPULATION

Primarily medically underserved African-Americans living in poverty in an eight-county services area in Arkansas

DESCRIPTION

Impoverished African-Americans with HIV have been traditionally underserved in the region. The *Jefferson Comprehensive Care System* established a "blended" system of care for the target population at a new health facility. This helps ensure delivery of a full complement of defined services, eliminates unnecessary duplication of services, and provides clients with one indistinguishable system in which their ambulatory health care needs can be met with "one-stop shopping." The project enhances case management and psychosocial support. Its primary aim is to improve clinical outcomes by strengthening resiliency factors of people living with HIV; reducing access barriers to necessary medical and supportive care services; and reducing risk factors for the spread of HIV.

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PARTNERS

Family Service Agency, Immune Enhancement Project, AIDS Benefits Counselors, Tenderloin AIDS Resource Center, Visiting Nurses and Hospice, Tom Waddell Health Center

TARGET POPULATION

Homeless adults living with HIV/AIDS who have a history of chronic substance abuse and/or mental illness

DESCRIPTION

The Bridge Project provides transitional rental assistance and comprehensive services to its target population who are without stable income or receive General Assistance. The project is a collaboration of seven service agencies and four residential hotels in the Tenderloin neighborhood of San Francisco. It is intended to serve people who have a long history of instability, and who have either been unable to access, or are alienated by existing service systems. By combining stable shelter with intensive support services, the program mitigates the stresses associated with chronic illness, addiction, isolation, and poverty. It offers chronically homeless individuals an opportunity to improve their health and well-being, while addressing issues which have contributed to their housing instability. Incorporating a philosophy of harm reduction, the program strives to eliminate barriers which often prevent the client population from utilizing services. A multi-disciplinary team is available on-site at the hotels to provide a range of services. These include primary medical care, home nursing services, mental health services, substance abuse counseling, case management, benefits advocacy, acupuncture, massage, and health education. Rental assistance is provided for up to 12 months through HOPWA. While in the program, clients are assisted in obtaining stable income and permanent housing.

The Miriam Hospital

"Project Bridge"

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PARTNERS

SSTAR, Adult Correction Institute, Sunrise House, Marathon House

TARGET POPULATION

HIV-positive inmates who are being released from prison, & HIV-positive clients exiting drug detoxification programs

DESCRIPTION

Inmates with HIV being released from prison and HIV clients exiting drug detoxification programs are typically under- or unserved populations. For example, inmates being released from prison are referred for primary care, but are not followed past the first appointment. They quickly become lost to medical follow-up care. To promote utilization of primary care for treatment of HIV disease, intensive case management, and outreach to the target population is provided through *Project Bridge*. It employs the use of skilled social work staff and outreach workers to provide follow-up services for HIV-positive inmates as they exit from prison and drug detoxification programs. Assessment information is entered into a client database, and the clients are followed for 18 months post discharge. Services provided to them include primary care, intensive case management, psychosocial support, and community outreach.

Montefiore Medical Center

"Culturally Competent Integrated HIV/AIDS Care for Persons of Color in the Inner City"

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PARTNER

Comprehensive Family Care Center, Pelham

TARGET POPULATION

Ethnic and language minorities, including Latinos who may be illiterate in or unable to speak English, and African-Americans

DESCRIPTION

At the end of 1995, 52 percent of the adult/adolescent AIDS cases in the country were persons of color. Of the pediatric AIDS cases, 82 percent were children of color. Persons of color face shrinking resources and healthcare systems that often fail to respond to their cultural needs. The *Culturally Competent Care Project* offers a comprehensive program with an integrated healthcare team approach. Specific emphasis is placed on culturally competent care, and non-stigmatizing, culturally appropriate psychosocial and mental health services. The healthcare team, which receives continuous in-service training on cultural competence, addresses systemic barriers in the form of provider knowledge and attitudes; holistic, rather than compartmentalized care; and one-stop shopping, rather than off-site referrals. The services include such non-traditional activities as patient self-care training, workshops on parent training and primary prevention, family field trips, and psychotherapy and psychiatric care which address patients' individual and cultural barriers.

National Native American AIDS Prevention Center
"Native Care: HIV/AIDS Integrated Service Network"
134 Lindan St
Oakland, California 94607

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PARTNERS

Eight regional case management sites: Phoenix, O'ahu and Maui Counties, Oklahoma City/Tulsa, Navajo Nation, Minneapolis, Robeson County (NC), Kansas City, New York City

TARGET POPULATION

American Indians, Alaska Natives, Native Hawaiians

DESCRIPTION

Native Care responds to the increasing crisis of the spread of HIV among Native American populations. It is a unique program, unmatched anywhere in the country. Its goals are twofold: client welfare and capacity building. Native Care offers a comprehensive, integrated service delivery program that expands on a successful, free-standing, culturally responsive, and adaptable case management model. The expansion incorporates input from clients, case managers, and providers. Through this collaborative project, clients are given coordinated access to provider services which include medical, mental health, nursing care, social, essentials of life, substance abuse, and traditional healing services. A national network office makes available administrative oversight, training, technical assistance, information exchange and dissemination, and program design and evaluation services. All participating sites have established collaborative agreements with service agencies in their local regions. Innovative features of Native Care include the development of new types of linkages--for clinical training, correctional institutions, and substance abuse treatment--with significant potential for replication in virtually any other location.

The Navajo Nation
"Navajo Integrated HIV/AIDS Service Delivery Model"
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PARTNERS

Navajo Division of Health, The Navajo HIV/AIDS CBO Network, Navajo Housing Authority, NNAAPC, ICHS, NAN, States of Arizona and New Mexico, HIV Coordinating Council of New Mexico, Navajo Area IHS, Native Resource Development, DHHS/PHS/IHS/GIMC

TARGET POPULATION

Navajo people with HIV, including specific high-risk, sub-populations such as MSM, youth, IVDUs, and substance abusing persons and their sexual partners

DESCRIPTION

Lack of a tribally coordinated and consistent HIV/AIDS care, treatment, and support services network on the Navajo Nation results in fragmented services. A comprehensive Navajo Nation-specific, HIV-disease needs assessment has never been implemented. Also, HIV service development is compounded by significant under reporting and diagnosis. The *Navajo Integrated Service* is a multi-dimensional and multi-sectoral project that integrates existing scientific and professional disciplines with community-based service providers and traditional practitioners. It incorporates HIV services into existing programs currently provided by the Indian Health Service, the Bureau of Indian Affairs, Navajo Nation community-based providers, and native traditional practitioners. It identifies and prioritizes service gaps and needs. A clinical specialist oversees the planning effort for development of an HIV care and treatment protocol and the institution of a formal patient treatment data base.

New Jersey Medical School
"DAYAM Adolescent HIV Project"
Division of Adolescent and Young Adult Medicine
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Newark, New Jersey 07103-2714

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PARTNERS

University Hospital, Blatner Associates, Inc., Newark
Board of Education, International Youth Organization

TARGET POPULATION

High-risk and HIV-infected adolescents

DESCRIPTION

One-quarter of all new HIV infections in the country currently occur among people between the ages of 13 and 21. To overcome barriers to early diagnosis and treatment of HIV-infected adolescents, *DAYAM* provides a three-step approach. *POWER* (Peer Outreach Workers Educating Risk-takers) uses high-risk teen peers for outreach to teens on the streets with messages that increase awareness of HIV risk behaviors and acceptance of HIV testing. This effort is linked with the availability of an immediate on-the-street HIV test. *STOP* (Spend Time On Prevention) is a mobile HIV testing van that works in conjunction with *POWER* to make testing more accessible to high-risk teens. In combination with tracking and case management, it ensures the return for post-test counseling and linkage to HIV treatment. *START* (Screening Treatment and Risk Reduction for Teens) provides adolescent-specific treatment and medical monitoring for HIV-infected teens. Services include routine periodic physical examinations, testing, and general and specific medical care. It also provides a full range of case management, crisis intervention, mental health services, substance abuse treatment, and social services to HIV-infected teens and their families.

Northeast Valley Health Corporation
"HIV Cybermall"
8215 Van Nuys Blvd., Ste. 306
Panorama City, California 91402

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PARTNERS

AIDS Healthcare Foundation, Being Alive, Beinestar-Valley, Cri-Help, Inc., El Proyecto del Barrio, Hands United Together, High Desert Hospital, Home Pharmacy, Homestead Hospice, Hospital Home Health Care, North Hollywood Medical, Tarzana Treatment Center, Valley Community Clinic, Valley HIV Center

TARGET POPULATION

Homeless and immigrant populations, and ethnic and language minorities

DESCRIPTION

The *HIV Cybermall* is a computer network designed to link 18 partner agencies in order to enhance client access to HIV-related social services. The partner agencies provide a variety of HIV-related medical and social services throughout the San Fernando Valley (northern Los Angeles County). The Valley is a large geographic area, and no one agency provides a full range of services. The *HIV Cybermall* is client service-driven, and access to all data is controlled by client-held passwords. The *HIV Cybermall* will allow any partner agency to act as an entry point (or "storefront") for a client; data are entered by the agency worker into a common template, and referrals and appointments are made electronically for necessary services at other agencies.

United Bronx Parents (UBP), Inc.
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PARTNERS

New York State Department of Social Services/Homeless Housing Assistance Program, New York City Department of Housing Preservation and Development, New York City Human Resources Administration/Division of AIDS Services

TARGET POPULATION

Homeless adult men and women living with HIV or AIDS who have active alcohol and other drug problems

DESCRIPTION

The project is a low-threshold, recovery readiness program which combines both emergency shelter with transitional supportive housing and a broad range of substance abuse and other services. Twelve emergency beds will be available for up to 60 days for new participants, including those entering or recently discharged from inpatient detoxification services and/or awaiting residential treatment placements. Thirty transitional beds will accommodate participants for up to 5 months who can benefit from ongoing low threshold/recovery readiness counseling with possible transition to UBP's licensed medically supervised day treatment program, other outpatient substance abuse treatment services or harm reduction/recovery readiness programs. Other services include HIV education and risk reduction counseling, independent living skills training, permanent housing placement and an intensive case management team which will facilitate comprehensive service planning and coordination and access to community-based primary care, mental health services, social services, and HIV supportive services. The project's goals are to increase access to and retention in comprehensive services, assist participants in resolution of their homeless situation, and provide a safe haven and supportive environment where participants learn about and take the next step in dealing with their substance use.

University of Miami
"Teen Outreach Project-UM (TOP-UM)"
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Division of Adolescent Medicine, School of Medicine
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PARTNERS

University of Miami Adolescent Outreach Project, Comprehensive AIDS Program, AIDS Clinical Trial Groups, Pediatric Demo Project Ryan White Title IV, South Florida AIDS Network, Adolescent Med HIV/AIDS Research Network, Health Crisis Network

TARGET POPULATION

Youths 13-18 years old in Dade County, FL, at high risk for HIV infection and other sexually-transmitted diseases

DESCRIPTION

TOP-UM addresses HIV infection and STDs in a vulnerable youth population. It encourages and provides the means for adolescents 13-18 years of age with HIV infection to be identified and entered into a comprehensive primary and specialty care program. Trained adolescent specialists staff a mobile testing van for outreach to youth in community venues where adolescents congregate. In the van, adolescents are confidentially screened for HIV infection, sexually-transmitted diseases, and mental health coping difficulties. Standard prevention materials and counseling are available to clients. Eligible youth are offered free STD treatments and hepatitis-B vaccination. Those newly identified or previously known to be HIV infected, but are not in care and treatment, are entered into care at the UM Adolescent Medicine HIV/AIDS Program. Free pregnancy testing, PAP smears, and access to free oral contraceptives and intramuscular medroxy-progesterone are available for females who desire family planning aid. Follow-up mental health services are also available.

University of Miami

"Whole Life: A Service Integration Model for HIV-Infected Women and Families"

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PARTNERS

Jackson Memorial Hospital (Prenatal Special Immunology, Special Gynecology Immunology), Pediatric Special Immunology Clinic, Florida AIDS Education Training Center (Department of Family Medicine), Center for Family Studies (Department of Psychiatry), Biopsychosocial Learning Center on AIDS (Department of Psychiatry)

TARGET POPULATION

HIV-infected women and children

DESCRIPTION

Whole Life offers a woman-centered, family-focused, and culturally-competent, one-stop model program for HIV-infected women and children that integrates primary care, obstetrical and gynecological care, mental health and substance abuse treatment services, protective intervention from violence and abuse, and a range of supportive case management and social services. It enhances the ability of primary care providers to detect and/or manage mental health problems and to facilitate patients'/families' adherence to treatment plans. Mental health services are integrated with HIV primary care services. It increases access to, utilization of, and satisfaction with available mental health services by HIV-infected women and their families. The project enhances mental health functioning of women, children, and families who receive HIV primary care services.

University of Texas

"La Frontera: HIV and the Border/Migrant Families of South Texas"

Health Science Center at San Antonio
Division of Community Pediatrics
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San Antonio, Texas 78284-7818

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PARTNERS

South Texas AIDS Center for Children and Their Families, National Center for Farmworkers Health, Inc., Midwest Migrant Health Information Office, Valley AIDS Council, United Medical Centers of Maverick Cty., Migrant Network

TARGET POPULATION

Migrant and seasonal farmworker families residing along the US-Texas-Mexico border

DESCRIPTION

Texas is home to the second largest population of migrant and seasonal farmworkers (MSFW) in the country, a population among the most impoverished and medically underserved. The goals of *La Frontera* are reduction of HIV disease through education, an increase in the number of MSFW who are aware of their HIV status, and improved access to care and quality of life for those who are HIV-infected. The project is developing a coordinated delivery system of HIV care and services for the target population during migration and at their destination site. HIV-risk factors and related demographic characteristics of the predominately Mexican-American families in the target group are being compiled. Early identification of HIV is facilitated through confidential testing of persons living in colonias (rural slums). HIV services for MSFW families focus on culturally appropriate education, counseling, testing, and HIV prevention and treatment.

University of Washington

"Tri-County Collaboration: HIV/AIDS, Mental Health, Substance Abuse and Corrections"

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PARTNERS

Seattle-King County Community AIDS Service Unit,
AIDS Housing of Washington, Downtown Emergency
Service, Harborview Medical Center (Madison Clinic),
King County Mental Health Division, Snohomish
Health District (Community Health Division),
Snohomish County Human Services, Department of
Corrections (Snohomish County), Island County Health
Department (Human Services), Island County Jail,
Seattle-King County Department of Public Health (Jail
Health Services)

TARGET POPULATION

Persons with HIV/AIDS and chronic mental illness,
chemical dependency, and/or records of incarceration

DESCRIPTION

Persons with HIV/AIDS and histories of chronic mental illness, chemical dependency, and/or incarceration traditionally receive services from a fragmented care delivery system. The *Tri-County Collaboration* seeks to improve integration of health care delivery to persons with multiple issues. It also seeks to improve collaboration among service providers by facilitating linkages and cross-training between individual care providers; addressing agency and system policy issues which create barriers to service integration; and establishing a team of experts who disseminate information to care providers for the target population and family members. HIV/AIDS patient care is mainstreamed into existing service systems. An information/referral telephone line, an e-mail/on-line service, and a bi-monthly newsletter supplement project efforts.

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University of Washington-AIDS Education and Training Center	18

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Cook County Children's Hospital	7
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INNOVATIVE SERVICE DELIVERY COMPONENTS OF PARTNERSHIP STEERING COMMITTEE GRANT PROJECTS

Capitated Payment Plan

Duke University Medical Center (Medicaid financed)	8
East Boston Neighborhood Health Center (managed care techniques for case management and interagency contracts)	8

Case Mapping

Duke University Medical Center (for clinical and ambulatory care service elements and network)	8
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The Asian and Pacific Islander Coalition on HIV/AIDS, Inc. (utilizing bilingual peer advocates to guide clients through service settings)	4
Houston Regional HIV/AIDS Resource Group, Inc. (linking clients to housing and alcohol and substance abuse services)	11
National Native American AIDS Prevention Center (providing coordinated client access to provider agencies)	14

Computer Networking

- Northeast Valley Health Corporation 15
(network linking 18 agencies with a common client data base)
- Duke University Medical Center 8
(assisting case coordinators in tracking all health and social services)
- National Native American AIDS Prevention Center . 14
(maintains a national data base)

Cultural and Language Appropriate Services, Training and Curriculum Development

- American Indian Health and Services 4
(training providers in culturally appropriate care)
- The Asian and Pacific Islander Coalition on HIV/AIDS, Inc. 4
(provider training and bilingual peer advocates)
- Chugachmiut 6
(cultural training provided when establishing linkages)
- Cook County Children's Hospital 7
(access clients through community service agencies and provide culturally appropriate training)
- Montefiore Medical Center 13
(cultural competence training for multi-disciplinary teams)
- National Native American AIDS Prevention Center . 14
(culturally responsive case management)
- The Navajo Nation 14
(combines community based services providers and traditional healers)
- University of Miami-School of Medicine 16
(women and family centered, culturally competent services)
- University of Texas-Health Sciences Center at San Antonio 17
(community lay health workers provide education to clients)
- University of Washington-AIDS Education and Training Center 18
(overcomes agency and system barriers to care)

Distance Linkages

- Chugachmiut 6
(out-of-village and village-based providers work together)
- The Fortune Society 9
(through discharge planning upstate prisoners are linked to New York City services)
- National Native American AIDS Prevention Center . 14
(links eight regional sites, including Hawaii and New York City)
- The Navajo Nation 14
(service linkages across three states)

- University of Texas-Health Sciences Center at San Antonio 17
(developing a continuum of care for migrant workers from Texas to Michigan)
- University of Washington-AIDS Education and Training Center 18
(service linkages across three counties)

Vocational Services and Job Training

- Baltimore City Office of Homeless Services 5
(job training and placement through a community resource center)
- Harbor-UCLA Research and Educational Institute ... 9
(life skills, job seeking, job skills, and job placement)

Mainstreaming Strategies

- University of Texas-Health Sciences Center at San Antonio 17
(linking population specific services with the health care system)
- University of Washington-AIDS Education and Training Center 18
(patient care mainstreamed into existing service system)

Mental Health Services

- Bernal Heights Housing Corporation 5
(counseling and support for homeless families)
- Catholic Community Services 6
(services for the severely mentally ill)
- University of Miami-Dept. Of Psychiatry and Behavioral Science 17
(integrates mental health services into existing HIV clinics)

Case Management/Case Coordination

- American Indian Health and Services 4
(coordinates and ensures access to all health services)
- Baltimore City Office of Homeless Services 5
(coordinates the services of eleven agencies)
- Chugachmiut 6
(comprehensive intake into a highly collaborative service network)
- Duke University Medical Center 8
(case coordinators track care and facilitate service access)
- East Boston Neighborhood Health Center 8
(co-location of social worker trained in dual diagnosis)
- The Fortune Society 9
(discharge planning and case management for ex-offender and family)
- Harbor-UCLA Research and Education Institute 9
(nurse case manager facilitates service delivery)
- Health Care for the Homeless, Inc. 10
(clients are tracked through a continuum of care)

Jefferson Comprehensive Care System, Inc.	12
(enhanced case management in a blended care setting)	
Lutheran Social Services of Northern California ...	12
(care management by a multi-disciplinary team)	
The Miriam Hospital	13
(combines case management and outreach services)	
National Native American AIDS Prevention Center .	14
(free-standing, culturally responsive and adaptable case management model)	
University of Miami-Dept. Of Psychiatry and Behavioral Science	17
(one stop service model using case management)	

Cook County Children's Hospital	7
(youth directed organization of peer outreach workers)	
New Jersey Medical School-Division of Adolescent and Young Adult Medicine	15
(high risk teen peer outreach workers)	
University of Miami School of Medicine	16
(outreach to youth in community venues)	
University of Texas-Health Sciences Center at San Antonio	17
(outreach to migrant and seasonal laborers and their families)	

Outreach Teams - Peer/Bilingual Advocates

The Asian and Pacific Islander Coalition on HIV/AIDS, Inc.	4
(bilingual peer advocates)	
Catholic Community Services	6
(trained peers guide clients through service system)	
Chugachmiut	6
(village based health care workers provide services)	
Cook County Children's Hospital	7
(youth directed organization of peer health educators)	
New Jersey Medical School-Division of Adolescent and Young Adult Medicine	15
(peer outreach workers)	
Health Care for the Homeless, Inc.	10
(multidisciplinary outreach team)	
University of Miami-School of Medicine	16
(mobile peer case manager and outreach specialist)	
University of Texas-Health Sciences center at San Antonio	17
(trained lay health workers)	

Transitional and Long-term Housing

Baltimore City Office of Homeless Services	5
(twelve beds for the medically fragile)	
Bernal Heights Housing Corporation	5
(four units of permanent, supportive housing)	
Catholic Community Services	6
(supportive and permanent housing facilities)	
Housing Authority of Santa Cruz County	11
(motel vouchers, rental assistance and moving expense funds)	
Houston Regional HIV/AIDS Resource Group, Inc. .	11
(short-term crisis housing and housing coordination)	
Lutheran Social Services of Northern California. ...	12
(rental assistance and SRO accommodation)	
United Bronx Parents, Inc.	16
(transitional housing with on-site clinic)	

Youth and Family Outreach

Bernal Heights Housing Corporation	5
(long-term planning for child placement)	

Summer 97

INNOVATIONS

Issues in HIV Service Delivery

*Public Service
Campaigns*

*The Success of
Skills Building*

*American Indian
Health Videos*

*Psychiatric
Homecare*

*Using Actors to
Train Providers*

*The Fate of the
Children*



Who Takes
Care of
Youth in
Managed
Care?

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Spring 97

INNOVATIONS

Issues in HIV Service Delivery

HIV Risk
Screening &
Testing for
Adolescents

HIV &
Homelessness

Bridges, A
Publication for
Youth Service
Providers

Unmasking
AIDS Related
Delirium

New Grants to
Support Native
American Service
Models

The AIDS
Psychiatric
Homecare
Program



in need

The Consumer's Impact
on the Worcester
Family AIDS Project

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Bureau of Health Resources Development

Health Resources and Services Administration
Rockville MD 20857

FAX TRANSMISSION COVER SHEET

DATE:

8/4/97

TO:

Sarah Hurwitz

202-456-5557

FROM:

Erica Buehrens

Division of HIV Services (DHS)

Bureau of Health Resources Development (BHRD)

Health Resources and Services Administration (HRSA)

This document consists of 6 pages, including this cover page. Should you have any problems with this transmission, please call the Division of HIV Services at: 301-443-6745. The FAX number for the Division of HIV Services is: 301-443-5271 OR 443-8143

Comments:

per your request to

Melanie Wieland

(Had copies in mail)

GB

AIDS Drug Assistance Programs
Table 3.a. Program Characteristics: State and U.S. Totals
 Source: Annual Administrative Report, Reporting Period January 1 to December 31, 1995

State	Number of Reports	Administering Agency					Medical Eligibility Criteria					Processing Period				Recertification Frequency					Waiting List	
		HIV/AIDS Unit of Health Department	Health Department (not HIV/AIDS unit)	Welfare or Income Maintenance Dep.	Other Public or Private Agency	AIDS Diagnosis	CD4 Cell Count	HIV-related Symptoms	CD4 Count and HIV-related Symptoms	Other	Less than 10 Days	10 to 30 Days	31 to 60 Days	More than 60 Days	Quarterly	Semiannual	Annual	Other	None	Missing / Unknown	Waiting List this Reporting Period?	Number on Waiting List at End of Period
Alabama	1	1					1			1							1				Yes	150
Arizona	1	1							1	1					1						No	NA
California	1	1							1	1						1					No	NA
Colorado	2				2			2		2						2					No	NA
Connecticut	1			1					1	1					1						No	NA
Delaware	2	1			1				1	1	2			1	1						Yes	122
District of Columbia	1	1							1	1					1						No	NA
Florida	1	1					1			1	1				1						No	NA
Georgia	1				1		1			1					1						No	NA
Hawaii	1	1						1		1					1						No	NA
Idaho	1		1				1			1									1		No	NA
Illinois	1	1						1		1						1					No	NA
Indiana	1				1			1		1	1			1					1		Yes	45
Iowa	6	1	1		4	1		5		5	1				1	2			3		No	NA
Kansas	1	1						1		1									1		No	NA
Kentucky	1	1						1		1					1						No	NA
Maryland	1	1						1		1					1						No	NA
Massachusetts	1				1				1	1						1					No	NA
Michigan	1	1					1			1						1					No	NA
Minnesota	1			1					1	1						1					No	NA
Mississippi	1	1					1			1						1					No	NA
Missouri	3	3				1			2		3					2	1				No	NA
Montana	1	1							1	1									1		No	NA
Nebraska	1				1			1		1					1						No	NA
Nevada	1	1							1		1					1					No	NA
New Hampshire	1	1							1	1						1					No	NA
New Jersey	1	1							1	1						1					No	NA
New York	1	1							1	1									1		No	NA
North Dakota	1	1						1		1									1		No	NA
Ohio	1	1							1	1				1							No	NA
Oklahoma	1		1				1			1						1					Yes	
Puerto Rico	3	1	1		1			1	1	2			1		1				2		Yes	
Rhode Island	1	1						1		1									1		No	NA
South Carolina	1	1						1		1									1		Yes	250
South Dakota	1		1						1	1									1		No	NA
Tennessee	1	1						1		1						1					No	NA
Texas	1	1							1	1										1	No	NA
Utah	1	1						1		1									1		No	NA
Virginia	1	1						1		1						1					No	NA
Washington State	1	1						1		1					1						No	NA
West Virginia	1	1							1		1								1		No	NA
Wisconsin	1	1								1									1		No	NA
Total	53	34	5	2	12	2	8	18	9	42	10	0	1	3	13	18	4	0	15		567	
Of Total	100%	64%	9%	4%	23%	4%	15%	34%	17%	79%	19%	0%	2%	6%	25%	34%	8%	0%	28%	14%		

AIDS Drug Assistance Programs

Table 3.b. Annual Funding and Expenditures: State and U.S. Totals

Source: Annual Administrative Report, Reporting Period January 1 to December 31, 1995

State	Annual Program Funding by Source								Percent of Total Funds from CARE Act Titles I and II	Percent of Program Funds from CARE Act Titles I and II			
	Annual Program Expenditures	Title I CARE Act	Title II CARE Act	Title III CARE Act	Other Federal (incl. Medicaid)	State or Local Public (not Medicaid)	Other Sources	Total		At Least 80%	25% to 49%	10% to 24%	Less Than 10%
Alabama	\$ 870,369	\$ -	\$ 820,369	\$ -	\$ -	\$ 50,000	\$ -	\$ 870,369	84%	x			
Arizona	\$ 609,578	\$ -	\$ 609,578	\$ -	\$ -	\$ -	\$ -	\$ 609,578	100%	x			
California	\$ 22,702,057	\$ -	\$ 9,804,408	\$ -	\$ -	\$ 12,070,230	\$ -	\$ 21,874,638	45%	x	x		
Colorado	\$ 569,740	\$ 226,873	\$ 109,539	\$ -	\$ -	\$ 219,409	\$ -	\$ 555,821	61%	x			
Connecticut	\$ 1,067,462	\$ 209,500	\$ 446,323	\$ -	\$ -	\$ 411,639	\$ 187,531	\$ 1,254,993	52%	x			
Delaware	\$ 105,000	\$ -	\$ 105,000	\$ -	\$ -	\$ -	\$ -	\$ 105,000	100%	x			
District of Columbia	\$ 526,530	\$ 74,801	\$ 541,405	\$ -	\$ -	\$ -	\$ -	\$ 616,206	100%	x			
Florida	\$ 7,068,028	\$ -	\$ 7,026,028	\$ -	\$ -	\$ 42,000	\$ -	\$ 7,068,028	99%	x			
Georgia	\$ 1,108,178	\$ 365,420	\$ 1,000,000	\$ -	\$ -	\$ 315,000	\$ -	\$ 1,680,420	81%	x			
Hawaii	\$ 270,049	\$ -	\$ 146,451	\$ -	\$ -	\$ 265,000	\$ -	\$ 411,451	36%		x		
Idaho	\$ 64,344	\$ -	\$ 64,344	\$ -	\$ -	\$ -	\$ -	\$ 64,344	100%	x			
Illinois	\$ 3,562,143	\$ -	\$ 1,892,143	\$ -	\$ -	\$ 1,517,874	\$ 152,126	\$ 3,562,143	53%	x			
Indiana	\$ 682,539	\$ -	\$ 637,610	\$ -	\$ -	\$ 199,537	\$ -	\$ 837,147	76%	x			
Iowa	\$ 74,169	\$ -	\$ 63,698	\$ -	\$ -	\$ -	\$ -	\$ 63,698	100%	x			
Kansas	\$ 326,554	\$ -	\$ 326,554	\$ -	\$ -	\$ -	\$ -	\$ 326,554	100%	x			
Kentucky	\$ 483,829	\$ -	\$ 338,575	\$ -	\$ -	\$ 149,976	\$ -	\$ 488,551	69%	x			
Maryland	\$ 982,332	\$ 171,047	\$ 961,187	\$ -	\$ -	\$ -	\$ -	\$ 1,132,214	100%	x			
Massachusetts	\$ 1,284,169	\$ 328,921	\$ 955,248	\$ -	\$ -	\$ -	\$ -	\$ 1,284,169	100%	x			
Michigan	\$ 646,241	\$ 242,395	\$ 321,734	\$ -	\$ -	\$ -	\$ 58,750	\$ 622,879	61%	x			
Minnesota	\$ 172,276	\$ -	\$ 172,276	\$ -	\$ -	\$ -	\$ -	\$ 172,276	100%	x			
Mississippi	\$ 825,188	\$ -	\$ 825,188	\$ -	\$ -	\$ -	\$ -	\$ 825,188	100%	x			
Missouri	\$ 1,114,597	\$ 331,725	\$ 831,345	\$ -	\$ -	\$ -	\$ -	\$ 1,163,070	100%	x			
Montana	\$ 44,000	\$ -	\$ 44,000	\$ -	\$ -	\$ -	\$ -	\$ 44,000	100%	x			
Nebraska	\$ 100,000	\$ -	\$ 100,000	\$ -	\$ -	\$ -	\$ -	\$ 100,000	100%	x			
Nevada	\$ 594,957	\$ -	\$ 261,609	\$ -	\$ -	\$ -	\$ -	\$ 261,609	100%	x			
New Hampshire	\$ 159,490	\$ -	\$ 128,905	\$ -	\$ 30,585	\$ -	\$ -	\$ 159,490	61%	x			
New Jersey	\$ 3,095,271	\$ 516,250	\$ 2,579,021	\$ -	\$ -	\$ -	\$ -	\$ 3,095,271	100%	x			
New York	\$ 31,854,725	\$ 18,487,842	\$ 8,309,344	\$ -	\$ -	\$ 495,120	\$ 4,562,419	\$ 31,854,725	84%	x			
North Dakota	\$ 17,077	\$ -	\$ 55,000	\$ -	\$ -	\$ -	\$ -	\$ 55,000	100%	x			
Ohio	\$ 1,008,229	\$ -	\$ 1,152,434	\$ -	\$ -	\$ 200,500	\$ -	\$ 1,352,934	85%	x			
Oklahoma	\$ 713,253	\$ -	\$ 507,253	\$ -	\$ -	\$ 206,000	\$ -	\$ 713,253	71%	x			
Puerto Rico	\$ 6,218,013	\$ 2,819,058	\$ 2,781,000	\$ 80,000	\$ -	\$ 7,157,051	\$ -	\$ 12,837,109	44%		x		
Rhode Island	\$ 89,003	\$ -	\$ 89,003	\$ -	\$ -	\$ -	\$ -	\$ 89,003	100%	x			
South Carolina	\$ 533,131	\$ -	\$ 447,500	\$ -	\$ 100,000	\$ -	\$ -	\$ 547,500	82%	x			
South Dakota	\$ 70,693	\$ -	\$ 70,000	\$ -	\$ -	\$ -	\$ -	\$ 70,000	100%	x			
Tennessee	\$ 198,304	\$ -	\$ 287,500	\$ -	\$ -	\$ -	\$ -	\$ 287,500	100%	x			
Texas	\$ 5,277,652	\$ -	\$ 2,058,216	\$ -	\$ -	\$ 3,109,427	\$ -	\$ 5,167,643	40%		x		
Utah	\$ 106,002	\$ -	\$ 95,000	\$ -	\$ -	\$ 114,000	\$ -	\$ 209,000	45%		x		
Virginia	\$ 1,638,008	\$ -	\$ 626,466	\$ -	\$ -	\$ 687,200	\$ -	\$ 1,313,666	46%		x		
Washington State	\$ 540,751	\$ 58,654	\$ 216,019	\$ -	\$ -	\$ 268,078	\$ -	\$ 540,751	51%	x			
West Virginia	\$ 50,286	\$ -	\$ 77,947	\$ -	\$ -	\$ -	\$ -	\$ 77,947	100%	x			
Wisconsin	\$ 232,800	\$ -	\$ 31,301	\$ -	\$ -	\$ 433,600	\$ -	\$ 464,901	7%				x
U.S. Total	\$ 97,857,029	\$ 23,832,486	\$ 47,916,501	\$ 80,000	\$ 130,585	\$ 27,909,641	\$ 4,960,828	\$ 104,830,039	68.4%	35	8	0	1
% of Total		22.7%	45.7%	0.1%	0%	26.6%	4.7%	100%	68.4%	83%	14%	0%	2%

Number of States = 42

AIDS Drug Assistance Programs

Table 3.c. Clients Served (Unduplicated): State and U.S. Totals

Source: Annual Administrative Report, Reporting Period January 1 to December 31, 1996

State	Reporting Period, Months	Clients Served		Gender			Race/Ethnicity						Age			
		Total Clients	New Clients	Male	Female	Missing / Unknown	White	Black	Hispanic	Asian / Pacific Isl.	American Indian	Missing / Unknown	Under 19 Years	19-19 Years	Age 20 and Over	Missing / Unknown
Alabama	12	1,060	290	890	170	#	490	560	#	#	#	10	#	10	1,060	#
Arizona	12	640	410	580	60	#	460	40	130	#	#	#	#	#	630	#
California	12	13,380	6,410	12,190	1,150	50	6,350	2,210	3,970	240	80	630	10	30	13,220	120
Colorado	12	710	370	640	60	#	450	80	120	#	#	60	#	#	710	#
Connecticut	12	1,450	880	1,100	350	#	470	490	350	#	10	120	10	#	1,430	#
Delaware	12	110	40	80	30	#	60	50	10	#	#	#	#	#	110	#
District of Columbia	12	390	390	300	90	#	70	270	40	#	#	#	#	#	390	#
Florida	12	9,060	4,090	6,720	2,300	40	3,030	4,340	1,480	20	20	170	80	100	8,880	#
Georgia	12	1,280	530	1,010	270	#	400	660	20	#	#	#	#	10	1,270	#
Hawaii	12	140	50	130	10	#	80	#	10	40	#	#	#	#	140	#
Idaho	12	60	10	50	10	#	50	#	10	#	#	#	#	#	60	#
Illinois	12	2,050	1,450	1,680	180	#	1,020	610	290	60	60	#	#	#	2,040	#
Indiana	12	470	160	420	40	#	380	70	10	#	#	#	#	#	410	60
Iowa	12	140	70	120	20	#	110	10	#	#	#	#	#	#	130	#
Kansas	12	220	30	190	30	#	180	30	10	#	#	10	#	#	220	#
Kentucky	12	330	190	290	40	#	200	80	10	#	#	40	#	#	300	30
Maryland	12	420	170	330	100	#	150	230	30	#	#	10	#	#	420	#
Massachusetts	12	1,020	660	860	160	#	400	100	220	#	10	290	10	#	1,010	#
Michigan	12	320	130	280	30	#	190	110	20	#	#	#	#	#	320	#
Minnesota	12	450	0	410	30	#	370	40	20	#	10	10	#	#	450	#
Mississippi	12	840	290	650	180	#	330	500	#	#	#	#	10	#	820	#
Missouri	12	1,420	660	1,270	150	#	950	400	20	#	#	50	10	10	1,400	#
Montana	12	30	10	20	#	#	20	#	#	#	#	10	#	#	30	#
Nebraska	12	180	90	160	20	#	130	40	10	#	#	#	#	#	170	#
Nevada	12	260	80	230	40	#	180	30	40	#	#	#	#	#	250	#
New Hampshire	12	110	50	90	10	#	50	#	#	#	#	40	#	#	110	#
New Jersey	12	2,300	950	1,600	700	#	850	850	530	#	#	70	40	10	2,240	#
New York	12	17,140	5,280	13,130	3,410	600	5,950	5,810	5,390	160	40	#	150	70	16,920	#
North Dakota	12	20	10	10	#	#	10	#	#	#	#	#	#	#	20	#
Ohio	12	590	210	520	70	#	430	120	20	#	10	20	#	#	580	#
Oklahoma	12	450	130	380	70	#	360	60	20	#	20	#	#	#	450	#
Puerto Rico	12	5,550	2,530	3,520	1,400	630	#	#	4,960	#	#	690	40	40	4,880	590
Rhode Island	12	130	50	110	20	#	70	10	20	#	#	30	#	#	130	#
South Carolina	12	480	250	350	140	#	130	330	10	#	#	10	10	#	460	#
South Dakota	12	40	20	30	#	#	30	#	#	#	#	#	#	#	40	#
Tennessee	12	180	110	150	30	#	100	80	#	#	#	#	#	#	180	#
Texas	12	4,710	1,500	4,030	680	#	2,380	1,150	1,030	10	10	120	20	10	4,680	#
Utah	12	120	60	110	10	#	100	#	10	#	#	#	#	#	120	#
Virginia	12	850	490	660	160	30	290	470	30	#	#	60	10	#	840	#
Washington State	12	720	290	660	60	#	650	50	80	10	20	10	#	#	720	#
West Virginia	12	60	20	60	#	#	60	10	#	#	#	#	#	#	60	#
Wisconsin	12	270	90	250	20	#	190	60	20	#	#	#	#	#	270	#
U.S. Total		70,090	29,490	56,440	12,290	1,360	28,060	19,950	18,940	580	320	2,250	440	320	68,530	810
% of Total		100%	42.1%	80.5%	17.5%	1.9%	40.0%	28.5%	27.0%	0.8%	0.5%	3.2%	0.6%	0.5%	97.8%	1.2%

Number of States = 42

Counts are rounded to nearest 10 (to 10 if between 1 and 14), except that # replaces demographical values less than 6. U.S. totals are calculated on unrounded data.

HEALTH RESOURCES AND SERVICES ADMINISTRATION



FACT SHEET

BUREAU OF HEALTH RESOURCES DEVELOPMENT

JULY, 1997

The Ryan White CARE Act AIDS Drug Assistance Programs

The Health Resources and Services Administration (HRSA), an agency of the Department of Health and Human Services, administers the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act. Enacted in 1990 and reauthorized in May 1996, the CARE Act is the largest source of Federal funding specifically directed to provide primary care and support services for persons living with HIV disease.

Under Title II of the CARE Act, formula grants are awarded to the States and other eligible areas to improve the quality, availability, and organization of HIV health care and support services. In addition to other specific service programs, Title II funds AIDS Drug Assistance Programs (ADAPs). ADAPs provide medications to low-income individuals with HIV disease, who have limited or no coverage from private insurance or Medicaid; in all 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, and Guam.

In 1996, ADAPs served almost 83,000 persons with HIV disease who had limited or no coverage from private insurance or Medicaid. At any one time, ADAPs were serving about 40,000 individuals.

Title II requires that: *"A State shall use a portion of the amounts provided to establish a program... to provide therapeutics to treat HIV disease or prevent serious deterioration of health arising from HIV disease in eligible individuals, including measures for the prevention and treatment of opportunistic infections."*

ADAPs have served clients since 1987 (see box), but recent treatment advances have focused increasing attention on the program. The newest class of HIV drugs, protease inhibitors (PIs), have proven to be very effective when used in combination with two or three other medications. As a result, demand for the promising new combination therapy has grown rapidly—not only among individuals already in care but also among those who had not previously sought treatment. Because the cost of combination therapy with PIs is very high—between \$10,000 and \$12,000 a year per person—ADAPs are

greatly challenged in responding to the increased client demand.

Even before the expensive new drugs became available, many ADAPs were experiencing strains. The rapid growth of the HIV epidemic among poor and historically underserved populations, and evolving treatment standards which involve more than one antiviral drug, contributed to these strains. In addition, the number of people seeking and receiving treatment for HIV and AIDS continues to increase on a monthly basis.

ADAP funding has increased dramatically in recent years. In fiscal year (FY) 1996, \$52 million in Title II CARE Act supplemental funds was appropriated specifically for ADAPs. This was in addition to the \$53 million that States had already committed from their base Title II awards. In FY 1997, \$167 million was earmarked for ADAPs. Fiscal year 1998 appropriations have not yet been finalized.

State Roles In Managing ADAPs

States have the authority to establish income and medical eligibility criteria and to determine how drugs will be purchased and distributed to clients. States also determine which drugs to include on their formularies. States covering 25 or more drugs.

The ADAP began 10 years ago. In March 1987, zidovudine—better known as AZT—became the first drug approved by the Food and Drug Administration (FDA) to treat HIV disease. However, the annual cost of AZT per person, about \$10,000, placed it out of reach for many people. Congress responded (a month later) in April 1987, by approving \$30 million in funding under a public health emergency provision, and later enacted Public Law 100-71 authorizing the establishment of an ADAP program nationwide.

As HIV treatment advances occurred and as resources permitted, States expanded the program to cover drugs in addition to AZT. In 1990, when ADAP became part of the newly enacted CARE Act, States had the option to cover any FDA-approved drug that could prolong life or prevent deterioration of health.



Covered Drugs

As the number of FDA-approved HIV treatments has increased, States added some or all of the newer drugs within the limits of available resources. The availability of new, effective drugs, combined with the greatly increased cost of new medications, has affected the expansion of formularies. Today, there is considerable variation in the number of drugs on ADAP formularies, ranging from 5 to more than 100, with one-half of the States covering 25 or more drugs.

Purchase and Distribution of Pharmaceuticals

Most ADAPs were established to operate under a pharmacy reimbursement model similar to Medicaid. This allows patients to go to a participating pharmacy, show their ADAP cards and have their prescriptions filled. The pharmacy then bills ADAP.

A few States with a system of pharmacies attached to a network of public health clinics have opted to use that system to purchase and distribute drugs for ADAP clients. Only a few ADAPs directly purchase drugs and mail them to clients.

Cost-Containment Measures

With the significant growth in clients seeking treatment, dramatic increases in the cost of new treatments, and rapidly changing standards of care, ADAPs are challenged to contain costs at the same time they are asked to expand access. As a result, ADAPs have taken a number of steps to stretch dollars. These include changing the system used to purchase/distribute drugs; seeking larger price discounts (e.g., by participating in the Office of Drug Pricing Program administered by HRSA, or negotiating voluntary manufacturers' rebates); tightening income eligibility criteria; deleting some drugs from State formularies; setting caps on ADAP benefits; and/or establishing guidelines for prescribing drugs.

Income Eligibility

Because Title II gives States the authority to set income and medical eligibility criteria for ADAPs, there is wide variation among States. The table below summarizes income eligibility criteria.

The variation in eligibility generally reflects the type and availability of other health care resources for low-

Criteria as Percent of Federal Poverty Level (FPL)	Number of States/Grantees
100% or below FPL	1 ADAP
100 to 200% FPL	20 ADAPs
200 to 300% FPL	18 ADAPs
Over 300% FPL	10 ADAPs
Three States use some other criteria not related to Federal Poverty Level.	

1997 Federal Poverty Level is \$7,890/year per individual.

income individuals with HIV disease. It must be noted that even in States with more generous income eligibility standards, the overwhelming majority of enrolled individuals have incomes below 200 percent of FPL.

Medical Eligibility

All States require individuals who meet income threshold criteria simply to provide proof of their HIV status. Fourteen States also require a laboratory test showing a CD4 count of 500 or less (indicating significant damage to the immune system). For individuals to obtain access to protease inhibitors and/or antiretrovirals, 17 States have additional specific criteria.

ADAPs In Context

A number of factors affect key State decisions regarding ADAPs. The ADAP is just one of multiple important sources of public and private funding for HIV treatment. Medicaid is by far the largest payer, providing treatment to an estimated 60 percent of persons with AIDS nationwide.

However, State Medicaid plans vary widely, in terms of eligibility and covered services. States with more restrictive Medicaid eligibility, limited prescription benefits, and/or no optional coverage for medically needy populations, place special challenges on ADAPs. Too often, however, these are also States with limited or no State contributions to the program. Those constraints are most often reflected in restrictive financial eligibility criteria and limited formularies. Other factors include the availability of affordable private insurance, insurance risk pools, and whether or not the State limits the extent to which private insurers may cap prescription benefits.

For media inquiries, contact Office of Communications, HRSA

Room 4126, Lane Room 14-11 • Rockville, MD 20857 • (301) 443 3376 • Fax (301) 443 1302

All other inquiries, contact Division of HIV Services, 2000 Francis Lane, Room 7A 55 • Rockville, MD 20857

(301) 443 6745 • Fax (301) 443 8143

Date: Wednesday, July 24, 1996
FOR IMMEDIATE RELEASE
Contact: Dorothy Bailey (301)443-3376

AIDS Drug Assistance Program

The AIDS Drug Assistance Program ("ADAP") provides medications and treatment to low income individuals with HIV disease, who are not protected by Medicaid or private health insurance prescription programs. ADAP is part of the Ryan White CARE Act, which provides emergency services to private and public nonprofit entities in areas most deeply affected by the AIDS epidemic.

Why is ADAP Needed ?

ADAP makes it possible for low income individuals with HIV disease and without other health insurance to have access to therapies they could not otherwise afford. Promising new drug therapies like protease inhibitors have significantly reduced the progression of disease in infected individuals, but these drugs are very expensive. Three of these drugs -- Ritonavir, Indinavir, and Saquinavir --are estimated to cost \$6,500, \$6,000, and \$7,200 per year, respectively.

How Many States Have ADAPs?

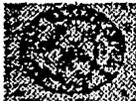
All 50 states, the District of Columbia, and Puerto Rico, have ADAP programs, although five states currently use no federal funding.

What Are The Funding Sources, And What Has The Federal Government Contributed To ADAP?

ADAP is generally funded by combined state and federal contributions. States generally are required to contribute one dollar for every two federal ADAP dollars received. The federal government contributed over \$105 million to ADAPs in 1995, an increase of \$24 million over the previous year. During the first seven months of calendar 1996, the federal government contributed \$115 million to ADAPs. For FY 1997, President Clinton has increased his ADAP budget request to \$196 million.

How Many People Are Served By ADAP?

In 1995, over 69,000 people were served by ADAP.



**Health Resources & Services Administration
Bureau of Health Professions
Division of Medicine**

National HIV/AIDS Education and Training Centers Program

5600 Fishers Lane
Parklawn Building, Room 9A-39
Rockville, MD 20857

DATE: 8/20/97

TO: Sarah Horowitz

PHONE: (202-456-5557)

FAX: ←

FROM: Bruce Martell

PHONE: (301)443-6364

FAX: (301)443-9887

Pages (including cover) 3

Message:

NATIONAL HIV/AIDS EDUCATION AND TRAINING CENTERS (AETC) PROGRAM

Background: The National AIDS Education and Training Centers (AETC) Program is a network of 15 regional centers (with more than 75 local performance sites) that conduct targeted, multidisciplinary HIV education and training programs for health care providers. The mission of these centers is to increase the number of health care providers who are effectively educated and motivated to counsel, diagnose, treat and manage individuals with HIV infection and to assist in the prevention of high risk behaviors which may lead to infection. Goals of the Program include: 1) to provide training to increase the competence and willingness of health care professionals to diagnose, treat, and manage HIV infection and to offer interventions that will prevent HIV infection; 2) to disseminate state of the art HIV information to providers; and, 3) to develop HIV provider materials.

In 1987, the program began with four AETCs that focused on educating providers about the epidemiology of HIV and how to identify groups at increased risk of infection. By 1989, in response to the growth of the epidemic, the Program increased the number of regional AETCs to fifteen to provide coverage for all fifty states, the Virgin Islands, and Puerto Rico. Clinical training of primary care providers (physicians, nurses, dentists) became a major focus, with less emphasis on training mental health and allied health providers. The majority of resources were concentrated on areas of high HIV prevalence/incidence, and the remaining resources were focused on suburban and rural needs.

Accomplishments: Demand for provider training has increased every year. To date, more than 600,000 providers have received training under the AETC Program (more than 100,000 in 1996). A 1993 study shows that AETC-trained providers are more HIV-competent and more willing to treat persons with HIV than are primary care providers in the general population. Program training and information dissemination activities are based on a comprehensive local/state/regional needs assessment process. The toll free National HRSA/AETC HIV Telephone Consultation Service (800-933-3413) is especially helpful to providers less experienced with HIV care or those practicing in rural areas. Information dissemination efforts emphasize electronic communication (e.g., AETCNET, Satellite Teleconferences) and include co-sponsoring the quarterly national HIV Clinical Conference Call Series.

Future Directions (1995-2000): The new project period began June 1, 1995, and runs until May 31, 1998. National priorities in HIV education and training include: prevention, implementation of the Public Health Service recommendations on ACTG 076, the training of providers in "Ryan White"-funded organizations, and increased emphasis on information dissemination activities related to new treatment protocols, combination drug therapies, and the use of protease inhibitors. In addition, the program will continue to emphasize the training of minority health providers and providers who serve minorities.

June 1, 1995 - May 31, 1996

Number of Participants by Racial or Ethnic Status

11530	African American
3439	Asian/Pacific Islander
42549	Caucasian (non-Hispanic)
1175	Mexican/American Hispanic
1115	Native American
3531	Puerto Rican Hispanic
1755	Other Hispanic/Latina(o)
1579	Other
6197	No response
★ 72870	Total (must be the same number as answer to Question 11)

Number of Participants by Gender

34952	Woman
34674	Man
3244	No response
72870	Total (must be the same number as answer to Question 11)

This number reflects the number of participants that completed an information form. The total number of participants was 123,303.



**U.S. Department of Housing and Urban Development
OFFICE OF HIV/AIDS HOUSING**

PAUL YANDURA
202-708-1934 x4619
202-708-1744 FAX

TO: Sarah Hurwitz

DATE: August 1, 1997

COMMENTS: HOPWA INFO

OF PAGES: 5

**U. S. Department of Housing and Urban Development
Office of HIV/AIDS Housing
451 Seventh Street SW, Room 7154
Washington, DC 20410-7000**

Correspondence Code	Originator	Concurrence	Concurrence	Concurrence	Concurrence	Concurrence
Name						
Date						

Housing Opportunities for Persons With AIDS

Community Collaborations to Provide Housing and Related Services for Persons Living with HIV or AIDS

Office of Community Planning and Development
U.S. Department of Housing and Urban Development

PROGRAM: The Housing Opportunities for Persons with AIDS (HOPWA) program provides housing assistance and supportive services for low-income persons with HIV/AIDS and their families. Grants are provided: (1) by formula allocations to States and metropolitan areas with the largest number of cases and incidence of AIDS; and (2) by selection through a national competition of projects proposed by State and local governments and nonprofit organizations. Grantees are encouraged to develop community-wide comprehensive strategies and form partnerships with area nonprofit organizations to provide housing assistance and supportive services for eligible persons.

CONSOLIDATED PLANNING: HOPWA formula grants are available as part of the area's Consolidated Plan, which also includes the Community Development Block Grant, HOME and Emergency Shelter Grants. Plans are developed through a public process that assesses area needs, creates a multiple-year strategy and proposes an action plan for use of Federal funds and other community resources in a coordinated and comprehensive manner. Ninety percent of the appropriation is allocated by formula to eligible communities.

FORMULA AWARDS: In FY 1997, a total of \$176.4 million is being allocated by formula to the qualifying cities for 53 eligible metropolitan statistical areas (EMSAs) and to 27 eligible States for areas outside of EMSAs. Eligible formula areas have at least 1,500 cumulative reported cases of AIDS, as of March 31, and metropolitan areas have a population of at least 500,000. The formula uses AIDS statistics from the Centers for Disease Control and Prevention for cumulative

cases and area incidence in allocating funds to eligible jurisdictions.

COMPETITIVE GRANTS: Ten percent of the appropriated funds are awarded by competition. During fiscal year 1997, \$19.6 million will be made available on a competitive basis pursuant to a Notice of Funds Availability (NOFA) to be issued. In 1996, the NOFA was published in the Federal Register on February 28, 1996 (61 FR 7664) and HUD selected 19 applications on August 23, 1996 for \$17.1 million in awards. A notice was published on October 23, 1996 (61 FR 55009) for:

(1) nine grants for **Special Projects of National Significance (SPNS)** which, due to their innovative nature or their potential for replication, are likely to serve as effective models in addressing the needs of eligible persons; and

(2) eight grants under the **HIV Multiple Diagnoses Initiative (MDI)** which target assistance to homeless persons living with HIV/AIDS who also have chronic alcohol and/or other drug abuse problems and/or serious mental illness. Applications for these two categories can be submitted by States, units of general local government and nonprofit organizations. In addition, awards were made for a third component:

(3) two grants in non-formula areas for **Projects which are part of Long-term Comprehensive Strategies** for providing housing and services for eligible persons; applications for this category can be submitted by States and local governments in areas that did not qualify for formula allocations during that fiscal year.

expand GRANTS
expand States

PROGRAM USES: HOPWA funds have helped communities establish strategic plans, better coordinate local and private efforts, fill gaps in local systems of care, and create model programs. HOPWA funds may be used for a wide-array of housing, social services and program planning and development costs. Eligible activities include, but not limited to, the acquisition, rehabilitation or new construction of housing units, costs for the operation and maintenance of facilities and community residences, rental assistance and short-term payments to prevent homelessness. HOPWA may also support services, such as health care and mental health services, drug and alcohol abuse treatment and counseling, intensive care when required, nutritional services, case management, assistance with daily living, housing information and placement assistance and other services. The rule at 574.300(b) provides for eligible activities, subject to certain standards and limitations.

EMSA APPLICANTS: The city that is the largest unit of general local government in an EMSA will serve as the applicant for the metropolitan area's formula allocation. The planned activities are coordinated with other local governments to provide assistance to eligible persons who reside in that area.

GOALS: As stated by the National Commission on AIDS in Housing and the HIV/AIDS Epidemic, issued in June 1992, there is "frequently desperate need for safe shelter that provides not only protection and comfort, but also a base in which and from which to receive services, care and support." Additionally, the program is authorized by statute "to provide States and localities with the resources and incentives to devise long-term comprehensive strategies for meeting the housing needs of persons with acquired immunodeficiency syndrome and families of such persons."

AUTHORIZATION: AIDS Housing Opportunity Act (42 U.S.C. 12901) as amended by the Housing and Community Development Act of 1992 (Pub. L. 102-550, approved October 28, 1992). Funds were appropriated in FY 1992 and for subsequent years. The Department's appropriation for Fiscal Year 1997 provides \$171 million under a HOPWA line item and an additional \$25 million that may become available during the year from recaptured funds.

REGULATIONS: The program is governed by the HOPWA Final Rule, 24 CFR Part 574, as amended, and the Consolidated Submissions for Community Planning and Development Programs, Final Rule, 24 CFR Part 91, as amended.

For More Information

Contact the HUD State or area Office or the Office of HIV/AIDS Housing, U.S. Department of Housing and Urban Development, 451 Seventh Street, S.W., Room 7154, Washington, D.C. 20410, or phone (202) 708-1934; TTY 1-800-877-8339, FAX: (202) 708-1744.

Information is available on HOPWA, including descriptions of the 1996 competitive grants and area consolidated plans and other related topics on the HUD HOME Page on the World Wide Web at <http://www.hud.gov/home.html>.

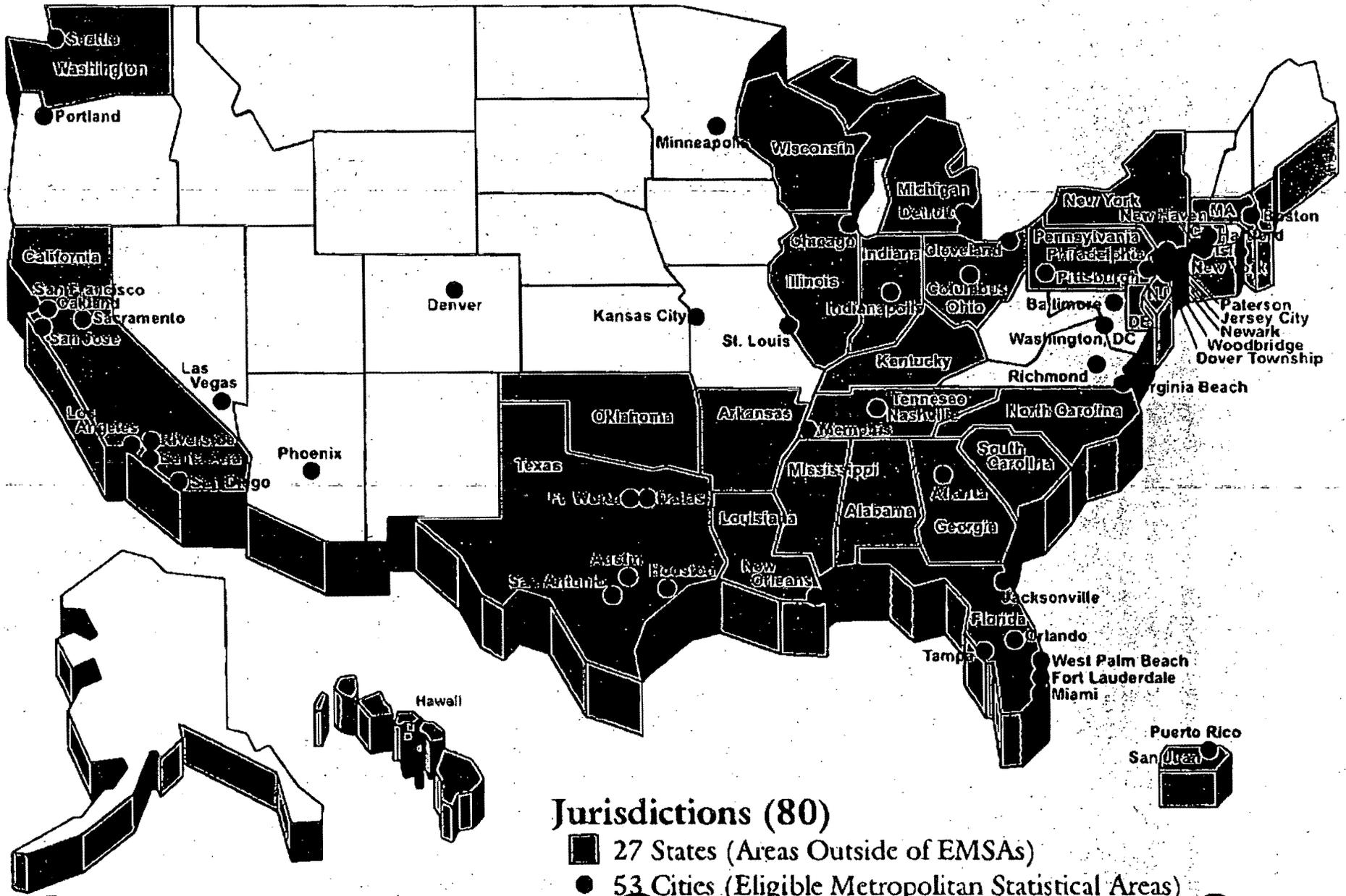
Technical assistance, information and other support is available under a National Technical Assistance Program operated by AIDS Housing of Washington and can be reached at (206) 448-5242 or by email at: HN3836@handsnet.org.

In establishing the Office of HIV/AIDS Housing, the Secretary noted:

Being homeless and living with HIV is a devastating situation. We know the importance of a stable, supportive home environment in providing treatment and other services to persons with HIV/AIDS. We understand. We care.

Henry Cisneros

HOPWA 1997 Formula Jurisdictions



Jurisdictions (80)

- 27 States (Areas Outside of EMSAs)
- 53 Cities (Eligible Metropolitan Statistical Areas)

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Office of HIV/AIDS Housing

Office of Community Planning and Development

In 1994, Department of Housing and Urban Development (HUD) Secretary, Henry Cisneros, established the Office of HIV/AIDS Housing to administer programs and advocate within HUD in order to eliminate barriers to providing housing assistance for persons living with HIV/AIDS and their families. As part of the Office of Community Planning and Development, the Office of HIV/AIDS Housing is the focal point for the Department on housing and related HUD initiatives developed to serve this population. The Office provides a coordinating link with other Federal agencies and the White House HIV/AIDS initiatives.

Specifically, the office is responsible for:

- developing responsive HIV/AIDS policies and related programs;
- maintaining interactive communications and outreach with clients, advocates, housing providers and other interested parties;
- establishing and maintaining effective liaison to other Federal offices and programs, including the National AIDS Policy Office in the White House;
- providing technical assistance to improve access to agency programs;
- managing the Housing Opportunities for Persons with AIDS (HOPWA) program and other assigned initiatives; and
- evaluating the effectiveness of current programs in addressing the housing and supportive services needs of this population.

For More Information

Contact the HUD State or area Office or the Office of HIV/AIDS Housing, U.S. Department of Housing and Urban Development, 451 Seventh Street, S.W., Room 7154, Washington, D.C. 20410, or phone (202) 708-1934; TTY 1-800-877-8339, FAX: (202) 708-1744.

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Henry Cisneros

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