Guiding Principles for Programs Serving HIV Positive Substance Users

June 2003

This project was funded by a grant from the Health Resources and Services Administration, U.S. Department of Health and Human Services, grant #4H97HA001580201. The contents herein are solely the responsibility of the authors and do not necessarily reflect the opinions of the funding agencies or the US government.

Table of Contents

Acknowledgments

This document was prepared by staff of the Health and Disability Working Group at the Boston University School of Public Health, under a Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, Special Projects of National Significance grant from the Health Resources and Services Administration. It is important to acknowledge the valuable input from and contributions of five sets of reviewers. The project's National Advisory Committee reviewed and revised the principles at three stages in their development. The following reviewers commented once: HIV primary care provider experts; Substance abuse treatment experts; Case management and outreach experts; and Consumers.

National Advisory Committee Members – Review of all principles:

Paul Bogey, PhD	Jacquelyn F. Green, PhD	Felipe Roche, MSW
Karen Brown	Warren Hewitt, MS	Geoffrey Smereck, JD
Yolanda Cantu, MPH	Robert L. Johnson, MD	Fredi Walker
Laura Gillis, MS, RN	Jeanette Lazam	Alfred White
		Steven Young, MSPH

Second Level Review by providers of HIV primary care:

John Bartlett, MD	Kathy Kochan, RNP	Jeffrey Samet, MD
Freddi Close, RN	Marla Gold, MD	Sharon Stancliff, MD
Susan Cu-Uvin, MD	Christine Lubinski, PhD	Kate Whetten-Goldstein, PhD
Lisa Hirschhorn, MD	Ellen Neuhaus, MD	

Second Level Review by substance abuse treatment providers:

Brianne Fitzgerald, RN	Robert Nye, M.Ed	Anne Rossi, RNCS
Leah Holmes, MSW	Bruce Occena, MSW	Mark Winiarski, PhD
Michael Manusi, MS		

Second Level Review by providers of care coordination or outreach services:

Omowale Amuleru-Marshall, MD	Daniel Munoz	Bernard Parks
Betty Kavanagh, LICSW	Jimmy Parham	Natasha Williams
Robert H. Hairston, LICSW	NNAAPC Native Care Network Case Managers	

Consumer Review:

William Aldridge	Nancy Hall	Johnnie Rios
Julian Dewitt Bain	Gregory Huang-Cruz	Pamela M. Sacks
Mark W. Baker	Thomas L.	Tina A. Saxton
Judy B. Barlon	Joey Lopez	Heidi Taubenfeld
Paulette C.	Darren Layman	Usungu Utshudi
Anthony Canora	Brown McDonald	Geri V.
Carolyn Carreiro	Mimi Medina	Luther Ware
Phil De	Tracy Raymond Moral	Dicxon Waldenuten
John Garotta	Simflex Nyame	Joan Warner
Pamela Goodrich	Anita Paige Bowman	John Wikiera
7 anonymous individuals		

Executive Summary

Since the beginning of the HIV/AIDS epidemic in the United States, substance use[1], particularly injection drug use, has been linked to a significant number of the cumulative and annual AIDS cases reported to the Centers for Disease Control and Prevention (CDC). Because HIV positive substance users need primary health care, substance abuse treatment, and support services, they require health care delivery strategies that are comprehensive, innovative, and coordinated. Without such strategies, the reduction in mortality and morbidity seen in other HIV-infected populations is unlikely to be duplicated (HRSA, 1999a)[2].

Despite all of the epidemiologic evidence illustrating the strong association between substance use and HIV disease, and the data indicating that substance users are less likely to access outpatient HIV care (NIDA, 1999a; Eldred and Cheever, 1998; Selwyn, 1996)[3], there has been little effort to date to link HIV medical care with substance abuse treatment. As the literature reveals, the clinical culture and approach to care in the HIV and substance abuse treatment systems are still quite different. Likewise, research has shown that existing performance standards for the delivery of care to this population typically target either HIV or substance use, rather than integrated service delivery.

HRSA has responded to this alarming trend by funding a number of projects that link medical care, substance abuse treatment, and mental health treatment in an effort to improve health outcomes for HIV positive substance users. However, in order to evaluate these programs and improve their performance, it is also important to establish guidelines for optimal standards of care that can be linked to successful outcomes. Although guidelines exist for separate components of the service delivery system, there are few commonly accepted standards that are particularly focused on the delivery of care to HIV positive substance users. With support and direction from HRSA and a National Advisory Committee, the Health and Disability Working Group (HDWG) developed these Guiding Principles to assist funders, purchasers of service and service providers in improving the delivery of services specifically to this special population.

To present this set of current and comprehensive guidelines, HDWG performed an extensive literature review, collaborated with its National Advisory Committee and other key informants, surveyed consumers throughout the country, collected locally developed standards of care from Ryan White-funded organizations, and obtained input and critiques from a number of external reviewers. Reviewers were chosen to represent consumers with HIV and the three major professional groups that work with the target population (HIV medical care providers, substance

---

[1] Throughout this document, the term "substance abuse" is used to describe the treatment setting and general reference to the issue, while the term "substance user" refers to individuals with a history of, current problem with, or who are at risk of substance addiction.

[2] Health Resources and Services Administration. (1999a). *HRSA Care ACTION*: HIV/AIDS in racial and ethnic minorities. Health Resources and Services Administration, Rockville, Maryland.

[3] National Institute on Drug Abuse. (1999a). Drug abuse and AIDS, Infofax. 24 January 2000 <http://www.nida.nih.gov/Infofax/DrugAbuse.html.

Eldred, L., & Cheever, L. (1998). Update on adherence to HIV therapy. *The Hopkins HIV Report*. 28 January 2000 <http://www.hopkins-aids.edu/publications/report/jan98_5.html.

Selwyn, P.A. (1996). The impact of HIV infection on medical services in drug abuse treatment programs. *Journal of Substance Abuse Treatment 13*(5), 397-410.

abuse treatment providers, and outreach/case management providers). The guidelines were revised several times based on input from reviewers and the advisory committee. Finally, the guidelines were reviewed for feasibility of application through a survey of fifty programs nationwide that have a strong record in serving the target population. Feedback from these programs confirms that these Guiding Principles are on target, have applicability to important programmatic issues that need to be addressed, and can be realistically implemented in the field.

Overall, the Guiding Principles are based on the following three key themes:

1) Both substance abuse and HIV disease are preventable and treatable.

2) All HIV positive substance users should receive the same level of high quality of care as any other individuals accessing health care and/or substance abuse treatment.

3) Services should be provided in a manner that encourages engagement and retention in care.

The Guiding Principles were developed within the framework of these themes and represent the first comprehensive set of standards of care for HIV positive substance users. The principles consider the diverse needs of this population and present programmatic considerations across disciplines, including primary care, substance abuse treatment, outreach programs, and care coordination programs. The principles are organized into the following general categories:

Integrated Services – HIV positive substance users have a wide spectrum of health care needs and are typically involved in multiple systems of care. To promote continuity of care and effectively address the diverse needs of this population, services such as primary care, substance abuse treatment, mental health treatment, and support services should be integrated and easily accessible.

Care Coordination – Research has demonstrated that coordination of care, particularly for consumers accessing multiple sectors of the care system, facilitates the access and utilization of services across settings, resulting in improved health outcomes.

Assessment – Frequent assessment of health status, for both HIV positive substance users and those at high risk, is essential for the appropriate delivery of services. Assessment can also allow for early intervention and client education aimed at preventing disease progression and/or transmission.

Referral – Referring clients to appropriate medical, counseling, and support services is a cornerstone of the overall treatment process of the HIV positive substance user. Strong referral networks for this population result in a more seamless treatment process.

Staff Education and Support – Continuous staff training, supervision, and evaluation enhance the success of reaching consumers and improving health outcomes.

Consumer Education – Consumer education is an effective tool to dispel myths about HIV and substance use, and to provide consumers with accurate information geared towards reducing risk, preventing infection, and initiating behavior change.

Quality Improvement – Treatment protocols for HIV positive substance users are continuously evolving. Provider facilities must have quality improvement activities in place to continually measure the effectiveness of the treatment process in improving health outcomes for this population.

Confidentiality – Literature reveals that the stigma associated with both HIV and substance use remains pervasive and can become a barrier to identifying and treating individuals with these conditions. Written confidentiality policies, protocols, and practices can help alleviate client hesitation to reveal their health status.

Cultural Sensitivity and Competence – Cultural sensitivity in the treatment of HIV positive substance users helps to establish trust between provider and consumer, and is critical to engaging and retaining clients in treatment.

Consumer Involvement - Consumer input and involvement is an important component of high quality care. Consumer preference must be a priority in making service planning decisions, as consumers are more likely to adhere to plans if their preferences are considered. Consumer involvement helps persons with limited experience or ability in making independent choices, make decisions for themselves and/or assume increasing responsibility for making decisions.

The document first describes the general Guiding Principles applicable to all facets of care for the target population, including primary care, substance abuse treatment, care coordination, and outreach. More specific guidelines for each of these categories are then discussed.

Part One: General Principles for Primary Care, Substance Abuse Treatment, Care Coordination, and Outreach Programs

Principle 1: Integrated Services

Clients should have access to closely linked, easily accessible, and coordinated HIV primary care, gynecological care, substance abuse counseling and treatment, mental health services, and support services.

Recommendations

A. HIV primary care, gynecological care, substance abuse counseling and treatment, mental health services, and support services should be offered in a centralized location (one-stop shopping) wherever possible.

B. Where this model is not possible, provider agencies should have written agreements and referral protocols with medical care, substance abuse treatment mental health and support service providers that allow individuals who need these services to receive prompt attention. Written agreements and/or referral protocols should include a mechanism for tracking and feedback.

C. Staff knowledge of substance abuse treatment programs should include:
   i. The type of services available;
   ii. Referral and admissions processes;
   iii. Accepted forms of insurance;
   iv. Linguistic and cultural capabilities;
   v. The type of treatment approach (e.g. harm reduction[4], self-help, abstinence); and
   vi. The availability of appropriate support services (e.g. transportation and child care).

Principle 2: Care Coordination

Consumers should have access to comprehensive care coordination[5] services.

Recommendations

A. Care coordination services should be made available to any HIV positive individual who does not already have that service from another agency[6].

[4] "Harm reduction is a set of strategies and tactics which encourages users to reduce the harm done to themselves and their communities by licit and illicit drug use. By allowing users access to the tools to become healthier, we recognize the competency of their efforts to protect themselves, their loved ones and their communities." Dan Bigg Chicago Recovery Alliance, 10/26/93.

[5] Care coordination – can be labeled care coordination, case management, peer advocacy. What is important here is the function of the service rather than the label.

[6] These services should be available for people, but it does not mean that they are required to use them.

B. Care coordinators should be responsible for:
    i. Assistance in accessing entitlements;
    ii. Coordinating primary care, substance abuse treatment, mental health, and support services;
    iii. Following up on missed appointments;
    iv. Providing referrals as needed; and
    v. Ensuring consumer involvement in treatment and care planning.

C. Care coordinators should help consumers arrange for support services, including transportation to services, housing, and assistance in obtaining medications.

Principle 3: Cultural Sensitivity and Competence

Programs should support and maintain cultural sensitivity and competence.

Recommendations

A. Programs should provide all staff with 6 – 8 hours of cultural competence training annually.

B. Cultural competency training should include understanding the role of culture in communications, attitudes, beliefs and behaviors, and behaving in a way that reflects respect for the consumer's culture, religion, and belief system.

C. Cultural competency training programs should be made available to consumers.

D. Programs should devise recruitment strategies to hire clinicians and/or peer support staff that represent and reflect the cultural and ethnic backgrounds and life experiences of the consumers who are likely to use the agency's services based on HIV demographic information for the area.

E. Staff should also consider the cultural trends of HIV, the impact of HIV within cultural groups, and the effective culturally relevant treatment and prevention strategies.

F. Programs should make arrangements to have interpreters available for non-English speaking and hearing-impaired consumers.

G. Programs should work collaboratively through coalitions or referral arrangements with other community-based organizations that serve distinct groups.

Principle 4: Assessment

All consumers should receive an assessment of their substance use and mental health history and treatment as part of the intake process.[7]

[7] Intake may occur over the course of several visits or contacts.

Recommendations

The assessment should include:

A. Types and frequencies of past and current drug use;
B. Age of first and last drug use;
C. Usual route of administration;
D. History of formal and informal substance abuse and mental health treatment;
E. Review of current medications, including psychotropic medications;
F. Family substance use and mental health history;
G. Sexual history; and
H. Readiness for change (e.g. Pochaska change model).

Principle 5: Referrals

Referrals to treatment and support services should be a routine consideration for consumers.

Recommendations

A. Discussion of treatment options and referrals to treatment programs should be routine components of care provided to individuals who are actively abusing drugs/alcohol or seeking continued support with their recovery.

B. Referrals should also be available for family members and significant others if requested.

C. Staff should ask consumers about their experience with the referral provider.

Principle 6: Staff Education and Support

Programs should establish, implement, and periodically update written protocols for staff orientation, training, supervision and support around issues related to serving HIV positive substance users.

Recommendations

A. Orientation and training of new staff should include:
   i. Basic knowledge of HIV, hepatitis, and related conditions;
   ii. The ability to identify and follow-up on medical emergencies;
   iii. Basic knowledge of commonly used illicit substances and alcohol;
   iv. Basic knowledge of the signs and symptoms of withdrawal;
   v. Basic knowledge of sexual risk and safer sex practices;
   vi. How to screen for risk behaviors;
   vii. Basic training in interacting with individuals with impaired mental states; including the timing of interviews regarding substance use;
   viii. A comprehensive overview of the spectrum of substance abuse treatment modalities;
   ix. Program, federal and state confidentiality guidelines for HIV positive and substance abuse treatment; and
   x. Cultural competency training.

B. Within three months of hire[8], all staff with direct consumer contact should receive additional training in:
   i. Building trusting relationships with consumers;
   ii. Instilling a sense of hope for consumers while helping them maintain positive with realistic expectations;
   iii. Showing warmth, empathy, and positive regard for consumers, regardless of their behavior or presentation;
   iv. Functioning as a member of a multi-disciplinary team; and
   v. Local resources and services for HIV and substance abuse.

C. Providers/staff should receive 6 - 8 hours[9] of ongoing education annually related to HIV, HIV-related conditions, and substance use through in-service or external training.

D. Consumers should be part of the faculty training for new staff orientation and continuing education.

E. Providers should receive regular medical updates as new information becomes available.

F. Staff should be assessed for their competencies in serving HIV positive substance users within the first six months of hire[10].

G. Programs should establish procedures to provide clinical support for all providers who deliver services to HIV positive substance users.

Principle 7: Consumer Education

Consumers should receive verbal and written information about HIV and substance use and abuse as a routine component of their care, and should be educated on this information at each visit.

Recommendations

A. Consumer and family[11] education is a continuous process that includes prevention, risk reduction practices, harm reduction**,** licit and illicit drug interactions, medical complications of substance use, hepatitis, important health and self-care practices, and information about referral agencies that are supportive of people living with HIV and AIDS.

[8] Three months is recommended because it is not practical to conduct all training as part of orientation, but this training should occur before the individual's probationary period is complete.

[9] 6-8 hours is recommended as a minimum standard because it can be met through a combination of one full-day conference, seminar, or continuing education training, and 1-2 in-service trainings.

[10] After six months of employment, most individuals move from a probationary to more permanent employment status, and this is the time to assess their competency in performing their job.

[11] Families – this refers to traditional, extended, and non-traditional families. While family information is highly desirable, it requires the consent of the consumer.

B. The information should be culturally relevant, and reflect as much diversity as possible including race, gender, ethnicity, age, sexual orientation, religion and disability[12] status.

C. Every effort should be made to provide materials in languages and formats used by those who are likely to use the agency's services based on HIV demographic information for the area.

D. All materials should be written at an appropriate reading level.

E. Consumers should be involved in reviewing materials for appropriateness.

F. With consumer consent, families should receive the same information that is made available to consumers.

Principle 8: Quality Improvement

Performance improvement systems should incorporate standards, measures and goals related to services provided to HIV positive substance users.

Recommendations

A. Provider agencies should develop or adopt indicators to measure performance in serving HIV positive substance users.[13]

B. Provider agencies should develop and implement a performance improvement plan that includes specific goals for the delivery of services to HIV positive substance users.

C. The documentation of consumer care should be monitored on an ongoing basis for accuracy, completeness and objectivity.

D. The agency should obtain consumer feedback, such as written satisfaction surveys, as part of the performance monitoring and improvement process.

E. Provider agencies should involve consumers in the quality improvement process, beyond obtaining feedback. This could include involving consumers in quality improvement goal determination, establishment of measures, or in data collection, as appropriate.

[12] Disability – physical, psychiatric, and developmental disability

[13] This standard should be required once performance indicators for HIV positive substance users have been developed nationally – it is unrealistic to expect each individual agency to develop its own indicators specific to this population.

Principle 9: Confidentiality

Agencies should implement written confidentiality policies, protocols and practices that meet all federal and state guidelines for both HIV disease and substance abuse treatment.

Recommendations

A. All staff should be trained in this policy and sign a confidentiality agreement.

B. The agency's confidentiality policy should be given to consumers in writing, explained verbally, and be clearly posted on the premises.

C. All staff should receive a minimum of one hour of consumer confidentiality training on an annual basis.

D. Consumers must be informed about confidentiality practices as they relate to their rights to, and the release of, their health care information, as mandated by law.

Part Two: Principles Specific to HIV Primary Care Programs

Principle 1: Multi-Disciplinary Team Approach

HIV primary care should be provided through a multi-disciplinary team approach in a centralized location whenever possible.

A. All programs should have the capacity to provide gynecological examinations and case management services on-site.

B. At least one member of the multidisciplinary team should have a degree or certification in substance abuse counseling or a related field, and one member of the team should be a licensed mental health provider (can substitute a single dual-licensed provider).

C. Teams should have a consulting psychiatrist on staff who is knowledgeable about substance use or as a consultant available for immediate consultation.

D. Regular case conferences should be convened of all providers (HIV primary care, substance abuse counseling, mental health, care coordinators), whether the services are provided on-site or through referral.

E. Confidentiality agreements should be constructed to support multi-disciplinary care while protecting consumers' rights.

Principle 2: Provider Knowledge of HIV

Primary care providers should have a strong knowledge base in HIV, HIV related conditions, substance use, and hepatitis.

Recommendations

A. Primary care providers should be knowledgeable about the following topics:
   i. Working with consumers who use and abuse alcohol and other substances;
   ii. The clinical and behavioral manifestations of substance use,[14] hepatitis, and mental health issues;
   iii. Medication interactions between prescribed and illicit drugs;
   iv. Medication interactions between opiate substitutes,[15] anti-retroviral or combination therapies, and psychotropic medications; and
   v. The medical sequelae of substance use and differential diagnoses.

B. Prior experience or specific training in these areas should be a priority for new providers.

[14] including alcohol, prescribed drugs, club and designer drugs, and other illicit drugs.
[15] Such as methadone, LAAM

C. All topics described in Section A above should be included in the orientation of new providers and in continuing education programs.

Principle 3: Assessment

Primary care providers should assess all new consumers and routinely assess ongoing consumers for substance use. Those who are determined by the provider to have a substance use problem or those who are at risk should be referred to appropriate services.

Principle 4: Access to Treatment

Consumers who are actively abusing substances should not be prevented from accessing HIV treatment even if they are not participating in substance abuse treatment.

Recommendations

A. All active substance users should be informed of the potential benefits of HIV treatment, as well as the requirements of adherence, and the consequences of non-adherence.

B. All consumers, including active substance users, should be given the opportunity to initiate a plan of treatment.

C. Primary care providers should encourage and support individuals to participate in treatment.

Principle 5: Medication Adherence

Primary care sites should develop medication adherence support strategies that consider the particular needs of active substance users and consumers in recent recovery.

Recommendations

A. Primary care sites should develop and implement strategies for supporting adherence to therapeutic regimens. Protocols should take into account the needs and lifestyles of active substance users and consumers in recent recovery.

B. The effectiveness of these strategies should be evaluated at each consumer visit and be modified as needed.

Principle 6: Consumer Education

Primary care sites should provide consumer education about risk reduction strategies, including the ramifications of substance use, hepatitis, and HIV infection.

Part Three: Principles Specific to Substance Abuse Treatment Programs[16]

Principle 1: Admission and Discharge

Policies and procedures on admission and discharge should reflect the special needs of individuals with HIV disease, hepatitis, and related medical conditions.

Recommendations

A. The program's admission policy should give priority admission for individuals who are HIV positive.

B. At intake, assessment should include questions about:
   i. Medical history and risk behaviors;
   ii. Psychological history and current status;
   iii. Activities of daily living as affected by medical or psychological conditions;
   iv. Consumer knowledge about her/his HIV status and treatment, hepatitis and related medical conditions; and
   v. Other services received.

C. At discharge, staff should develop a written aftercare plan that includes specific substance abuse treatment recommendations utilizing different modalities and approaches, as available.

D. Consumers should be offered the opportunity to participate in the aftercare planning process and should receive a copy of the plan and active referrals[17] to appropriate services.

E. Individuals who relapse or leave before treatment is completed should receive active referrals to appropriate services. Upon discharge under these circumstances, programs should implement strategies that increase the likelihood of incremental changes and improved health status. Consumers should leave knowing they are welcome to come back when ready.

F. Programs should maintain contact with individuals post-discharge and conduct follow-up[18] to re-engage consumers in services as needed.

[16] Substance abuse treatment programs include acute detoxification, outpatient, methadone maintenance, and residential

[17] Active referral – a referral where staff make or facilitate contact between the consumer and the referral agency and assist in making the initial appointment, as contrasted with a referral where the consumer is given a piece of paper with a name and telephone number.

[18] Follow-up by mail, telephone, or in person.

Principle 2: Treatment Program Environment

Substance abuse treatment programs should create a welcoming environment, which encourages and supports individuals with HIV and AIDS to disclose their status as appropriate and obtain support in maintaining their health.

Recommendations

A. Substance abuse treatment should be provided through a multidisciplinary team.

B. At least one member of the team should be a psychiatrist or Registered Nurse Clinician with expertise in mental health issues, and one member of the team should have clinical expertise in HIV.

C. Individuals should be supported to remain on all necessary medications, including psychotropic medications, methadone, and HIV-related medications, and should be under the care of a physician who is knowledgeable about drug interactions.

D. The structure of the program should provide avenues of support for HIV positive substance users including HIV specific groups and groups that welcome people with HIV in a broader setting.

E. Personnel will assess issues relevant to different populations such as women, older adults, or adolescents, as applicable, and treat each as deemed necessary within the existing care delivery system.

Principle 3: On-Call and Back-Up Systems

Access to medical and mental health backup is critical to prevent complications. Emergency and crisis services should be available to consumers 24 hours/day, 365 days/year.

Recommendations

A. For acute detoxification services and methadone maintenance, a physician should be available on-site at least 10 hours per week. For all types of treatment, a physician or mid-level provider should be available by beeper 24 hours a day, 7 days a week for immediate access in the event of medical complications and for medical supervision.

B. Programs should have protocols and established relationships to address psychiatric emergencies, in order for consumers to receive prompt and appropriate care. These protocols should include a relationship with an emergency department that offers psychiatric emergency care at a hospital convenient to consumers.

Principle 4: Staff Education

Substance abuse treatment staff should receive the following orientation and training:

i. Mental health conditions associated with HIV and substance use,
ii. Interactions between methadone, HIV medications, and psychotropic medications,
iii. Risk reduction assessment and education, and
iv. Harm reduction.

Part Four: Principles Specific to Outreach Programs

Principle 1: Staff Education

Outreach programs should provide orientation, training, and continuing education to outreach workers to ensure that they understand their responsibilities as outreach staff.

Recommendations

Training should cover the following areas[19]:

A. Building trusting relationships with consumers;
B. Instilling a sense of hope for consumers while helping them remain positive with realistic expectations;
C. Showing kindness, warmth, and empathy regardless of a consumer's behavior or presentation;
D. Using good judgment, intuition, and street sense; that is, safety for oneself and the consumer;
E. Having a non-judgmental attitude;
F. Acting as a team player, but also knowing when to ask for help;
G. Setting realistic expectations in knowing that an outreach worker cannot "cure" or "save" consumers;
H. Making the transition from consumer to provider when former clients of the agency are hired as staff;
I. Ethics and boundaries;
J. Information about local resources and services for HIV and substance abuse, including a variety of approaches to care
K. "Street sense" or survival skills; and
L. Harm reduction.

Principle 2: Staff Supervision and Support

Outreach programs should provide ongoing, consistent supervision by highly skilled professions for their outreach workers.

Recommendations

A. Outreach workers should meet on a regular basis with a supervisor to discuss work, including outreach activities, consumer progress, concerns, consumer interactions, cultural sensitivity, and boundary issues.

B. Outreach programs should ensure that work assignments/caseloads are tailored to outreach worker experience and capacity in order to prevent burnout and maximize success.

[19] Erickson, S. and Page, J. To Dance With Grace: Outreach & Engagement To Persons On The Street. Presented at Practical Lessons: The 1998 National Symposium on Homelessness Research, U.S.Department of Housing and Urban Development and the U.S. Department of Health and Human Services, August 1999

C. Programs should provide ongoing and consistent support services for their peer outreach workers, including stress reduction, crisis management, and relapse prevention services.

Principle 3: Advocacy

Outreach programs should provide advocacy and assist consumers in getting concrete services.

Recommendations

A. Outreach workers should advocate on behalf of their consumers.

B. Outreach workers should help individuals meet their immediate and basic needs.

C. Outreach workers should escort consumers to appointments as needed.

Principle 4: Consumer Education

Outreach programs should educate consumers about risk reduction activities and tools, and community resources.

Recommendations

A. Outreach programs should educate their consumers about health topics related to HIV/AIDS, substance use, and Hepatitis C.

B. Outreach programs should have relevant educational materials to give to consumers. These materials should be available in languages and formats that are culturally appropriate.

C. Outreach workers should educate consumers about community resources.

Principle 5: Follow-Up

Outreach programs should maintain a follow-up system with consumers.

Recommendations

A. After consumers become connected with services, outreach programs should follow-up with consumers in a timely manner to ensure that service connections have been made.

B. Outreach programs should establish protocols on the frequency and the duration for follow-up contacts with consumers.

Principle 6: Staff Recruitment

Outreach programs should make every effort to hire some outreach workers who have personal experience with HIV and substance use.

Part Five: Principles Specific to Care Coordination Programs

Principle 1: Consumer Involvement

Consumer input and involvement is an important component of high quality care. Consumer preference must be a priority in making service planning decisions. Consumers are more likely to adhere to plans if their preferences are considered.

Recommendations

A. Care coordinators should ask for consumer preferences and input about service delivery options.

B. Care coordinators should assist the consumer in discussing his/her needs and preferences with other health care providers as needed. With the consumer's permission, care coordinators should share this information with other providers if necessary.

Principle 2: Medications

Prescribed medical and psychotropic medications, including methadone, should not be interrupted when consumers receive care coordination services.

Recommendations

A. Care coordinators should make themselves aware of the consumer's current medication regimen.

B. Care coordinators should assist consumers in advocating with other providers for continuity of care around medication issues if needed.

Principle 3: Aftercare Planning

In the event of transfers or discharge, care coordinators should develop a written aftercare plan that includes specific substance abuse treatment recommendations.

Recommendations

A. Consumers should be strongly encouraged to participate in the aftercare planning.

B. Consumers should receive a copy of the plan, including the addresses and phone numbers for referral services.

C. The aftercare plan should maintain a high level of quality care and fit the individual's lifestyle and needs.

D. If aftercare services are not easily available, the care coordinator should work with the consumer to find appropriate resources.

Principle 4: Follow-Up
After program discharge, care coordinators should follow-up with consumers to provide additional assistance with linkages to other services.

Recommendations

A. Care coordinators should develop mechanisms to assist consumers with keeping appointments.

B. Care coordinators should establish protocols about the frequency and duration for follow-up contacts with consumers, and should communicate this information to the consumer.

Standard 5: Referral Networks
Care coordinators should maintain an extensive referral network within the community and refer their clients to appropriate providers.

Recommendations:

A. Care coordinators should be aware of the complex needs of HIV positive substance users and the multiple types of health care and support services they may need.

B. Care coordinators should help link consumers with health care and support services in a pro-active manner.

C. Care coordinators should be familiar with a range of different programs and agencies within the community and assess the strengths and weaknesses of each for different individuals, based on the individual's characteristics and preferences.

D. Care coordinators should make a linkage with, and become familiar with, the intake staff at a range of referral agencies.