

## **BARRIERS AND FACILITATORS TO IMPLEMENTING ACCESS TO HIV CARE INTERVENTIONS: A QUALITATIVE ANALYSIS OF THE POSITIVE CHARGE INITIATIVE**

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Research indicates that less than half of people living with HIV (PLWH) have undetectable levels of virus, despite recent findings that viral load suppression dramatically reduces the transmissibility of HIV. Linkage to HIV care is a crucial initial step, yet we know relatively little about how to effectively implement linkage interventions to reach PLWH who are not in care. AIDS United's initiative, Positive Charge (PC), funded five U.S. sites to develop and implement comprehensive linkage interventions. Evaluation of the initiative included qualitative interviews with management and service staff from each intervention site. Sites experienced barriers and facilitators to implementation on multiple environmental, organization, and personnel levels. Successful strategies included developing early relationships with collaborating partners, finding ways to share key information among agencies, and using evaluation data to build support among leadership staff. Lessons learned will be useful for organizations that develop and implement future interventions targeting hard-to-reach, out-of-care PLWH.

Recent research has shown that reducing HIV viral load to undetectable levels dramatically reduces HIV transmission and can stem the significant HIV epidemic in the U.S. (Cohen et al., 2011). Early connection to and retention in HIV care is critical to

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reaching and maintaining viral load suppression (Mugavero et al., 2012) but current information indicates that only 19.0–43.4% of people living with HIV (PLWH) have undetectable viral levels (Gardner, McLees, Steiner, Del Rio, & Burman, 2011; Gray et al., 2014; Hall et al., 2013).

The limited evidence-based interventions to find, link, and retain PLWH in HIV care focus mostly on individual-level factors (Bradford, Coleman, & Cunningham, 2007; Craw et al., 2008; Gardner et al., 2005; Higa, Marks, Crepaz, Liao, & Lyles, 2012; Mugavero, Norton, & Saag, 2011; Willis et al., 2013). Yet, systems-level approaches are needed to redress the fragmentation in systems of care in communities that present challenges to linking and maintaining PLWH in care (Mugavero et al., 2011; Philbin et al., 2014). For example, access to ancillary services like transportation is associated with greater care engagement (Andersen et al., 2007; Messeri, Abramson, Aidala, Lee, & Lee, 2002; Philbin et al., 2014), and access to stable housing is associated with reduced viral load (Hawk & Davis, 2012; Leaver, Bargh, Dunn, & Hwang, 2007). In addition, the healthcare system structure and the ease with which individuals can access and navigate services facilitate care access (Kempf et al., 2010; Mugavero et al., 2011; Philbin et al., 2014; Sprague & Simon, 2014). Finally, individuals who are not newly diagnosed are harder to link and retain in care than the newly diagnosed (Gardner et al., 2005). Understanding the characteristics of interventions successful in reaching this population is critical.

In 2010, AIDS United launched Positive Charge (PC). Five U.S. sites were funded to develop and implement comprehensive efforts to link to care PLWH who were not currently in care. Specifically, PC targeted the hardest-to-reach individuals, who often experienced co-occurring challenges such as homelessness, substance abuse, and/or other chronic illnesses. PC made a particular effort to reach PLWH who knew their status but were out of care, although any PLWH not receiving care was eligible for participation. Interventions focused on addressing both individual-level and structural factors related to engagement in care. To address the limited literature on access to care interventions overall (Craw et al., 2010), and specifically interventions including structural change as a goal, this article describes the multifaceted barriers and facilitators to implementing interventions.

## METHODS

Positive Charge (PC) access to care interventions were implemented in five U.S. sites from 2010 to 2013 (Table 1). Each project was unique based on geographic reach, community characteristics, and identified needs, but all employed multiple evidence-based strategies to link and retain individuals in care. These included care navigation, case management, motivational interviewing, and addressing structural barriers to care (such as providing transportation or providing same-day appointments). Because the interventions aimed to engage the individual and increase coordination among service providers to facilitate access to care, each lead agency had at least two local collaborating agencies. Additional information about the initiative has been published elsewhere (Jain et al., in press).

A national evaluation strategy was developed to complement site-level evaluations in order to measure progress in improving access to care across all five PC sites. Evaluation strategies included monitoring participant-level data, conducting comprehensive qualitative and quantitative case studies of each site, and conducting a cost analysis of the projects (Kim et al., 2014). As part of the case study process,

TABLE 1. PC Intervention and Interviewee Characteristics

PC Site	Target Population	Intervention Strategy	Interviews Conducted	
			Management Staff	Direct Service Staff
San Francisco – Oakland, CA	Multiple populations, including men who have sex with men, transgender individuals, and incarcerated individuals	Peer/patient health navigation, community outreach, intensive case management	4	5
Chicago, IL	Men who have sex with men	Peer health navigation	4	3
Louisiana	Incarcerated individuals, individuals who are newly diagnosed, and individuals who are out of care	Pre/post release case management, peer/patient health navigation, intensive case management, HIV disease intervention specialist	4 <sup>a</sup>	3
New York, NY	Medicaid-eligible individuals enrolled in the AmidaCare health insurance plan	Client centered outreach, health navigation, flexible scheduling and reduced visit time	4	2
North Carolina	Out of care individuals in rural, suburban, and urban locales	Peer health navigation, community education and outreach	4 <sup>b</sup>	4

<sup>a</sup>In two interviews, management and direct staff were interviewed at the same time. <sup>b</sup>In one interview, three management staff were interviewed at the same time.

semistructured interviews were conducted with management- and service-level staff at all or most partner agencies at each site. Management staffs were individuals who were responsible for supervising the intervention within their agency, or in the case of the lead organization, the entire site and collaborating partners. Service-level staffs were responsible for providing logistical and emotional support, coordinating with other service providers, and assisting PLWH address and overcome barriers to care.

The type and name of direct service staff differed by PC site, but included peer navigators (individuals who were themselves PLWH) and patient or health navigators (individuals who were not PLWH), and less often disease intervention specialists (DIS) or pre- or post-release case managers for the incarcerated population. Throughout this article, the umbrella term *care coordinator* will be used.

Interviews were conducted by the Johns Hopkins University (JHU) evaluation team using a semistructured interview guide. Most interviews were conducted with one interviewer and one interviewee, but in three instances both management and service staff were interviewed simultaneously due to scheduling constraints. This research received a non-human subjects determination from both the JHU Institutional Review Board and the University of Pittsburgh Institutional Review Board.

Transcripts were digitally recorded, professionally transcribed, and analyzed using ATLAS.ti 7.0. Data were analyzed using directed content analysis, a method by which codes based on a predetermined framework are further refined based on the data (Hsieh & Shannon, 2005). Initial codes were based on our a priori research question, which was to identify the barriers and facilitators to implementing the Positive Charge interventions. Within the barriers and facilitators codes, we then identified major themes and sub-themes. A primary coder coded 100% of the interviews while a secondary coder coded approximately 20%. Codes were compared and conflicts were resolved by consensus between the two coders. Cohen’s Kappa score for the barriers and facilitators codes was overall 0.55 (range: 0.40–0.58), indicating moderate agreement.

To maintain anonymity, names and/or other identifying characteristics (such as the name of an organization) are redacted.

## RESULTS

A total of 35 interviews with 37 staff were conducted one to two years into implementation (Table 1). Descriptions of implementation barriers and facilitators fell into four major themes: environmental factors; collaboration; staffing; and, role confusion. Results described below are organized by major theme and then sub-theme, with the exception of role confusion, for which no sub-themes were identified. Responses of management versus service-level staffs and between different sites were largely similar across the identified themes, but differences are noted in the text below.

### ENVIRONMENTAL FACTORS

#### INTRA-ORGANIZATIONAL ENVIRONMENT

Interviewees indicated several factors influencing an organization's readiness to implement an intervention. Importantly, agencies had to be ready to employ active outreach strategies, which interviewees indicated was not always the case. Agencies reporting implementation challenges described using initial inefficient strategies, such as not being geographically located near the target population, employing passive outreach strategies such as posting flyers, and expecting outreach workers to spend a good deal of time in the office. Agencies reporting greater initial success were creative in their outreach strategies, which required staff to work outside of the office finding PLWH, meeting them in neutral locations, and/or accompanying them to appointments. Also, organizations that came to the initiative with expertise with a target population and/or had existing relationships with other organizations that provided services to PLWH described an easier and quicker implementation start-up.

In an era of reduced nonprofit resources and interest in demonstrating effectiveness of interventions, it is important to note that the ability to track service and client-level data for the purposes of process and outcome evaluation was crucial to intervention success. Recommendations from interviewees on this front included being prepared to train staff and devote adequate resources to administrative tasks.

For many of the sites, the design of the intervention required care coordinators or other PC staff to work within or closely with clinic or medical providers. Some interviewees described initial friction integrating the linkage intervention, which operated largely from a social service model, into the medical model. The medical model was described as being accustomed to passive outreach, waiting for individuals to come to them, while the purpose of these interventions was to conduct active outreach, making significant efforts to find and link people who had dropped out of care. Sites described misunderstandings from the medical providers about the depth of work needed to support individuals in care:

The providers are not accustomed to going outside and bringing people into care. Since it is an infectious disease there is an urgency to get people in care—there is a bit of resistance—why are these people getting so much special treatment. If they are not in care that is their problem. (Management Staff, Organization 20)

Education and relationship building with medical staff were cited as key strategies in order to overcome this tension. PC staff scheduled educational sessions or brown bag lunches with providers to inform them about the specifics of the efforts. Although fitting trainings into busy providers' schedules was difficult, they did help when providers were able to attend. Some staff met with providers individually to explain the work. One interviewee who described meeting resistance from hospital colleagues ultimately saw success from this strategy:

At first medical providers didn't understand what I was providing nor did they want to know. I have a hospital badge on why am I being treated like this. Said can I please speak to you in private whenever you have time. And then I would just talk to them individually one on one. ... A few made referrals to me of family members, well that broke the barrier right there. (Direct Service Staff, Organization 20)

### INTERORGANIZATIONAL ENVIRONMENT

Factors related to the broader sociopolitical and existing care system in PC communities affected implementation of the interventions. Lack of infrastructure in the community care system to serve PLWH was repeatedly mentioned as a concern and barrier to linkage. Interviewees that worked with the incarcerated or recently released population suggested that the expense of HIV testing and care to the prison system led to systemic resistance to partner with PC agencies. Sites in the U.S. South were particularly concerned with provider shortages that limited their ability to refer patient to providers, although PC sites outside of the South also mentioned this limitation. Of particular concern to Southern sites was the closure of AIDS-service organizations that resulted in reduced support services to PLWH, the few physicians who accepted Ryan White or Medicaid-insured patients, and AIDS Drug Assistance Program (ADAP) waiting lists. One Southern management staff recounted the fact that due to the long wait for appointments, staff has to tell clients, "Just be patient. Hopefully you can make a doctor appointment soon and hopefully you'll still feel like doing that" (Management Staff, Organization 7).

The exhaustive process of completing the paperwork and other administrative requirements necessary to get into care was another reason cited as why PLWH were disengaged from care.

Interviewees from all PC sites emphasized the critical inability to meet PLWH's needs beyond simply medical care. Most frequently mentioned gaps in services were housing and transportation. Given the level of effort needed to find and link a person to care, not meeting these other needs was particularly challenging for staff. "Barriers to housing for me is really huge for us because [the care coordinators] are torn. They are so frustrated when they can't get these guys into a place to stay" (Management Staff, Organization 16).

Staff from one rural and one urban site were particularly concerned with their ability to transport clients to medical appointments, both because of the distance required to travel to providers (for the rural site) and the cost of transportation (for both sites). Recommendations were to include adequate transportation funds in the project budget and remove bureaucratic barriers so care coordinators could transport patients to appointments.

The lack of funding limits a lot of what we can do. It becomes an issue when transporting clients back and forth to different services. That is why we deliver them, so we can be assured that they can access the services—gas has gone up. (Direct Service Staff, Organization 19)

The quality of care that exists within a community was also a concern for interviewees. Staff felt that one of the reasons PLWH are not in care is that they had a bad experience with a medical provider and are reluctant to return. As such, care coordinators said they needed to have a good working knowledge of the quality of care available in the community so that they knew to whom to refer and whom to avoid.

## COLLABORATION

Both as part of the intentional design of the PC intervention and the nature of engaging out-of-care PLWH, cooperation and collaboration both within and between agencies in the community was essential to the work.

### INTRA-ORGANIZATIONAL COLLABORATION

Collaboration of staff and programs within agencies was often fostered by collocating services. Having smooth hand-offs of patients (e.g., from care coordinator to case manager, or from doctor to care coordinator) was repeatedly mentioned as easing patient linkage. Moreover, agencies that had medical clinics collocated with service sites had an easier time linking to care because handoff to medical staff could happen within the same building.

Regardless of whether a site had medical collocated with social services, collaboration among different initiatives or programs was a factor in success. The PC initiative required a much greater interaction among programs within an agency in order to find and link PLWH and the expectation of increased integration and communication was described as a cultural shift by one interviewee.

To facilitate collaboration, many agencies described rearranging the office so that care coordinators could sit near other staff. This not only enabled informal team building and better established the care coordinator as a member of the agency but also made it easier for staff to coordinate care. One interviewee mentioned that the increased coordination between departments within an agency resulted in higher utilization of all agency services, not just PC services.

One of the consequences of increased intra-agency collaboration is that clients had more support options. For example, having a team of people (e.g., care coordinators, case managers, and clinical providers) who care for a person means that clients were more likely to be able to get someone on the phone.

The more people that are involved in their stuff legally and medically, they'll follow through with. So it's like, to keep that person engaged we have to kind of stay on that person. Build the relationships with the case managers, and just say, "I am calling to update you about so and so. This is what he did this weekend." (Direct Service Staff, Organization 13)

Frequently, interviewees described the benefit of the care coordinator/case manager collaboration as extending the quantity and quality of support available to clients. High caseloads restrict case managers' ability to spend in-depth time with clients, but care coordinators had the ability to provide a more intensive level of support. Both care coordinators and case managers appreciated this synergy, as it then freed up the case managers' time to provide other services to clients.

Our case managers actually love [care coordinators] and feel like they're a great addition to the team. They like that they actually can talk with the clients because . . . it

actually freed them up a little bit where [the case managers] could actually work with more of the clients with the services and then the [care coordinators] were taking over the counseling piece that they were doing, so it actually was a benefit. (Direct Service Staff, Organization 6)

### INTERORGANIZATIONAL COLLABORATION

Inter-agency collaboration was also instrumental in implementation success. Locating and linking PLWH required that the broader care system actively refer out-of-care patients to the PC agencies, who could then find and recruit them back in to care. Successes and challenges in forging these referral pathways was a frequent topic in the interviews.

The intentional network design of PC was a strength of the initiative, as interviewees saw membership in a defined network of agencies that were all collectively working to connect PLWH to care as crucial to success. Requiring concrete partnerships benefitted some organizations because it afforded formal opportunities to learn about each other's services and strategies to improve the overall network effort. It allowed contact with different types of agencies with whom some agencies might never have been able to partner.

Without the... network it would have been hard because we are a grassroots organization and they are a county-level organization but because we both have this grant it allows us, it gives us that container to saying we should be working together. (Management Staff, Organization 12)

Outside of the PC network, primary care physicians (or other medical care providers who provided care for PLWH) were key targets for collaboration as they had a mutual interest in reengaging individuals in care. Some interviewees said that they wished they had reached out to physicians earlier in the project.

. . . I've realized that maybe we should have been more upfront putting out the information to others in the network . . . it seemed like there was still some people that missed the information and didn't know some things so I definitely think that would have been . . . better upfront if we would have went to the hospitals, doctors offices, all that kind of stuff up front. We did some of that a little later in the game. It would have turned out a lot better. It wasn't negative but it would have made it better. (Direct Service Staff, Organization 6)

Health departments' access to surveillance data was another key link for PC agencies. Indeed, a staff person from a health department who was partnering with the collaborative acknowledged,

We can take a name and go through the state's HARS program and find out when an individual's last labs were done. We can also work with our vital records to see if an individual has passed away . . . So I would suggest, or recommendation, if an agency has the opportunity to really partner with the public health department, and if there is specifically an AIDS office, an office of AIDS administration, it does really increase the avenues of information . . . (Management Staff, Organization 9)

Agencies that did not have formal partnerships with health departments said they were particularly hindered in their efforts because without access to client-level data: "We're going out there cold" (Direct Service Staff, Organization 13).

Interviewees described a great deal of relationship building that had to take place before a true collaboration and referral network developed. One-time outreach

to recruit potential referral partners was generally unsuccessful. Instead, ongoing, continual contact with agencies was needed to build lasting relationships between organizations. Several interviewees said it took up to a year before external providers/agencies were fully on board and committed to the effort. A majority of sites said that building relationships early—even before the project officially begins—is necessary. Agencies that did not do that experienced delays in getting referrals. This was especially important for agencies trying to work with incarcerated populations, as building those relationships is challenging due to the closed nature of prisons/jails. The benefit of cultivating relationships is that it greatly facilitates not only referrals into the intervention but linkage to care for Positive Charge clients, “because I could pick up my phone and say, ‘Look, I need an appointment in two days’” (Direct Service Staff, Organization 13).

### CONFIDENTIALITY

Patient confidentiality laws impacted the implementation of this project. The Health Information Portability and Accountability Act (HIPAA) provides one such set of rules for certain entities, although not all participating agencies were accountable to HIPAA. Interviewees endorsed the importance of client confidentiality but also said it was a major barrier to figuring out who to target with access to care services and, once found and linked, coordinating care among different agencies within a community. Collaborating providers and agencies were frequently reluctant to even engage with the PC interventions for fear of violating patient confidentiality.

Some PC agencies tried to facilitate information sharing by asking providers to have patients sign release of information forms. However, many reported that providers did not consistently follow through.

However what we can do is establish a relationship with them and from now on when a new client comes in for service they’ll have them sign that release and if they do fall out of care they’ll be able to get that contact information . . . that hasn’t happened . . . One more piece of paper for someone to sign . . . Unless you were to call them up, we can remind them about this idea then it’s going to fall to the wayside and if you call them every week, they’ll get tired of hearing about it. (Management Staff, Organization 7)

One agency ascribed this resistance to following through with getting signed releases as a symptom of broader, systemic burdens on agencies such as shrinking Ryan White Program dollars:

I just think a lot of providers are saying my hands are tied with so many things with Ryan White and now you’re going to require something else. I don’t want to put a strain on an already strained relationship. (Management Staff, Organization 7)

Client releases, though, require that an individual already be identified and located, so this strategy is not helpful in that respect. The nature of the target population is that they are challenging to locate, so even if an agency knows who to locate they may not know how: “Phones don’t work. Addresses don’t work” (Management Staff, Organization 8).

It is important to note that challenges related to confidentiality were largely discussed in relation to initiating the intervention and developing partnerships and processes. When discussing actual implementation, interviewees were able to cite many examples of when the process worked well. For example, when releases are

signed among a network of organizations, retention can be monitored and addressed immediately.

Now we're getting calls from the sites themselves, be it a nurse or the PCP and they say, "Hey, I just want to put this person on your radar. They haven't seen me in like six or seven months," and maybe that name hasn't made it to our lists yet, but so now we're kind of getting these referrals directly from the sites. (Direct Service Staff, Organization 1)

## STAFFING

Across the board, personnel were cited as the reasons contributing to (or hindering) the success of these interventions. Part-time staff was limited in their ability to follow-up with out-of-care clients. In some cases, additional funding had been secured to increase a person's time to full-time and this was almost always cited as a factor that increased the project's capacity to find and link individuals to care.

### LEADERSHIP SUPPORT

Leadership who supported the intervention facilitated implementation. A few interviewees described executive directors (EDs) who were reluctant to support the project. One ED wasn't sure that the agency's out-of-care population was large enough to warrant a special project. Another thought the level of effort was too great given the funds available. However, in both cases, presenting these leaders with data about the extent of the problem and/or the initial success of the intervention was sufficient to garner support.

### SPECIAL QUALITIES OF CARE COORDINATORS

As all of the sites utilized a care coordination model as an intervention component, there was a great deal of discussion about the qualities of the care coordinators and how that facilitated implementation. First, care coordinators who were familiar with and well-known within the community were better able to develop relationships with other organizations that could help them identify and care for out-of-care individuals. This familiarity with the community and care system was deemed essential by several interviewees: "I don't think someone who's new to the city or new to the business could be successful with it" (Management Staff, Organization 18).

Care coordinators who were living with HIV were able to relate to participants on a personal level and share knowledge, experience, and challenges about the disease. A few care coordinators described their success as being due to the "passion" they brought to their position, in that their mission and reason for being was not simply to earn a paycheck but to truly make a difference. This passion provided motivation to persevere in locating and linking people. Finally, management staff in a few sites mentioned that having a diversity of experience, connections, and skillsets among care coordinators was helpful to match the diversity of the target population.

[W]e found that two navigators in particular that they used to work in a hospital setting, so they really know how to navigate those hospitals. They really know the lingo. They know how to say, "Hey, I want to meet with the discharge planner to introduce myself." (Direct Service Staff, Organization 1)

### CARE COORDINATOR TRAINING

The care coordinator role was not without challenges, however, especially in sites that utilized peers who came to the position with little formal professional experience. Although many care coordination jobs were entry-level, they did come with administrative responsibilities, including evaluation data tracking. Management staff cited the unexpected need to increase care coordinators' basic word processing and other administrative skills to meet the project's goals. A few management interviewees said that if given the chance to do it over, they would increase this type of training.

Some management staff expressed concern about maintaining boundaries between care coordinators and clients. Care coordinators may have known clients as friends but then were expected to interact with them in a professional role. For example, one supervisor cited care coordinators giving personal cell phone numbers to clients as example of poor boundaries that needed to be addressed. One recommendation from project staff about the care coordinator role was to keep the job description narrow and manageable in order to avoid burnout.

### ROLE CONFUSION

Another major theme of the interviews was the extent to which the care coordinator role was confusing for the medical and social service field and as a result care coordinators were met with resistance, at least initially.

When care coordinators and case managers worked together within the same agency, role confusion was less prevalent. However, some sites reported that case managers were territorial about their clients and job duties. Interviewees reported that this often improved over time as case managers and care coordinators worked together and understood that the care coordination role complemented, not superseded, the case manager role. When care coordinators were promoted from within—e.g., when agencies hired existing staff or volunteers into the care coordinator role at the outset of the grant—the transition was much easier because the case managers were familiar with and trusted the individuals. And some sites that initially hired care coordinators as a stipended staff found that the role was better respected when they transitioned to a paid staff position.

Territorialism extended beyond case managers within the same agency, as interviewees recounted that other agencies were reluctant to refer to the PC agencies, so outreach efforts were unfulfilled.

What I found then is that some of the agencies we were visiting were a little hesitant about making referrals from their clients to us almost as if we were looking to take their case-managed clients. So we didn't find that straight outreach was very helpful at all . . .  
(Management Staff, Organization 18)

Involving case managers early on was recommended so that they understood the role of the care coordinator and the rationale behind the enhanced access to care efforts. Here again evaluation results were helpful in demonstrating the utility of the care coordinator role. "When they started really paying attention to the results that were coming out of my position they started really understanding what I do" (Direct Service Staff, Organization 19). Another successful tactic employed by care coordinators was continually educating their colleagues about their role.

Thus, sites that had initial friction between care coordinators and case managers described an eventual process of role clarification and increased collaboration. However, some care coordinators remained frustrated when they felt they could assume some case management responsibilities as needed (for example, when the case manager was not on duty), but were limited by these defined duties.

## DISCUSSION

The results of interviews with Positive Charge intervention staff from five different communities reveal a number of factors that facilitated or presented challenges to finding and linking PLWH to care. Lack of infrastructure in the broader medical and social service care system was a frequently mentioned challenge, as it limited the ability of staff to follow through with linkage efforts and risked losing already tenuous connections to out-of-care PLWH. Yet, staff that had deep connections to communities and intimate knowledge of the types and quality of care available in their community was a strong facilitator to linkage. Interviewees enumerated several other successful implementation strategies, summarized in Table 2.

Two interesting findings emerged. First, confidentiality of health information proved a formidable barrier to coordinating care for PLWH. Developing a system by which client information could be confidentially and lawfully shared among organizations in the community was essential to both locating out-of-care individuals as well as monitoring their engagement in care. For example, knowing when a person failed to follow up with an appointment enabled immediate response. This issue presents a challenge not only for PC agencies but also any similar initiative involving collaboration between healthcare or service-providing entities. Any organization implementing a future linkage intervention will need to understand its accountability to federal and state laws in order to negotiate the line between protecting individual privacy and providing quality care (O'Connor & Matthews, 2011; Rothstein, 2010).

Second, the care coordinators filled a key function but were met with a great deal of initial resistance by other colleagues. Future interventions that utilize care coordinators or similar roles might include social workers or other staffs who will work closely with care coordinators in formative planning to lessen this tension. This insight has applicability to a number of fields given the increased recognition of the utility of integrating individuals with care coordination responsibilities into primary care (Pittman, Sunderland, Broderick, & Barnett, 2015).

These results are similar to other findings about implementing linkage to care programs. For example, Craw et al. (2010) found that collaboration among organizations within a community was an important factor in the ARTAS-II implementation. He also noted the challenging distinction between linkage case management and long-term case management, which is similar to the tension described between care coordinators and case managers.

## STRENGTHS AND LIMITATIONS

This analysis was descriptive with no comparison group, which limits generalizability. Interviews were collected at one time point, so we cannot describe changes in barriers and facilitators to implementation over time. We interviewed one management and one direct service staff person per agency, but perhaps a richer understanding could have been obtained by interviewing more staff from each organization.

TABLE 2. Successful Positive Charge Implementation Strategies

Theme	Successful Implementation Strategies by Sub-themes
Environmental Factors	<i>Intra-organizational</i>
	Using creative outreach strategies and allowing outreach staff to be out in the community
	Having existing relationships with the target population and/or collaborating with agencies that served the target population
	Devoting resources to train and support staff to handle administrative tasks related to data and evaluation
	Educating and developing relationships with medical staff
	<i>Interorganizational</i>
Collaboration	Budgeting for client transportation costs
	Becoming familiar with the quality of care delivered by different providers in the community
	<i>Intra-organizational</i>
	Co-locating services (e.g., medical and social) to allow for smooth patient hand-offs
	Co-locating staff to facilitate communication and establish the care coordinator as a member of the care team
	<i>Interorganizational</i>
Staffing	Creating a defined network of organizations with concrete partnerships
	Making early connections with medical providers
	Partnering with health departments that have access to surveillance and vital records data
	Starting relationship-building early, and continuing to nurture them throughout the project
	<i>Confidentiality</i>
	Obtaining releases of information from patients
	<i>Leadership Support</i>
	Using data (to describe the problem or preliminary program success) to encourage leadership buy-in
	<i>Special Qualities of Care Coordinators</i>
	Hiring care coordinators who were familiar with the local care system
Hiring care coordinators who were people living with HIV	
Role Confusion	Selecting a team of care coordinators that was diverse in terms of experiences, connections, and skillsets
	<i>Care Coordinator Training</i>
	Providing training to care coordinators in word processing and other basic administrative skills
	Keeping the care coordinator job description narrow and manageable to avoid burnout
	Where possible, promoting care coordinators from within the organization so that case managers and other staff were familiar with them
	Making the care coordinator position a salaried position (rather than stipended)
	Developing early relationships with case managers
Using evaluation data to demonstrate the utility of the care coordinator position	
Conducting continual education with staff about the role of the care coordinator	

Also, staff turnover within the Positive Charge-funded agencies could have limited the ability to fully explore barriers and facilitators.

Given these limitations, however, this analysis has many strengths. The fact that similar themes emerged from five very different interventions, agency networks, and communities speaks to the validity of the findings. These findings also mirror the extant literature on systems-level access to care efforts.

## CONCLUSION

Given the increased interest in engaging PLWH in care, the findings from this study have the potential to greatly inform community-based interventions in the U.S., as linkage and retention in HIV care is now understood to be critical to stemming the epidemic (Mugavero, Amico, Horn, & Thompson, 2013). It is also important to note that many of the barriers enumerated by the interviewees, such as unmet care needs and lack of coordination among medical and social service providers, are ones

that have been reported for decades (Bonuck et al., 1996; Conviser & Pounds, 2002; Lee-Ougo et al., 2003). The fact that these challenges remain is indicative of the persistent macro- and micro-level factors that contribute to the complexity of delivering care to PLWH in the U.S. Given this, the facilitating strategies provided by Positive Charge sites will be critical to developing effective interventions in the future (Coates, 2013). As the epidemic is becoming concentrated in marginalized populations—e.g., young men who have sex with men (MSM), poor, racial/ethnic minorities (Dinunno, Oster, Sionean, Denning, & Lansky, 2012; Prejean et al., 2011)—ensuring there is a culturally competent system of care that is responsive to their needs is a crucial task for the public health system. As the work of linkage and retention in care in the U.S. is just beginning, future studies examining this process will greatly add to nascent current knowledge and build on the insights presented here.

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