**AIDS and Substance Abuse Program for**

**African Americans and Latinos with HIV** — **ASAP Plus**

This is an electronic version of the ASAP+ proposal as submitted to SAMHSA/CSAT. Several blank pages have been deleted as these were place holders for form pages or other documents. Therefore, the pagination in the Table of Contents will not be correct.

**Abstract**

The **AIDS and Substance Abuse Program for African Americans and Latinos with HIV** (**ASAP+)** will provide substance-abuse counseling using Motivational Interviewing to 410 African American and Latino men and women living with HIV and their partners over the 5 years of the project, 70 in Year 1, 90 per year in Years 2 – 4, and 70 in Year 5. The project is an expansion of the AIDS and Substance Abuse Program (ASAP) of the AIDS Health Project of University of California, San Francisco.

ASAP Plus will provide outpatient substance-abuse counseling and associated case management. Clients with co-occurring mental illness (estimated to be 60 percent of the population) will receive psychiatric care. Sexual and drug-injecting partners will be actively sought out and provided rapid HIV testing, counseling, and referrals to any needed services including primary care.

The ASAP+ goals are to reduce clients’ substance abuse, improve mental health, reduce HIV risk behaviors, and increase compliance with HIV medical regimens. To achieve these goals, the process objectives are: 1. substance-abuse counseling using Motivational Interviewing to 410 clients over five years, 2. rapid HIV testing offered to all participants’ injection-equipment-sharing and sexual partners estimated as 200 over five years, 3. risk reduction services, 410 project participants over five years, 4. linkage with medical services, as needed (estimated 50 to 100 over five years), 5. case management, as needed to 410 clients over five years, and 6. psychiatric services: assessment, prescriptions, and medication management (estimated 260 assessments and 180 clients receiving medication and medication management over five years). The outcome objectives are 1. reduced illegal drug use, 2. reduced alcohol use, 3. improved mental health, 4. reduced HIV transmission behavior, 5. increased adherence to antiretroviral medications, 6. increased self-sufficiency including employment, 7. improved social support and functioning, including housing and social connectedness. A variety of means are used to measure these, including the GPRA and ASI instruments, review of client charts, and client focus groups.

AHP has assembled a multicultural service team of African Americans and Latinos, experienced in serving the target population and trained in Motivational Interviewing and cultural competency. An advisory board, including consumers, will have input on planning, implementing, and evaluating the program. The principal referral agencies will include HIV clinics serving people of color: Mission Neighborhood Health Center’s *Clinica Esperanza* (primarily Latino), UCSF Positive Care *Men of Color Program* (primarily African American), and Women’s Center of Excellence in HIV Care (primarily African American), the UCSF HIV Clinic at the county hospital (both African American and Latino), and other service components of AHP. Other significant referring organizations include the Black Coalition on AIDS, the SF AIDS Foundation (sponsor of minority focused programs, El Grupo and Black Brothers Esteem) and the Forensic AIDS Project.

**AIDS and Substance Abuse Program for**

**African Americans and Latinos with HIV** — **ASAP Plus**

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**Guide to Abbreviations**

ACM Assertive Case Management, AHP’s intensive treatment program for high-needs clients.

AHP AIDS Health Project, the applicant agency.

ASAP AIDS and Substance Abuse Program, the service to be expanded.

ASAP Plus The working title of the new program. Re-naming the program will be considered.

ASI Addiction Severity Index, an evaluation instrument often used with people of color

BCA Black Coalition on AIDS, a referring agency

CoE Women’s Center of Excellence in HIV care, a collaboration of the UCSF Women’s HIV

 Clinic, Rita da Cascia, Lyon Martin Women’s Health Center, UCSF PHP at SFGH, et al.

DPH Department of Public Health; SF DPH is the San Francisco DPH.

IDU Intravenous drug use or user

MOCP Men of Color Program, an HIV primary treatment/social service program of UCSF

MI Motivational Interviewing, an evidence-based practice effective with people of color

SFAF San Francisco AIDS Foundation, sponsor of El Grupo and Black Brothers Esteem,

 which will refer people to the program

SFGH San Francisco General Hospital, the county hospital serving indigent people.

SHE Sex and Health Empowerment program of the Women’s CoE. Positive SHE workers

 provide advocacy and support to women and their children

TIP Technical Information Protocol, a SAMHSA publication series

UCSF University of California, San Francisco. AHP is part of UCSF, as are some of the

 referring HIV primary care clinics, including the Women’s CoE collaborative.

**Section A: Statement of Need**



Centrally located program site, the

AIDS Health Project (AHP) Service Center at 1930 Market Street

**Figure 1**. **Geographic area to be served — the City and County of San Francisco — shown with the distribution of people living with HIV/AIDS** (San Francisco Department of Public Health {SF DPH}, 2006)

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**Geographical area to be served.** The area to be served is the City and County of San Francisco, shown in Figure 1 above. San Francisco County covers an area of only 47 square miles, making it the sixth smallest county in the US in terms of land area. San Francisco service agencies typically serve populations within the County because it is geographically divided from surrounding areas. The population of San Francisco is 739,425 (U.S. Census Bureau, 2006).

**Target Population:** African American and Latino men and women living with HIV/AIDS who need substance-abuse treatment and are not currently enrolled in a formal substance-abuse treatment program, and their partners. The risk groups specified in the announcement include people living with HIV/AIDS; the target population will be these individuals, or their sex or injection equipment sharing partners. In terms of HIV exposure category, the population will include women exposed through heterosexual sex, MSM, people released from incarceration within the past two years, and injection drug users. Based on AHP’s experience serving this population we anticipate that 60 percent will have a co-occurring mental illness.

**Nature of the Problem and Extent of the Need**

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**Figure 2. San Francisco AIDS cases by race/ethnicity and year of diagnosis, showing that new AIDS cases among Whites have declined while recent AIDS cases among Latinos and African Americans have stayed at approximately the same level.** (SF DPH 2006)

If AIDS cases only among Whites were considered it would seem like the HIV/AIDS problem in San Francisco is greatly declining. But as Figure 2 shows, AIDS cases are not substantially declining among African Americans and Latinos. And as Table 1 shows (next page), there are substantial numbers of African Americans and Latinos living with HIV/AIDS in San Francisco. While the HIV epidemic in minority communities has resulted in many African Americans and Latinos in San Francisco who have HIV/AIDS and need treatment for substance abuse, the funding for treatment for this population has been drastically reduced. In FY-2003/04 six outpatient substance-abuse programs were funded with Ryan White CARE Title I dollars, totaling $759,750. However, in FY-06/07, essentially **no** treatment slots are funded — instead, a number of agencies receive portions of $299,960 in Ryan White CARE dollars for outreach and assessment for substance abusers. As a result, once those with HIV and substance-abuse problems are identified and assessed, there are few treatment resources for them to access.

The program we propose to expand — AHP’s AIDS and Substance Abuse Program, or ASAP, lost its Ryan White CARE funding, but the County’s General fund is paying for treatment of 30 clients (unduplicated count) per year — hardly enough to meet the need.

With their substance-abuse problems not treated, men and women of color who have HIV experience a decrease in the quality of their lives and have difficulty in participating in their own HIV treatment. And there are broader consequences: failure to treat this population puts the community at risk for the spread of HIV through this population’s potential injection equipment sharing and other unsafe behavior.

**Table 1. Persons living with HIV by**

**demographic and risk characteristics,**

**San Francisco, 2005** (SF DPH 2006).

|  |  |  |
| --- | --- | --- |
| **Gender** | Number | Percent |
| Male | 13,567 | 92 |
| Female | 884 | 6 |
| Transgender | 297 | 2 |
|  |  |  |
| **Race/Ethnicity** |  |  |
| White | 9,557 | 65 |
| African American | 2,116 | 14 |
| Latino | 2,103 | 14 |
| Asian/Pacific Isl. | 6574 | 4 |
| Native American | 101 | <1 |
| Other/Unknown | 214 | 2 |
|  |  |  |
| **Risk** |  |  |
| MSM only | 10,697 | 73 |
| IDU or MSM IDU | 3,069 | 21 |
| Heterosexual | 337 | 2 |
| Transfus./Hemoph. | 37 | <1 |
| Other/Unknown | 608 | 4 |
| **Total** | **14,748** |  |

**HIV/AIDS in San Francisco**

The early stages of the HIV epidemic affected mostly White gay men, but — as elsewhere in the country — as time has passed the disease has affected a larger proportion of Latinos and African Americans (Table 1). Antiretrovirals have resulted in increasing numbers of people living with HIV, most of whom have not developed AIDS.Despite this overall improvement in survival, disparities have occurred across racial/ethnic groups. For example, among persons diagnosed with AIDS between 1996 and 2005, a lower proportion of African Americans survived five years after being diagnosis with AIDS compared to other racial/ethnic groups. The 5-year survival rate was 71 percent for African Americans, 79 percent for whites, and 82 percent for Latinos (SF DPH, 2006).

A recent study of access to medical care found that approximately 10 percent of people living with AIDS and 22 percent of people living with HIV were receiving no primary medical care, though most of these had accessed care previously. Minorities and low-income people were less likely to be able to sustain their medical care (SFGH, 2006). Clearly there is a need for programs to support people of color with HIV in accessing medical care.

**Women**. The majority of heterosexually-acquired AIDS cases are African American women, according to the most recent SF DPH data (2006). Sex with an IDU partner was the most frequent exposure category, which emphasizes the need for services addressing the partners of IDUs with HIV. African American women comprise a disproportionate percentage of women with AIDS in San Francisco. Among female AIDS cases, 47 percent occurred among African Americans even though African American women comprise only 8 percent of the San Francisco female population. Latinas make up 14 percent of the women in SF, and 13 percent of the AIDS cases.

**Injection drug users (IDU).** IDU in San Francisco engage in very substantial HIV risk behavior. According to the National Behavioral Surveillance Survey, San Francisco (2005), 80.5 percent had shared injection equipment in the last 60 days and 48.6 percent said they had unprotected sex in the past 60 days. The self-reported HIV prevalence rate of IDU in San Francisco is 13.8 percent; the numbers who are HIV positive but have not been tested is unknown.

**Race/ethnicity of IDU with HIV/AIDS**. As shown below in Table 2, half or more of non-MSM AIDS cases were African American. Ten to 12 percent were Latino. Data on HIV infections not progressed to AIDS are not available but there is no reason to think the proportions are greatly different.

**Table 2. Injection drug use-associated AIDS cases by exposure category and race/ethnicity, diagnosed through December 2005, San Francisco** (SF DPH, 2006).



**Table 3. HIV Prevalence among San Francisco MSM by race/ethnicity, National Behavioral Surveillance Survey, 2004.**

|  |  |
| --- | --- |
| Race | HIV Prevalence |
| African American | 38.1% |
| White | 26.3% |
| Latino | 23.1% |
| Asian | 10.0% |

**MSM prevalence by race/ethnicity**. As Table 3 shows, African American MSM in San Francisco reported a 50 percent higher rate of HIV than Whites.

**Treatment needs of people with HIV and substance-abuse issues**. Providing substance-abuse treatment to people with HIV requires that the provider be thoroughly knowledgeable about the disease, its treatments, and the network of medical and other HIV service providers caring for people with the disease (CSAT 2000). To be sensitive to the clients’ concerns about the stigma of HIV, the treatment staff need to have worked through any stereotypes or prejudices they may have about HIV. The treatment program should have organizational ties with other HIV services, especially primary care, in order to expedite clients’ linkage and retention in these services. The pressure of having HIV tends to intensify co-occurring mental illnesses, so the program needs ready access to psychiatric services. Finally, to effectively serve African Americans and Latinos, the program should have a staffing pattern including African Americans and Latinos and provide ongoing cultural competence training and supervision.

Although there are a range of substance-abuse services offered in San Francisco, outpatient substance-abuse treatment containing these extra elements of cultural and linguistic competence‑ HIV expertise, mental health expertise, and linkage to primary care services — are currently available only from ASAP, for a general population (70 percent who are people of color).

**Need for slots.** Although an estimate of need could be derived from the numbers of African Americans and Latinos living with HIV in San Francisco, we have developed a more precise (if more conservative) estimate from local data by consulting with the principle agencies serving the population who have confirmed that they would immediately refer clients to the proposed project (letters, Appendix 1). As shown on Table 4, below, the referring agencies carefully reviewed their patient/client populations and indicated the following annual need, based on the number of African American or Latino clients who have been assessed and found to have a substance-abuse disorder, then reduced to the number who appear to be ready to accept a referral to a culturally competent, HIV-informed program, then estimated by year. The total need, estimated by this method, is 235 per year. Based on past experience serving the target population, AHP projects that, in addition, about 10 percent of these clients would be able to bring their sexual/needle sharing partners to the program for counseling and HIV testing, for a total of 221 potential slots needed.



**Table 4. Number of people in the target population who would be referred annually as estimated, based on to current numbers known to have a substance abuse disorder**. (In order: John, 2007; Machtinger, 2007; Gomez-Benitez, 2007; Hare, 2007; Dilley, 2007; McGurgin, 2007; Tierney, 2007.

|  |  |
| --- | --- |
| **Agency Assessing and Referring** | **#** |
| UCSF Positive 360 Men of Color Program  | 25 |
| UCSF Women’s CoE (HIV Clinic et al.)  | 60 |
| Clinica Esperanza  | 35 |
| UCSF Positive Health Program SFGH Clinic | 70 |
| AHP other programs  | 30 |
| Black Coalition on AIDS/Rafiki House  | 5 |
| SFAF / El Grupo, Black Brothers Esteem  | 10 |
|  Total | 235 |

**Baseline for the project.** Currently, zero slots are available per year for substance-abuse treatment specifically configured for Latino and African American men and women with HIV. For substance abusers with HIV of any race/ethnicity, the current ASAP offers 30 slots.

**Section B: Proposed Evidence-Based Service/Practice**

**Purpose, Goals and Objectives of the Project**

The overarching purpose of the project is to provide effective outpatient counseling services to 410 Latino and African American men and women with HIV, and their partners, over the five years of the project, thereby improving the quality of life of the clients served by the project and helping prevent the spread of HIV in the community.

The goals are to: help clients achieve abstinence from or reduction in substance use; for those with co-occurring mental illness, to bring about improved mental health; and to motivate clients to eliminate or reduce their risk behavior. To achieve these goals, the project will address the following measurable process objectives (Table 5) and Outcome Objectives (Table 6):

**Table 5. Primary process objectives and measures for the ASAP Plus project.**

|  |  |
| --- | --- |
| **Process Objectives** | **Measures, Quantitative Targets** |
| Provide outpatient substance-abuse counseling and related services to 410 clients in the target population | GPRA; client chart. Quantitative component: count of at least 410 over five years |
| 100 percent of clients identified or suspected of having a co-occurring mental illness will be referred to the program psychiatrist for evaluation/management | Client chart. Quantitative component: count is anticipated to be 240 over five years  |
| Offer rapid testing to all of clients’ partners and any other clients requesting additional testing | Client chart;Quantitative component: 100 percent of partners; projected # partners identified and tested is 44.  |
| Provide the services in a way that is sensitive to culture, gender, and other client characteristics  | Qualitative: documented advisory board input; documented client focus group input. Quantitative: AHP Satisfaction survey, at least 90 percent “Very Satisfied” with cultural, other sensitivity |
| Provide Motivational Interviewing with fidelity to the model | Quarterly progress reports document planned training implemented, interviews confirm staff comprehend practice. Quantitative: at least 90 percent score on Fidelity tracking forms |

**Table 6. Quantitative outcome objectives and measures.**

|  |  |
| --- | --- |
| **Outcome Objectives****At 6 months; to be maintained or increased at discharge.** | **Measures** (included in Appendix 2) |
| 1. Reduced illegal drug use. At least 30 percent to become abstinent, at least 50 percent to reduce days of illegal drug use. | GPRA, Addiction Severity Index (ASI).  |
| 2. Improved mental health. 70 percent of clients with co-occurring mental illness to improve at least .2 on the ASI psychiatric composite index. | GPRA, Addiction Severity Index (ASI), client charts.  |
| 3. Reduced alcohol use. At least 30 percent of clients who abuse alcohol to become abstinent; at least 60 percent reduce days of use.  | GPRA, Addiction Severity Index (ASI), client charts |
| 4. Maintain or increased access and adherence to antiretroviral regimens. 100 percent of HIV positive clients who have not been assessed for antivirals to be referred for this; of clients that have prescription, at least 80 percent will report using the medication as prescribed “all or almost all the time.” | AHP local evaluation instrument; referrals for evaluation of need for antivirals to be counted via chart review |
| 5. Reduced HIV transmission behavior. Of those reporting needle sharing or serodiscordant unprotected sex, at least 50 percent will report reduction.  | GPRA, local evaluation instrument; supplemented by qualitative data in client charts and focus groups client charts |
| 6. Increased self-sufficiency including employment, legal income; at least 50 percent to report improvement in employment or income.  | GPRA, ASI; supplemented by qualitative data in client charts and focus groups |
| 7. Improved social support and functioning, including housing status and social connectedness. At least 60 percent with substandard housing will show improvement in housing status; percent of clients in GPRA report scored as not “socially connected” to decline by 50 percent. | GPRA, ASI; supplemented by qualitative data in client charts and focus groups. Notes: “Substandard housing” is defined as not owning or renting own house or apartment. The GPRA site reports percentage “socially connected” using a subscale constructed from a number of items.  |

**Achievement of these goals and the related objectives will produce the following meaningful and relevant results**: increase the number of outpatient slots configured for the target population from 0 to 90 per year; provide evidence-based substance-abuse treatment, by African American and Latino providers, to African Americans and Latinos and their partners; provide risk reduction counseling to every client, thereby helping prevent the spread of HIV in the community; provide support in medication compliance and other participation in primary medical care, therefore helping clients improve their quality of life and reducing the chance of their spreading HIV to others.

In terms of protection of the community, studies show that individuals correctly using current antiretroviral medications are far less contagious to others, probably due to having a lower viral load (Quinn et al., 2000; Porco et al., 2004; Abbas et al., 2006). Risk reduction counseling has also been shown to be effective in reducing HIV risk behavior, even among people with an extensive history of engaging in such behavior (Weinhardt et al. 1999; Dilley, et al., 2002).

**Evidenced Based Practice**

The primary evidence based practice that will be implemented is **Motivational Interviewing.** This practice, which is currently in use at the applicant agency, is included in the SAMHSA/CSAT list of Effective Substance Abuse Treatment Practices (Appendix E of the grant announcement). **N.B**. The SAMHSA announcement states that, “If you are proposing to implement a service/practice included in . . . the list of Effective Substance Abuse Treatment Practices (see Appendix E), you may simply identify the practice and state the source from which it was selected. You do not need to provide further evidence of effectiveness.”

The Motivational Interviewing approach incorporates the Stages of Change Continuum (Figure 3, below), conceptualizing “unmotivated” clients as at one end of a continuum. The intervention of Motivational Interviewing can begin with clients who are not yet even contemplating change and aid them in seeing the benefits of change. After they change, they move to the stage where the change is maintained.

**Figure 3. Stages of Change Continuum** (Prochaska and DiClemente, 1982).

Pre-contemplative Contemplative Preparing to change Action Maintenance

The *Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illnesses and Co-Occurring Substance Use Disorder* states that “Motivational interventions that emerged in the substance use field (Miller and Rollnick, 1991) have been adapted for people with serious mental illnesses and/or co-occurring disorders . . .” Motivational interviewing was developed by William R. Miller and Stephen Rollnick (1991). It is a trans-theoretical model derived from a number of sources, including stages of change theory (Prochaska and DiClemente, 1982; 1984), client-centered approaches, and research into what clinician behaviors are associated with the best client outcomes. TIP 35 states that, “Motivational interventions can serve many purposes in treatment settings: as a means of rapid engagement, as a preparation for treatment to increase retention and participation, as a stand-alone intervention, and as a counseling style used throughout the process of change.”

TIP 35 shows how substance-abuse treatment staff can influence change by developing a therapeutic relationship that respects and builds on the client’s autonomy and, at the same time, makes the treatment clinician a partner in the change process. The TIP also describes different motivational interventions that can be used at all stages of the change process, from pre-contemplation and preparation to action and maintenance, and informs readers of the research, results, tools, and assessment instruments related to enhancing motivation.

**How the program will work.** As shown in Figure 3, below, clients will be identified by several types of referring agencies. The main HIV clinics that will refer are the UCSF *Men of Color Program* (primary care plus social services), Mission Neighborhood Health Center’s *Clinica Esperanza* program (primary care plus advocacy and education services), and *Women’s Center of Excellence in HIV Care (CoE*) (collaboration of agencies serving women with HIV including primary care, social services, and housing). All have funding to outreach to and assess the target population. Clients will also be identified by other programs of AHP, including the Mental Health Crisis Team, Outpatient Psychiatry and HIV Consultation-Liaison Psychiatry at SFGH, and HIV Counseling and Testing. Finally, referrals will be made by other community agencies such as the Black Coalition on AIDS, the Forensic AIDS Project, and the SF AIDS Foundation through its El Grupo and Black Brothers Esteem programs. ASAP Plus staff will go to the referring agencies to meet with potential clients who are in the pre-contemplative or contemplative Stages of Change. Referring agency staff will also send clients directly to ASAP Plus site when appropriate.

**Figure 4. Referral flow for the proposed ASAP Plus program.**

**HIV Clinics**

UCSF Men of Color Program

Women’s CoE on HIV

MNHC Clinica Esperanza

SFGH HIV Clinic at Ward 86

All conduct outreach, and assess for, but don’t treat, substance abusers.

**Other Agencies**

**and Groups,**

including —

SFAF (El Grupo, Black Brothers Esteem)

Black Coalition on AIDS

SFGH Community Health

 Network

Forensic AIDS Project

**AHP’s Other**

**Programs**

Psychiatry

HIV Testing/Counseling

Crisis Team

HIV Positive Support

 Groups

ACM for Triply Diagnosed

Proposed program,

**ASAP Plus**

When clients enter the program, they will be assessed for level of substance abuse, HIV risk behaviors, and other issues of concern, and, subject to informed consent, administered the baseline project evaluation and data collection instruments. They will be encouraged to invite their sexual and/or injection equipment-sharing partners for counseling and HIV rapid testing. Clients who appear to have significant co-occurring mental illness will be assessed by the ASAP Plus psychiatrist, and receive medication if indicated. Through outpatient counseling using the Motivational Interviewing approach, clients will be motivated to reduce their substance abuse, HIV risk behaviors such as unprotected sex, and to actively participate in their medical care, including taking all their medications as prescribed. Clients will be linked with other needed services at this time, as well as later during treatment if the need emerges. Referral for primary medical care will be expedited because of AHP’s close organizational relationship with the HIV clinics named in Figure 3 (including Women’s CoE), who also provide other needed services such as case management, treatment advocacy, childcare during treatment, and health education. Clients who need substance-abuse services more intensive than the ASAP Plus outpatient treatment, such as inpatient treatment will be served while a suitable referral is found in the interests of helping them maintain and increase their motivation. Clients leaving more intensive treatment will be admitted to ASAP Plus as step-down care when appropriate.

**Services to partners**. Even among non-IDU’s we know that those who use drugs are 3.5 to 5 times as likely to seroconvert as those who deny using drugs, (SF DPH, HIV Prevention Plan, 2005). Our clinical experience is that very often the partners of our clients are also using drugs. As mentioned above, counselors will make special efforts to encourage clients to bring in their partners for rapid testing. This will often proceed as a step-wise process, including encouraging the client to bring his/her partner in for a session with the counselor to first discuss ways in which the partner might be involved in supporting the clients’ efforts to change, followed by the introduction of the idea that the partner might also consider testing. This is a task which the client can be coached to do or, alternatively with the client’s permission, a task the counselor could take on directly. This partner involvement will be emphasized throughout the treatment.

**How ASAP Plus is configured for African Americans and Latinos.** 1) The program is linked through organizational connection and regular on-site meetings with the Men of Color Program, Women’s CoE, Clinica Esperanza, and other major providers of HIV medical care and related support services. 2) The program director is Latino and fluent in Spanish; one designated counselor is African American, and one is Latino and fluent in Spanish; the receptionist is African American, as is the medical advisor; a program-specific advisory board, to be built around a nucleus of African American and Latino members of AHP’s advisory board, will advise the project. Involvement of African Americans and Latinos as staff does not guarantee cultural competence, but it’s not a bad place to start. All of the staff and contractors are experienced in serving the target population and receive regular training and supervision in cultural competence.

 **Cultural competence of proposed practice, Motivational Interviewing**. In Project Match (CSAT, 1999), clients represented a range of cultural backgrounds. Neither Hispanic nor African-American samples responded differentially to the motivational enhancement therapy approach. In addition, analyses of clinical trials of motivational interviewing that had substantial representation of Latinos found no indication of ethnicity or socioeconomic status as predictors of outcome. CSAT (1999) concluded: “Evidence strongly suggests that motivational interviewing can be applied across cultural and economic differences.” There is no indication that sexual orientation, age, or other client variables limit the applicability of Motivational Interviewing.

**In AHP’s specific experience**, **Motivational Interviewing has proven to be appropriate for African American and Latino clients.** Qualitative data, including client focus group comments, input from our diverse Community Advisory Board, and Quality Improvement survey data all confirm that Motivational Interviewing is well-received by women and men, people of many ages, and people of color. We have found that Motivational Interviewing is equally well-adapted to delivery in English and Spanish. The practice can be adapted to people of different ages; sexual orientation is not an issue.

**ASAP Plus will address issues of age, race, ethnicity, culture, language, sexual orientation, disability, literacy, and gender** in the target population, while retaining fidelity to the Motivational Interviewing model. As noted above, there is no conflict between Motivational Interviewing and age, race, ethnicity, and other client characteristics. Other than globally supporting recovery and health, MI does not seek to inculcate a specific set of values nor require clients to learn and adhere to any theoretical system. Its basic tenet is to start where the client is, find her or his true goals, and by addressing the client’s ambivalence about change through encouragement and reinforcement of his or her strengths, move to recovery by continually re-focusing the client’s attention on the ability to embrace them. The adaptability of MI is one of the main reasons it was selected as the evidence-based practice. Of course, though MI has been shown to work well with Latinos and African Americans, men and women, people of different ages, and does not require literacy, and so forth, AHP recognizes the need to maximize cultural, linguistic, and gender competence in all aspects of the program. It makes a difference who provides MI and how it is provided. The project has identified bilingual, bicultural staff so that services can be offered in whichever language clients are most comfortable; the staff will be reflective of the target population (Latino and African American; men and women), and will be selected to have experience with the target population. The staff will be provided with ongoing training and supervision in cultural competency and sensitivity to other client characteristics (gender, age, disability, sexual orientation, literacy). The counselor/case managers to be hired will be selected for having proven abilities to work with diverse client populations. An advisory board of community members who are African American and Latino will have ongoing, regular input into the project. These issues are also addressed under *Organizational Capability*, *Linkages to the Target Population,* *Staffing,* and *Performance Assessment*.

**How the practice will meet the goals and objectives.** As documented in CSAT’s TIP 35 (1999), ample evidence shows that Motivational Interviewing is associated with increased participation in treatment and such positive treatment outcomes as reductions in consumption of alcohol and other drugs, higher abstinence rates, better social adjustment, and improved mental health. In addition, having a positive attitude toward change and being committed to change are associated with positive treatment outcomes. This very directly addresses ASAP Plus goals and objectives (previous page) around reducing or eliminating substance abuse and improving co-occurring mental illness. The improved social adjustment and commitment to change, along with reduced substance abuse, are directly related to better health practices and reduced HIV transmission behaviors.

**Logic Model**. The logic model, Figure 5 (next page), indicates in graphic form how the proposed project will achieve its goals and objectives. The UCSF AIDS Health Project will provide culturally competent intensive substance-abuse treatment services that incorporate Motivational Interviewing techniques, and will also provide linkage to primary care and other needed services, to men and women in San Francisco who have HIV and substance-abuse disorders and who also may have mental health disorders. Motivational Interviewing techniques will help the clients move through the stages of change. The primary service objective is to provide these services to at least 70 men and women in the first year, 90 men and women in years two, three and four, and 70 in year five, totaling 410 persons over the 5 years of the project. The intended outcomes are summarized in Figure 5, and detailed and quantified in Table 6, page 10.

**Figure 5. Logic Model of ASAP Plus** demonstrating how the proposed practice will meet its goals and objectives.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Needs** |  | **Practice and****Services** |  | **Outcomes****(short-term)** |  | **Impacts** **(long-term outcomes)** |
| Target population: African Americans and Latinos with HIV/AIDS need substance-abuse treatment Outreach and assessment is funded, but substance-abuse treatment slots for this population have been reduced — 35 slots available but ≥210 needed. |  | Culturally competent,evidence-basedpractices: Outpatient substance-abuse treatment using Motivational Interviewing Reinforcing linkage to primary health care and other needed servicesRapid HIV testingRisk reduction counselingPsychiatric services |  | Treatment for substance abuse and mental illnessMore consistent, sustained access to primary health careIncreased compliance with HIV medicationConnection to other needed services (housing, primary care, etc.) |  | Reduction in or abstinence from substance abuseStabilization or improvement in mental healthStabilization or improvement in physical healthImproved functioning and conditions, (housing status, employment, etc.)Improved quality of life  |

**Section C: Proposed Implementation Approach**

**The substance-abuse treatment services to be expanded in conjunction with HIV/AIDS services** is the outpatient substance-abuse counseling provided by the AIDS and Substance Abuse Program at AHP. ASAP was initiated in 1984, and has changed over the years as clients’ needs changed. For a period, the service emphasized case management. (AHP now has a separate Assertive Case Management, or ACM, program for triply diagnosed people with a history of homelessness.) As it is currently operating, the **goal**s of ASAP are to increase substance-abuse treatment of HIV-infected drug and alcohol users; to optimize clients’ utilization of the health care system; to increase compliance with medical treatment; and to improve the quality of life of these individuals. The **target population** consists of HIV-infected substance abusers who are low-income. **Services provided** are assessment and evaluation of substance-abuse and HIV concerns; counseling, including relapse prevention; and linkage to primary health care, mental health/psychiatric treatment, and other appropriate social services.

Services are designed with particular attention to the specific cultural concerns of substance users. These concerns include but are not limited to language, ethnic and gender differences, issues related to separation/alienation from family of origin, and participation in the criminal justice system. ASAP works closely with the client’s circle of providers and makes frequent referrals to other service providers. Because AHP is an integral part of the HIV Services Partnership (a collaboration among the San Francisco AIDS Foundation, the Shanti Project, and AHP), ASAP clients are eligible for services at these other two agencies. Additional long-standing working relationships exist between ASAP and the UCSF Men of Color Program, UCSF Positive Health Program at SFGH, the Black Coalition on AIDS, Native American Health Center, Clinica Esperanza, and many other community and institutional resources.

**Staffing**. In recent years, the program had two counselors, one funded through the Ryan White CARE Act and one funded by a pharmaceutical company. The pharmaceutical company has ceased funding of the second position, and CARE Act funding has ceased, but funding for the current program has been picked up by the SF Department of Public Health. ASAP currently serves 30 clients per year (unduplicated). Although the program, unlike the proposed ASAP Plus, is not specifically designed for people of color, 70 percent of clients are African American or Latino. The counselor (Erric White, proposed as a staff member for ASAP Plus) is African American; the clinical coordinator (Ramón Matos, proposed as program director for ASAP Plus) is Latino.

**How the Expansion Will Take Place**

When funding is confirmed, counselors Erric White and Claudia Figallo, and program director Ramón Matos will be assigned to ASAP Plus. (A different counselor will be hired or assigned to the existing ASAP program, which will continue to be funded by the county and will offer services to individuals who may not be in the ASAP Plus target population.) In addition, 1.5 FTE other substance-abuse counselors will be hired. As the hiring process is moving forward, the program director and other staff will seek out qualified African Americans and Latinos and encourage them to apply.

As soon as funding is confirmed, the project director will reassign the primary staff and initiate the contract with the designated evaluator, and arrange for training in Motivational Interviewing. In the program’s first two months, the staff will establish treatment and evaluation procedures, implementing those specified in the application, meet with collaborating agencies, and then begin serving clients in month three. We expect to serve 70 clients in the first year, less than the next years (90 per year) due to the extra time involved in start-up. The evaluator will aid in training the staff on the GPRA and other training tools and procedures, set up data systems, and then regularly analyze and report on the data. The staff will receive the official SAMHSA GPRA training as soon as it can be scheduled, but to speed implementation, the evaluators will conduct an initial GPRA training. (The evaluators are very familiar with the GPRA from their work on similar SAMHSA projects.) The service to clients will be ongoing. Analysis and reporting of data will take place quarterly. Attendance at grantee meetings will be annual, or as frequently as scheduled by SAMHSA. The final year’s client total is 70, anticipating the possibility that the program may be undergoing administrative changes as different funding is secured. For more information on management and implementation, please see the Timeline, Table 7 (next page).

**Table 7. Timeline for proposed project showing task, month, and person responsible. It is anticipated that Month 1 will be October, 2007.**

|  |  |  |
| --- | --- | --- |
| **TASK** | **Month** | **Person(s)** **Responsible** |
| **(Milestone: Project begins**.) 1. Assign counselors, receptionist, program director; initiate hiring process for new staff. Assign space for the project at 1930 Market St. | 1 | Project Director, Program Director |
| 3. Initiate evaluation contract | 1 | Project Director |
| 4. Inform primary referring agencies the project has started; meet jointly with staff  | 1 | Program Director & Case Managers |
| 5. Convene first advisory board meeting; generate list of additional candidates for board; consider re-naming project | 1, then bi-monthly | Program Director, Evaluators |
| 6. Track project implementation through meetings and observation; review and analyze GPRA and other data | 1 and ongoing | Evaluators |
| 7. Document and explicate program methodology and procedures, based on application | 1–2 | Program Director, Evaluators |
| **(Milestone.)** 8. Complete hiring process for new staff | 2 | Program Director |
| 9. Train staff on ASAP Plus policies and procedures | 1–2 | Project Manager |
| 10 Conduct initial GPRA, ASI, and other data collection training, then consult and trouble-shoot as needed | 2, thenongoing | Evaluators, other AHP staff |
| 11. Receive official GPRA (as scheduled by SAMHSA contractor) | When available | New staff (others already trained) |
| Provide training for new staff in Motivational Interviewing | 2 -3 | Training to be arranged |
| **(Milestone: Services begin.)** 12. Provide ongoing ASAP Plus services to clients — outpatient substance-abuse counseling, service linkage, risk behavior reduction counseling, using Motivational Interviewing techniques | 3 and ongoing | Counselors |
| 13. Provide mental health assessment, prescribe medications, consult with team on clients with mental illness | 3 and ongoing | Psychiatrist |
| 13. Collect GPRA data and local evaluation data | 3 and ongoing | Case Managers |
| 14. Meet with primary referral agency staff in regular case conferences to coordinate services | 3, ongoing at least monthly | Program Director, Counselors |
| **(Milestone.)** 16. Prepare and submit first quarterly report to CSAT, and first internal report to project team and community | 4, then quarterly | Evaluators |
| 17. Attend 1st grantee meeting; anticipated in month 6, but the meeting is scheduled by SAMHSA | 6; then annually | Project Director, Project Manager Evaluators |
| Conduct client first semiannual client focus group  | 6; thenongoing | Project Manager and evaluator |

**Summary of evidence that the expansion will address the overall goals and objectives of the project within the 5-year grant period**. 1) The evidence-based practice that will be implemented is Motivational Interviewing. This practice, which is currently in use at the applicant agency, is included in the SAMHSA/CSAT list of Effective Substance Abuse Treatment Practices. The SAMHSA announcement states that, “If you are proposing to implement a service/practice included in . . . the list of Effective Substance Abuse Treatment Practices (see Appendix E), you may simply identify the practice and state the source from which it was selected. You do not need to provide further evidence of effectiveness.” We do feel it worthwhile to add, however, that Motivational Interviewing has proven effective in our program and acceptable to our clients who are Latino and African American. 2) As illustrated in the Logic Model, Figure 5 page 16, the connection between the need, services, outcomes, and impacts is clear and straightforward. The need for effective substance-abuse treatment is documented, Motivational Interviewing has been proven effective, and the results it can be expected to bring about are the goals and objectives of the project, such as reduced substance abuse. 3) The primary referral sources, funded to outreach and identify people in the target population, are already “on board,” have clients who are ready to be referred, and have confirmed their participation (letters, Appendix 1).

**Number of individuals to be served, services provided, and outcomes.** As shown in Table 8, below, 410 clients will be served over five years. The services provided include outpatient counseling, along with linkage to other services. Based on prior experience, the level of partner participation is anticipated to be approximately 10 percent; therefore approximately 38 clients are expected to be sexual or needle-sharing partners of HIV positive clients. All these will be offered rapid HIV testing, counseling, and referral to medical services as needed. All HIV positive clients (approximately 372 individuals) will be provided with HIV risk behavior reduction counseling, and motivational enhancement techniques will be used to support them in participating in primary care and adhering to their medication. Approximately 60 percent of clients will have some degree of co-occurring mental illness, and these 240 will be provided with psychiatric services and linkage to other services when needed. The ASAP Plus psychiatrist will assess approximately 45– 55 clients per year and prescribe medication and medication management for approximately 30–40 per year, for a five-year total of 260 assessments and 180 clients receiving medication and medication management.

**Table 8. Number of individuals to be served.** Year 1 is start-up; Year 5 is transition to new funding. Total for all years is 410 clients.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| YEAR 1 | YEAR 2 | YEAR 3 | YEAR 4 | YEAR 5 | TOTAL |
| 70 | 90 | 90 | 90 | 70 | 410 |

**Anticipated outcomes.** 1. Reduced illegal drug use. At least 30 percent to become abstinent, at least 50 percent to reduce days of illegal drug use.2. Improved mental health. 70 percent of clients with co-occurring mental illness to improve at least .2 on the ASI psychiatric composite index.3. Reduced alcohol use. At least 30 percent of clients with alcohol addiction become abstinent, and at least 40 percent reduce days of use.4. Maintain or increased access and adherence to antiretroviral regimens. 100 percent of HIV positive clients who have not been assessed for antivirals to be referred for this; of clients that have prescription, at least 80 percent will report using the medication as prescribed “all or almost all the time.” 5. Reduced HIV transmission behavior. Of those reporting needle sharing or serodiscordant unprotected sex, at least 50 percent will report reduction.6. Increased self-sufficiency including employment, legal income; at least 50 percent to report improvement in employment or income. 7. Improved social support and functioning, including housing status and social connectedness. At least 60 percent with substandard housing will show improvement in housing status; percent of clients in GPRA report scored as not “socially connected” to decline by 50 percent. See also *Outcome Objective*s, Table 6, page 10.

**Identification, Recruitment, and Retention of Target Population**

The **initial identification and recruitment** of the target population will be performed by our primary referral agencies (see Table 4, page 9 and Figure 4, page 12), who serve the clients as primary medical caregivers or in related capacities, and who are funded and qualified to initially assess clients for substance-abuse disorders. The initial identification and recruitment may be conducted by physicians, or by other staff. For example, the Men of Color Program is staffed by physicians but also includes Peer Advocates and Social Workers, who interact frequently with patients; all can identify and begin recruiting clients. The Women’s CoE has physicians, and also Positive Sexual and Health Empowerment workers (called “Positive SHE” workers), who advocate for the client and provide emotional support, while the CoE housing component, Rita de Cascia, is staff with case managers who can refer clients to the program; the Clinica Esperanza, in addition to physicians, has Health Educators who work closely with clients**.** Referring agency staff will be oriented and advised, as necessary, as to how to conduct identification and referral. (In general, the medical and other staff of these agencies — whom we know from regularly working together — are experienced, linguistically competent, and well-informed in how to identify and refer people with substance-abuse problems. The problem has not been the ability to refer, but having resources to refer to.)

When the potential clients are identified by the referring agency, they will either be instructed to contact ASAP Plus on their own, or if judged not likely to follow through, they will be introduced to ASAP Plus at the clinic or other program site. ASAP Plus staff will regularly visit referral agency sites for this purpose, and to case-conference with referring agency staff.

In the initial meeting with clients, the ASAP Plus counselors will use Motivational Interviewing techniques to build a helping relationship with clients, determine the client’s immediate goals and interests, and connect the client’s goals and interests to participation in the project. The counselor will also gently probe for information related to initial screening for eligibility to the program. Once the potential client is determined to be possibly eligible and has agreed to initial assessment, the next step will be a first appointment at the AHP Service Center, where the client will receive further counseling and assessment, and be accepted into the program if eligible (i.e., have a substance-abuse disorder and be HIV positive or the partner of an HIV positive person).

**Retention** of the target population will be addressed through Motivational Interviewing, which has been shown effective for this purpose. The referring agencies will also help us track clients, subject to informed consent. A Client Locator Form, completed in the initial interview, will assist in the mechanics of locating clients when necessary. Retention for evaluation purposes will be facilitated by this locator form, and by $20 grocery certificates given at the time clients complete the follow-up and discharge GPRAs.

**Language.** The great majority of the target population speak English, but some of the Latinos will be most comfortable speaking in Spanish, and some of their family members may only speak Spanish.

**Beliefs, Norms, Values; Socioeconomic Factors**

**Lower incomes.** Almost without exception, the HIV-positive people of color coming for substance-abuse treatment to publicly funded programs have low incomes. This creates issues in terms of transportation, often, in scheduling treatment. A frequent issue is that poverty, combined with substance abuse, can make people’s lives so chaotic that it becomes very challenging to focus on recovery and health issues.

**Latinos.** There is no single, homogeneous Latino culture or set of values. Large-scale survey data (Brodie and Suro, 2002) shows strong attachment to family is evident among most Latinos. Immigrants are more conservative than most non-Hispanic whites on issues of gender, abortion, and homosexuality, but native-born Latinos, including the children of immigrants, express attitudes within the range of views voiced by non-Hispanics. A recent study found that Latinos in San Francisco did use primary care, but many underutilized it because it lacked cultural and linguistic competency (Giovannini, 2000). Concern about immigration status can also make people hesitant to try to access care. In terms of behavioral health care, many Latinos — especially recent immigrants — are mainly accustomed to receiving health care at primary care clinics, so closely linking behavioral health services to primary care is helpful (Herrera, 2006).

**African Americans.** African Americans make up 7.4 percent of the population of San Francisco (U.S. Census Bureau, 2006) but are 14 percent of the population of people in San Francisco living with HIV (DPH, 2006). African Americans have no single culture; there are many individual differences, and also differences in norms and beliefs depending on socioeconomic factors. Traditionally, much of community life revolves around family and church. The Baptist church typically emphasizes traditional teachings about chastity and faithfulness, and some feel that this does not encourage MSM and others to come forward to seek help with HIV risk behaviors (Anderson, 2000; Flunder, 2004). The aftermath of the Tuskegee experiment has made many African Americans concerned about accessing health services, especially sexual health services. Concerns about encountering racial prejudice, or simply not being understood, can also make African Americans reluctant to ask for substance-abuse treatment.

**MSM**. Many MSM in the target population come from backgrounds where homosexuality is not acceptable, are reluctant to disclose their behavior, and may feel a deep sense of shame. The stigma associated with HIV only intensifies this. While some identify as gay or bisexual, others do not, and there is a great variation among the target population in this regard. As Table 3 in the *Needs* section shows (page 8), African American MSM are about 50 percent more likely to be HIV positive than Whites. There is some evidence that people from backgrounds where homosexuality is strongly disapproved of, such as many communities of color, are less likely to take steps to protect themselves from HIV (Gonzalez et al., 1998). Also, the higher percentage of HIV positive people in some communities of color may result in increased risk (Hallfors, et al. 2006; see also Table 3, page 8).

**Women**. Women in the target population are often single, with children, whose care places multiple demands. Childcare needs can be a barrier to accessing services. Having to support children, along with receiving lower wages than men, brings more women into poverty, which creates many issues in terms of transportation and making time available to receive services. It is counter-normative for many women, especially Latinas and African Americans, to discuss their sexual risk behavior with males. Women who are sexual partners of HIV positive men often experience a power differential making it difficult for them to decline risky behavior. This is intensified by substance abuse, which may involve exchange of sex for drugs. Most of the women in the target population report past trauma, and many suffer ongoing trauma from abusive relationships and other problems associated with substance abuse and poverty.

**How proposed approach addresses these issues.** The staff is reflective of the target population — it includes Latinos, African Americans, and women. The staff were selected for experience with the target population. The staff to be hired will have demonstrated experience with the target population and will be diverse. The staff have received, and will continue to receive, frequent training in cultural competence, gender issues, and issues of sexual identity. Two of the identified staff — program director Ramón Matos and counselor Claudia Figallo — are fluent in Spanish. Family involvement will be welcomed — not only will client’s partners be invited, but clients who are close to family members will be encouraged to bring them to sessions as appropriate. The project will employ Motivational Interviewing, which is flexible and adaptable to people from many backgrounds and has been shown to be effective with Latinos and African Americans. The project will promote linkages with other needed services, for example, our collaborator, the UCSF Women’s CoE. includes housing (Rita de Cascia) case management, childcare, and other support services for women. Our collaborator, MOCP provides case management and other social services for men. Issues of trauma (including current domestic abuse) are addressed at AHP in training and supervision. Transportation issues are addressed through having vouchers, and are minimized because the service site is located centrally on Market Street, the largest public transportation corridor. Services will be offered at no charge, not require insurance, and scheduled when clients are available. Uninsured clients will be assisted in accessing MediCal (California’s version of Medicaid) and other healthcare resources.

**Project planning, implementation and assessment will include client input.** This application assures client input via previous client focus groups, and from the advisory board, which includes consumers. The project’s further planning, implementation, and assessment will continue to include client input, both from a project-specific advisory board of African Americans and Latinos, which will include clients, and from client focus groups. The advisory board will receive reports quarterly or more often and give feedback and suggestions. In addition, semiannual client focus groups will help assess the project, providing qualitative data to facilitate interpretation of the quantitative data, as well as providing clients’ unique perspectives on the project. Finally, ongoing client satisfaction surveys (example, Appendix 2) will provide additional client input.

**Project in relation to existing service delivery system.** As discussed previously, and illustrated in Figure 6, the project will be embedded in the existing service delivery system. The applicant, AHP, is a major component of the service delivery system for people with HIV — it is San Francisco’s largest provider of HIV testing and largest provider of mental health services for people with HIV. As documented in Appendix 1, the project will be closely linked to agencies that outreach and assess people of color with substance-abuse problems but do not provide substance-abuse treatment. This includes the main HIV medical care clinic serving low-income people at the county hospital, and special-population programs and groups (Men of Color Program, Women’s CoE Clinica Esperanza, Black Coalition on AIDS, El Grupo, Black Brothers Esteem) along with other important services (Ferguson House, Forensic AIDS Project, etc.). Through being embedded in the service system, the project can access clients, leveraging the existing resources other agencies have for identifying and engaging clients. Their outreach and pretreatment components will be much more effective once ASAP Plus is funded and can meet the need they have identified (see letters) for more substance-abuse treatment resources. ASAP Plus can access in-house services for rapid HIV testing, psychiatry, case management for triply diagnosed homeless clients. This close relationship will also expedite ASAP Plus linking clients with services we do not provide, such as primary medical care, case management for clients who are not homeless, legal and financial services, and so forth.

**Participation of Other Organizations; Letters of Commitment in Appendix 1**. No other organizations will participate in terms of receiving CSAT funds or providing substance-abuse counseling services. However, the referring organizations have key roles in identifying potential clients and helping introduce them to ASAP Plus. The most important of these organizations are: UCSF Positive 360 Men of Color Program (HIV treatment, outreach, social services, case management); Women’s CoE (collaborative of women’s HIV treatment, outreach, education, housing, case management); Mission Neighborhood Health Center/Clinica Esperanza (HIV treatment, outreach, education); UCSF Positive Health Program SFGH Clinic (HIV treatment, outreach, social services); AHP other programs (HIV testing/counseling, psychiatry, Crisis Team, HIV positive support groups); Black Coalition on AIDS/Rafiki House (housing, social services); SF AIDS Foundation/El Grupo, Black Brothers Esteem (HIV positive support groups, social services, housing, and others). Following the application instructions to address this issue in various places, these organizations and their roles are discussed throughout this application.

**Implementation and Service Delivery within 4 months.** As detailed on the Timeline, Table 7, (page 17) implementation and service delivery will begin before four months after grant award. The necessary preliminary groundwork has been completed. The project director, program director, psychiatrist, two counselors, medical advisor, and evaluators have been identified and will be available immediately at the start of Month 1. The service site, 1930 Market, is identified and available. The principal referring agencies have been contacted, and have supplied data and agreed to participate (Appendix 1). The applicant organization’s identified staff have already received training in Motivational Interviewing and in administering the ASI and the GPRA. The proposed services are already being provided to the target population, but at a relatively low level; the proposed expansion builds on this work, and the existing relationships of the applicant agency, to expedite implementation and rapid service delivery.

**Potential barriers.** 1) Hiring 1.5 FTE staff who are highly qualified for the project will be a challenge, which will be addressed by a wide-ranging effort to recruit qualified Latinos and African Americans and encourage them to apply. In addition to the usual web postings and other advertising, we will network using our advisory board, existing staff, and AHP’s linkage with other organizations. Although the salaries are not generous considering area housing costs, UCSF’s excellent benefits package provides a strong incentive. 2) Especially at the start of the project, the pent-up demand for project services may make it challenging to provide the services to all the potential clients. We will address this through making groups available, referring to other agencies for supportive services while clients wait for slots, and if needed by assigning additional staff temporarily to the program. 3) Tracking clients for follow-up evaluation at the 80 percent or greater level is challenging. In our past CSAT project, we successfully addressed this with a locator form developed by the evaluators, and by training staff in follow-up techniques. We will draw on this experience in the new project.

**Sustainability.** AHP was successful in securing City and County of San Francisco funds to sustain the ACM project, which was funded by CSAT for its first three years. The approach we used, and which we will use in this project to continue the project after the funding period ends, is to operate proactively on several fronts. First, careful collection and reporting of process and outcome data (including cost data) puts the agency in the position of showing the effectiveness of the project. Second, we maintain close connections with the other service providers, so we can work together to identify gaps and assure the best mix of services, and work together to advocate for service funding. Third, we maintain ongoing communication with decision-makers (funding agency staff and elected officials) so that they understand the success of the project, and we understand their concerns and priorities. Finally, we keep a close watch on the ever-changing funding situation, so as CSAT funding comes to a close, we are positioned to phase in other funding. As we prepare for new funding, we will consider lessons learned, and modify the program design as appropriate.

**Continuity.** Program continuity will be maintained when there is a change in the operational environment (such as staff turnover) to ensure stability over time. Although the key service and management staff for this project have been at AHP for some years and have no plans to leave, the project will be prepared for changes. Many of the job descriptions, policies, procedures, and techniques are already documented, and new ones will be documented (as shown in the Timeline, page 17) for easy reference. Joint meetings of clinical and management staff assure that there is a broad base of knowledge within the program, so when any staff member leaves many other people have had the benefit of her/his experience. Quarterly reports also document lessons learned and thus aid in continuity. The budget contains funds for training each year so that new employees can be trained in Motivational Interviewing.

**Methods and approaches that will be used to reach the target population**. The target population will be identified by the primary referring agencies: UCSF Positive Care Center Men of Color Program (MOCP); Clinica Esperanza, which is the Mission Neighborhood Health Center’s HIV care program; and UCSF’s Women’s HIV Clinic. All are HIV medical care providers that serve primarily African Americans and Latinos, have the ability to identify and refer clients who need substance-abuse treatment, and have agreed to participate in the project. Each of these agencies has culturally competent, diverse teams to provide these services. Additional members of the target population will be identified through the secondary referring agencies, including AHP programs (previously listed), the Black Coalition on AIDS, USCF HIV Clinic at SFGY, SF AIDS Foundation El Grupo and Black Brothers Esteem, the Forensic AIDS Project, and others.

**Description of the methods and approaches that will be used to reach the specified target population of substance abusing people living with HIV/AIDS who are not currently enrolled in a formal substance-abuse treatment program.** This part of the application instructions essentially requests repetition of *Identification, Recruitment . . . of Target Population* (page 19). To summarize, the project will reach the population through connecting with HIV medical and support programs that serve the population, who will initially identify and then help refer the potential clients. ASAP Plus staff will be available to meet potential clients at the referring agencies on a regular basis, as well as welcome them at the AHP Service Center. Regarding how the referring agencies reach the target population, they use a variety of outreach approaches including other agency referrals and the efforts of community workers (e.g., at MOCP, “Peer Advocates;” at Women’s HIV Clinic, “Positive S.H.E. Workers;” at Clinica Esperanza, “Health Educators”) — all are culturally and linguistically competent paraprofessionals who go into the community to outreach to people of color with HIV and aid them in accessing services.

**Success in referring, engaging and retaining clients beyond substance-abuse treatment.** The ultimate goal of ASAP is that the clients fully recover and live independently. For this reason, retaining all clients beyond treatment is not an objective. For many clients, ongoing programming *is* appropriate, and a high percentage of ASAP clients — currently 31 percent — are successfully linked at the end of treatment with ongoing mental health services or substance-abuse recovery support. In addition, AHP operates support groups for people who are HIV positive, and many clients attend these, or are referred to the SF AIDS Foundation’s support groups, El Grupo and Black Brothers Esteem. (A letter from the SF AIDS Foundation is attached.) AHP also has close connections with housing providers, medical services (including, obviously, the referring agencies described in this application), and other agencies that provide ongoing services.

**Section D: Staff and Organizational Experience**

**Organizational Capability**

The AIDS Health Project, founded in 1984, is one of the oldest AIDS service organizations in the United States. It serves more than 10,000 clients per year, employs approximately 105 full- and part-time employees, and has an annual budget of about $7 million. AHP is a program of the Department of Psychiatry of the University of California San Francisco and is affiliated with San Francisco General Hospital. The AIDS programs of both of these institutions are ranked among the best AIDS programs in the United States. The mission of the UCSF AIDS Health Project (AHP) has been to provide culturally sensitive counseling and education to stop the spread of HIV infection and to help people face the emotional, psychological and social challenges of living with HIV disease. The AHPis an agency operating within the Department of Psychiatry of the University of California San Francisco, and is affiliated with San Francisco General Hospital, the county hospital. AHP provides direct mental health services to people with HIV disease and those close to them. To share our experience and magnify the effects of our expertise, we also have developed an extensive education program for mental health providers.

The AHP receives no funding from the University of California, and is primarily funded through contracts and grants from federal, state and local sources. The focus of the Project is not to conduct research, but rather to provide service and training.

As the HIV epidemic has changed, and the populations it affects has changed, AHP has adapted its service delivery and staffing. Today, AHP is involved in a complete scope of services, from public information and outreach to high-risk and ethnic communities, to the provision of intensive case management to people with HIV who have co-occurring mental illness and substance-abuse disorders. In fiscal year 2005/05, AHP provided HIV counseling and testing to 5,542 people. For those with HIV, AHP provided risk reduction counseling to 510 people; crisis services to 320 people, drug and alcohol groups for 278, outpatient substance-abuse and/or mental health services to 421, psychiatric medication evaluations to 335, and intensive case management for dually-diagnosed services to 61.

The existing **AHP ASAP project**. Founded in 1984, the AIDS and Substance Abuse Project provides the following services: weekly face-to-face individual counseling sessions, including substance-abuse counseling, and supportive counseling around psychological issues of HIV and mental health; HIV risk reduction counseling; Hepatitis B and C risk reduction counseling; support groups addressing HIV and substance use concerns; assistance in accessing medical and psychiatric care and other needed services. The project uses Motivational Interviewing techniques, and currently can serve 30 (unduplicated) clients per year. Seventy percent of the clients are people of color. The clinical supervisor of ASAP is Ramón Matos.

**Capability Providing Culturally Appropriate Services**

The AHP has extensive experience providing culturally competent substance-abuse services to people of color. We have a commitment to continuous improvement in the cultural competence of all its staff. Quarterly in-service trainings are provided to clinical staff on some aspect of cultural competence and the agency, through its annual Cultural Competence Report submitted to the San Francisco Department of Public Health, develops annual goals and objectives targeting cultural competence. AHP incorporates all Cultural and Linguistic Standards (CLAS) standards as the underpinning of its programs. We have hired a diverse staff, and we address cultural competency in regular supervision. We also closely monitor clients’ perception of cultural competency (recent results are reported below). As mentioned previously, the current ASAP program to be expanded now serves 70 percent people of color, with an African American counselor and a Latino clinical supervisor. Approximately half of the participants in the ACM program have been people of color, with one in four being African American.

**4.8 on a scale of 1 to 5**. An item on the AHP Quality Improvement survey asks clients, “How would you rate your satisfaction with your counselor’s sensitivity to your cultural needs?” and to answer from: *5. Very Satisfied* to, at the low end, *1. Very Dissatisfied*. An analysis of 2005 data from 359 clients, 32 percent of whom were people of color, found that the average rating given by people of color was 4.8 out of 5, which was the same average rating as given by all clients.

**Capability and Experience with Similar Projects and Populations**

As described earlier, the applicant organization has been providing the ASAP service since 1984 to a similar population (in recent years, 70 percent people of color). When the Ryan White CARE Act funding for ASAP was taken away, the City and County of San Francisco determined that the program was needed and was being operated by AHP effectively, so the City and County took over funding. Unfortunately, the size of the program is not sufficient to meet the need, which is why we are applying for this expansion.

**AHP ACM Project**. The Assertive Case Management project provides intensive case management, incorporating Motivational Interviewing, to individuals with co-occurring substance abuse and mental illness, are homeless or have a history of chronic homelessness, and who have accessed psychiatric emergency services three or more times in the 12 months before entry to ACM. Services include mental health and substance-abuse counseling, linkage to housing and primary care, and ongoing support to help keep clients engaged in the services they need. After three years of funding from CSAT, because of the demonstrated successful outcomes of the program, the City and County of San Francisco agreed to sustain the project with local funds in August, 2006. The ACM population, like the proposed ASAP Plus population, is made up of low-income San Francisco residents with HIV/AIDS and substance-abuse problems. The main difference is that ACM clients have more serious problems in functioning and require intensive, assertive case management. All ACM clients have co-occurring mental illness; 60 percent of ASAP Plus clients are expected to have some degree of co-occurring mental illness. ACM clients also were homeless or had a history of homelessness, and have been frequent users of mental health emergency services.

**Outcomes**. As shown on Figures 6 and 7 (next page) samples of AHP’s ACM program clients reported an increase in abstinence from alcohol and other drugs of abuse and an increase in percentage who had a current prescription for anti-retroviral medications. The 6-month follow-up rate was 86.9 percent; the 12-month follow-up rate was 73.7 percent.



Intake 6 months 12 months

% reporting abstinence

**Figure 6. Increase in percent reporting abstinence from alcohol/drugs within samples of ACM clients.** Left, 16 percent reported abstinence from AOD 30 days before intake; center, 36 percent of the same clients (N=60) reported abstinence the 30 days before 6 month follow-up. Right: 12-month FU sample (N=30) 56 percent reported abstinence in the 30 days before 12-month FU (N=25).

12-month FU group:

24% at intake

**Figure 7. Increase in percent of ACM clients who had a prescription for antiviral drugs.** 24 percent (12-month FU sample, N=25) to 42 percent (6 month FU sample, N=50) had prescriptions at intake (left). At 6 months, 64 percent had prescriptions (center), and at 12 months, 71 percent had prescriptions (right). Almost all clients said they took the medications as prescribed all or most of the time. (Figures 6 & 7: AHP, 2006).

% reporting antivirals

12-month FU group:

24% at intake

Intake 6 months 12 months

**12-month FU group:**

**24% at intake**

12-month FU sample at intake

% reporting antivirals

**Capability and experience of other participating organizations with similar projects and populations and in providing culturally appropriate services.** There are no “participating organizations” in the usual sense, that is, no other organizations are receiving CSAT funds from this project or are providing substance-abuse treatment. The primary referring organizations are important in the project because they help identify and recruit clients. The main HIV clinics that will refer are the UCSF *Men of Color Program*, Mission Neighborhood Health Center’s *Clinica Esperanza* program, and UCSF *Women’s HIV Clinic*. Referrals will also be made by other community agencies such as the Black Coalition on AIDS, the Forensic AIDS Project, and the SF AIDS Foundation through its El Grupo and Black Brothers Esteem programs. All of these agencies are culturally competent and already work with the target population and identify and refer them to other agencies, including AHP.

**Description of past evaluation efforts with similar populations.**All AHP projects are evaluated by means of client surveys; additional evaluation depends on the particular project. The evaluation effort most similar to that proposed in this application was the evaluation during the CSAT-funded period of the ACM project. Like the evaluation proposed in this application, the outside evaluators were Allen/Loeb Associates, who have other experience conducting evaluations of CSAT HIV projects for African Americans and Latinos. The evaluation used CSAT’s GPRA instrument, and developed a local survey, which is included in the proposed evaluation. Qualitative data were collected through client focus groups and staff interviews. A cost study was done and showed dramatic reduction in psychiatric inpatient and emergency costs for clients in the year after entering the program. The evaluation also revealed increases in housing stability and decreases in use of alcohol and illegal drugs, which were noted at six months and maintained or increased at 12 months. Based on our experience, we know the importance of close involvement and regular communication between evaluation team and staff, and the value of ongoing discussion of cultural competence in the design of evaluation instruments and the interpretation of data.

**Linkages to the Target Population and Ties to Organizations**

The AHP is an active participant in the San FranciscoCARE Council, which is 40 percent people with HIV/AIDS and is racially and ethnically diverse. The AHP has its own Community Advisory Board whose membership is representative of the San Francisco community, including African Americans and Latinos, and 20 percent are consumers (former or current clients who are HIV positive).

AHP also maintain close ties with community-based groups; we work side-by-side with them we work AIDS and, in the Mission district, Clinica Esperanza (both are participating in this project, and their letters are included in the appendix). We also maintain close relationships with community-based groups through asking them to provide staff training. For example, last year, Bishop Yvette Flunder of the Ark of Refuge, a community-based church and religious educational organization, conducted two in-service trainings for AHP staff on HIV and the African-American community. Probably our most important linkages to the different racial/ethnic communities in San Francisco are the full-time AHP management and service-provision staff, which includes people who are Latino, White, African-American, Asian, and Pacific Islander.

The AHP maintains close working and organizational ties to other groups, including other University of California, San Francisco programs. UCSF, with its medical school and treatment facilities, has been a leader in provision of HIV services to low income people since the start of the epidemic. As discussed previously, AHP works closely with the UCSF Positive 360 program Men of Color Program, which serves men of color and is led by men of color, including medical director Dr. Malcolm John who will serve as medical advisor to the project. MOCP conducts outreach groups for men of color using AHP’s facility at 1930 Market (the proposed project site) and relies on AHP for psychiatric assessment services. The MOCP will participate in the proposed project, as Dr. John’s letter confirms (Appendix 1). The Women’s CoE in HIV Care is the primary provider of HIV services to low income women, and the great majority (77 percent) of their patients are African American and Latino. AHP has an ongoing relationship with the Women’s CoE, which will be a primary referral agency in the proposed project (letter, Appendix 1).

The Mission Neighborhood Health Center’s HIV clinic, Clinica Esperanza, is an important treatment resource for Latino men and women with HIV, and maintains a strong linkage with AHP especially for culturally appropriate substance-abuse treatment and psychiatric services. Clinica Esperanza will be one of the referring agencies to ASAP Plus.

The largest clinic for low-income people with HIV is the UCSF Positive Health Program HIV Clinic at SFGH HIV Clinic at Ward 86. AHP currently provides psychiatric services on-site at Ward 86, and has a long history of providing services in collaboration with Ward 86, which will participate in the proposed project (Appendix 1).

The AHP is a member of the AIDS Services Partnership with the San Francisco AIDS Foundation (SFAF) which sponsors El Grupo, a support and health promotion group for Latinos with HIV, and Black Brothers Esteem, a support and health promotion group for African American men with HIV. The SFAF will participate in the project as will the Mission Neighborhood Health Center (see letters, Appendix 1).

**Staffing Roles, Level of Effort, and Qualifications**

Project Director, James W. Dilley, MD, 5 percent time in-kind. Dr. Dilley will direct the project overall, including assigning the staff and space, overseeing the implementation of the project, helping staff address clinical issues, ensuring compliance with all SAMHSA requirements. Dr. Dilley is Clinical Professor of Psychiatry at the UCSF School of Medicine. He has been the executive director of the AIDS Health Project since 1984 and has managed many similar grant-funded service projects, including the CSAT-funded ACM program from 2003 to 2006.

Program Director, Ramón Matos, MA, 60 percent time. Mr. Matos will supervise the day-to-day operations of the ASAP Plus program, including documenting methodology and procedures, training and supervising staff, and interfacing with other agencies. Mr. Matos has fifteen years’ experience developing, managing, and improving social-service programs. He has a Master of Arts degree in clinical psychology and has been working for the AHP as clinical supervisor of ASAP since 2002. He is trained and experienced in utilizing Motivational Interviewing and is familiar with project instruments including the GPRA and the ASI. Mr. Matos is bicultural Latino/Anglo and bilingual Spanish/English.

Substance-Abuse Counselor, Erric White, 100 percent time. Mr. White will provide substance-abuse counseling utilizing Motivational Interviewing, along with service planning, linkage to needed services, and intake and follow-up data collection. Mr. White will administer the GPRA and other instruments. Mr. White has been an ASAP counselor and a case manager at AHP since March of 2000. He has received extensive training while at AHP in cultural competence, case management, Cognitive Behavioral Therapy, and Motivational Interviewing, and is familiar with project instruments including the GPRA and the ASI. Prior to coming to AHP he was a counselor, substance-abuse counselor, and program coordinator at Ferguson Place, a residential facility for people with substance-abuse problems and HIV. Mr. White is African American.

Substance-Abuse Counselor, Claudia Figallo, 100 percent time. Ms. Figallo will provide substance-abuse counseling utilizing Motivational Interviewing, along with service planning, linkage to needed services, and intake and follow-up data collection. She will administer the GPRA and other instruments. Ms. Figallo is bicultural and is fluent in English and Spanish. She has been providing substance-abuse counseling and case management to multiply diagnosed individuals at AHP since 2003. She has received extensive training while at AHP in cultural competence, Cognitive Behavioral Therapy, and Motivational Interviewing. Ms. Figallo has considerable experience providing services for substance abusers, especially IDUs, and working in programs for children and women. She is familiar with project instruments including the GPRA and the ASI.

Substance-Abuse Counselors, 1.5 FTE, to be hired will provide substance-abuse counseling utilizing Motivational Interviewing, along with service planning, linkage to needed services, and intake and follow-up data collection. Qualifications will include proven effectiveness and experience serving the target population. People of color and bilingual bicultural individuals will be proactively recruited and strongly encouraged to apply. New hires will be trained in Motivational Interviewing and administration of the GPRA and ASI as necessary.

Receptionist/Data Entry, Chantal Salkey, 50 percent time. Ms. Salkey will be responsible for greeting clients and assisting clients in getting to the AHP Services Center and connecting clients with their counselors. The receptionist assists clients in speaking with their counselor in person whenever possible, thus decreasing the likelihood of client dropout. Ms. Salkey will also provide administrative support for the project and will work closely with the program director to assure that GPRA forms are distributed, collected, and input in a timely manner. Ms. Salkey will devote 50 percent effort in each year of the project. Ms. Salkey is African-American.

Medical Advisor, Malcolm John, M.D., 5 percent time in-kind. Dr. John will advise on medical issues pertaining to clients referred from the Men of Color Program. He will also advise on general HIV medical issues as time permits. Dr. John is an experienced HIV primary care provider and the medical director of the UCSF Positive 360 Men of Color Program. Dr. John is African American.

Team Psychiatrist, George Harrison, M.D., 10 percent time. Dr. Harrisonwill serve as psychiatrist for the project. Dr. Harrison is a board-certified psychiatrist with a specialty in HIV issues. Dr. Harrison is the medical director of UCSF AIDS Health Project. For the proposed project, his duties will include psychiatric assessment, medication management, and clinical consultation.

Contractor: Allen/Loeb Associates. Evaluators Tim Allen and Peter Loeb, at a total level of 444 hours per year (37 hours per month), will conduct the evaluation, supervising the collection, analysis, and interpretation of GPRA and local data, including qualitative data. They will train staff on data collection, including follow-up techniques; prepare GPRA and other evaluation reports, attend project meetings, observe the project on site, and attend the grantee meetings. Allen and Loeb have been evaluators on similar SAMHSA projects, including two CSAT-funded projects in San Mateo County, California, for African American and Latino substance abusers at-risk for HIV, and the recent CSAT-funded Assertive Case Management project for homeless people at AHP.

Advisory Board. Although the advisory board will not be staff, they will have an important role in the project and be compensated for each meeting. Two African American and one Latino members of AHP’s overall advisory board have volunteered to be the nucleus of a program-specific ASAP Plus advisory board. They will advise on cultural competence and, because some of the members will be consumers, will also offer the consumer perspective to supplement the client focus groups and Quality Improvement surveys. The first task of the advisory board will be to help us consider the name “ASAP Plus.” Another name might be more effective. The advisory board will also have ongoing input into the planning, implementation, and evaluation of the project. AHP’s advisory board members are normally not compensated except to facilitate the participation of consumers, most of whom are low income. Especially in the case of women raising children, they may not have a great deal of extra time to volunteer.

**Staff experience and familiarity with cultures of target population.** The proposed staff are familiar with the target population through many years of experience at the existing ASAP project as well as through providing similar services in other programs (see biographical sketches for more details). Project director Jim Dilley, program director Ramón Matos, and counselor Erric White have all filled these roles in the existing ASAP, which serves the target populations (70 percent African American or Latino). Counselor Claudia Figallo has served the target populations in AHP’s ACM program, among others. Mr. White is African American, and Mr. Matos and Ms. Figallo are Latino, which has helped familiarize them with the cultures of the population. Project psychiatrist George Harrison has worked closely with the target population in ASAP, ACM, and other AHP projects. Evaluators Tim Allen and Peter Loeb have provided direct service to the target population before becoming evaluators, and been evaluating projects serving the target population for over twenty years, including served as evaluators on AHP’s ACM project, and on two CSAT projects for African Americans and Latinos at risk of HIV in nearby San Mateo County. All of the members of the team, including the evaluators, regularly participate in cultural competency training.

**Target population is multi-linguistic; staffing pattern includes bilingual and bicultural individuals.** Program director Ramón Matos and counselor Claudia Figallo are both bicultural Anglo/Latino and bilingual English/Spanish. Additional bilingual bicultural people will be proactively recruited and strongly encouraged to apply.

**Resources, facilities, and equipment.** ASAP Plus will be located at the AHP Service Center at 1930 Market. This central location (shown on Figure 1, *Section A*) is centrally located, near where many low-income people congregate, and is easily accessed by public transportation, including the underground trains and Market Street buses. The Service Center includes private and group meeting rooms, and includes computers, fax machines, copier, and other needed equipment. The Service Center is ADA compliant, and has proved acceptable to members of the target population, as shown by the Client Satisfaction survey data.

**Section E: Performance Assessment and Data**

**Ability to collect and report on the required performance measures.** AHP has previous successful experience in collecting, entering, and reporting GPRA data. AHP has used GPRA data to report performance in the domains of clients’ substance use, family and living condition, employment status, social connectedness, access to treatment, retention in treatment, and criminal justice status in our “Assertive Case Management for Triply Diagnosed Persons” (ACM), which served HIV positive people who had co-occurring substance-abuse and mental health disorders and a history of homelessness. Staff have received GPRA training and have collected intake, discharge, and 6-month follow-up GPRAs and entered the GPRA data on the web site. AHP staff have also achieved the 80 percent GPRA follow-up rate or better. The evaluator, Allen/Loeb Associates, has extensive experience aiding grantees in using the GPRA tool, including training staff, designing locator forms, setting up data collection protocols, and producing reports of the data for feedback to the project. Allen and Loeb were the evaluators on the ACM grant, and now serve as evaluators on Door to Treatment, a CSAT HIV TCE in San Mateo County that outreaches, engages, and treats Latinos and African Americans at risk of HIV. Door to Treatment’s follow-up rate exceeds 80 percent. Allen and Loeb have served as evaluators in prior CSAT projects in Northern California that used the GPRA data collection tool, all of which achieved the 80 percent follow-up rate or better.

**Plan for Data Collection, Management, Analysis, and Reporting**

**Data collection.** GPRA data will be collected in a face-to-face interview at baseline (intake into the project), 6 months after intake, and at discharge. Project staff will administer intake instruments, including CSAT’s GPRA. Typically the baseline GPRA will be collected by the treatment staff immediately after assessment indicates that the client meets the entry criteria and is accepted into the project. Follow-up GPRAs will be administered by the project staff. All staff administering the GPRA will be trained by the evaluation team to maximize reliability, as well as receiving CSAT’s official GPRA training. All staff administering the ASI will be trained by certified trainers. To compensate individuals for their time completing follow-up instruments, and to participate in focus groups, the project will give participants twenty dollar certificates redeemable for groceries or fast food. Clients who do not wish to participate in evaluation data collection will have access to all services of the project, including food.

**Data management.** GPRA data will be entered into CSAT’s GPRA Data Entry and Reporting system via the internet within 7 business days of the forms being completed. Data will be entered by project staff, with supervision by the program director and technical assistance of the evaluation team. The evaluation team will collect the quantitative data from the GPRA site, and via e-mailed files or CD from the site. The evaluator will collect data from the County after it is stripped of identifying information. The data will be entered into the project database. Identifying numbers rather than names will be used in data sets transferred off site.

**Analysis and reporting.** The data will be analyzed and reported in detail to the project team and to CSAT. The evaluation team will produce reports on 1) project demographics, substance-abuse history, HIV risk behaviors, and other characteristics of interest, and 2) service amount and patterns, including referral patterns. The data will also support investigation into correlations of outcomes by service type and amount, and other characteristics. For example, the evaluation team will investigate outcome’s relation to race/ethnicity; if outcomes are found to be less for some populations, the project may need additional improvement in cultural competence. Should such results be found, then further investigation, including comparing results while controlling for substance-abuse history and other potential confounding variables, will be undertaken and the results reported to the project team — including the advisory board — and CSAT.

**Interpretation.** Interpretation will be made by the project team with input from the evaluators, and from focus groups. The qualitative data — especially the input of advisory board and focus groups — will provide an important perspective, helping the team understand not just what happened, but why, and suggesting approaches for improving the project. Reports of the interpretations will be made to the project team, the community, and CSAT.

**Additional measures or instruments.** Additional measures and instruments will include the Addiction Severity Index (ASI), management information system data, review of client charts, and client focus groups. The additional instrument proposed, the ASI, is justified because the psychometric properties of the GPRA, including reliability and validity, have not been assessed and the ASI has been extensively normed and validated for African Americans and Latinos. Review of client charts, and the use of a local survey asking about risk behaviors and antiretroviral and psychiatric medication use are justified as these data sources provide additional information not captured in the GPRA and ASI, including compliance with medication regimens, diagnoses, treatment plans, length of treatment, services received, and referrals to other services. Focus groups are justified as this source of qualitative data is the best way to collect feedback from service recipients regarding the project and how it is delivering services to them and how the project can be improved to better address their needs. Particular areas of interest that will be addressed in the focus groups are the cultural competence of the project and client satisfaction with project services.

**Quantitative Goals and Objectives**

**Number of individuals to be served.** The numbers of individuals to be served is 410 unduplicated clients over the course of the 5 years of the project – 70 in year 1, 90 individuals per year in years 2 through 4, and 70 in year 5. This number equates to 20.5 individuals per quarter over the 5 years of the project.

 **Types and numbers of services to be provided.**

1. Substance-abuse counseling using Motivational Interviewing – at least 410 participants over 5 years,
2. Rapid HIV testing – offered to all participants injection equipment-sharing/sexual partners, estimated as 200 over 5 years,
3. Risk reduction services – 410 project participants over 5 years,
4. Linkage with medical services, as needed – estimated 50–100 over 5 years,
5. Case management into needed services – available as needed to 410 project participants over 5 years
6. Psychiatric services: assessment, prescription of medication, and medication management — estimated five-year total of 260 assessments and 180 clients receiving medication and medication management.

**Quantitative outcome objectives.** (For detail on measures used, see Table 6, page 10.)

1. Reduced illegal drug use. At least 30 percent to become abstinent, at least 50 percent to reduce days of illegal drug use.2. Improved mental health. 70 percent of clients with co-occurring mental illness to improve at least .2 on the ASI psychiatric composite index.3. Reduced alcohol use. At least 30 percent of clients who abuse alcohol to become abstinent; at least 60 percent reduce days of use. 4. Maintain or increased access and adherence to antiretroviral regimens. 100 percent of HIV positive clients who have not been assessed for antivirals to be referred for this; of clients that have prescription, at least 80 percent will report using the medication as prescribed “all or almost all the time.” 5. Reduced HIV transmission behavior. Of those reporting needle sharing or serodiscordant unprotected sex, at least 50 percent will report reduction. 6. Increased self-sufficiency including employment, legal income; at least 50 percent to report improvement in employment or income. 7. Improved social support and functioning, including housing status and social connectedness. At least 60 percent with substandard housing will show improvement in housing status; percent of clients in GPRA report scored as not “socially connected” to decline by 50 percent.

**Appropriateness of Outcome Measures**

# Reliability and validity.The outcomes will be evaluated using the GPRA tool, the Addiction Severity Index (ASI), review of client charts, and focus groups. The ASI is used because it is the most widely used standardized instrument for client screening, determining treatment needs, and assessing treatment outcomes. It has been normed on a variety of client samples, including different racial/ethnic groups and clients in inpatient, partial hospitalization, and outpatient treatment programs. The ASI is also translated into several languages, including Spanish. Previous researchers have evaluated inter-rater agreement, test-retest reliability, and concurrent validity. The ASI has been shown to have high reliability and validity, and stability of scores in longitudinal work (Stoffelmayr, Mavis, and Kasim, 1994). “The ASI is probably the most thoroughly developed and researched instrument available for intake assessment, tracking of clients in treatment, and treatment outcome evaluation” (Friedman and Granick, 1994). The validity of any instrument depends on the context of its use and how it is interpreted. Through the use of the GPRA data and client chart data, the evaluation will have the benefit of another perspective on behavioral change. Qualitative data, obtained from client focus groups will provide a larger context, improving the validity of interpretations made of the quantitative data.

**Sensitivity to age, gender, sexual orientation, culture, language, disability, literacy, and racial/ethnic characteristics of the target population.** The sensitivity to these many characteristics comes in part from the measure, but it also depends on who administers it and how they administer it. The cultural competence, race/ethnicity, gender, and overall empathy of the person who administers a survey affects how the respondent feels and answers. For this reason, the service team that administers the instruments is multi-ethnic, linguistically competent in both English and Spanish, and includes people of both genders.

The approach of the interviewer will adapt to reflect the participant being interviewed in terms of language and culture, race/ethnicity, gender, and sexual orientation. We anticipate that many female clients may not be comfortable disclosing sexual risk behaviors to male interviewers, and so female interviewers will be made available. All interviewers will have received cultural competence training and will be trained to be sensitive to issues of culture, sexual orientation, disability, and working with persons with low or no literacy.

When helpful, the project will use Spanish versions of the GPRA measure and the ASI. These and the other instruments (local survey, Quality Improvement survey) have been acceptable to Latino and African American people receiving services at AHP.

**How data will be used to manage the project and assure continuous quality improvement.** Evaluation data will be used to manage the project by preparing monthly reports of the data and presenting them to the project team, including the advisory board, and preparing quarterly and annual reports of the data for presentation to the project team and to CSAT. These data will be used to identify areas needing attention and preparing action plans to address emerging problems such as not meeting the intake or follow-up rate targets, issues such as staff turnover, client retention, and not meeting quantitative process or outcome objectives. These data will also be shared with the AHP’s Quality Improvement Program. The project team, the evaluators, and the Quality Improvement program director will collaborate to assure continuous quality improvement.

**Plan for conducting the performance assessment.** As noted above in *Plan for data collection, management, analysis, and reporting*, the plan for conducting the performance assessment is that project staff will administer the GPRA, local survey, and the ASI to the project participants at intake, 6-month follow-up, and discharge. Typically the baseline GPRA will be collected by the treatment staff immediately after assessment indicates that the client meets the entry criteria and is accepted into the project. Follow-up GPRAs will be administered by the project staff. All staff administering the GPRA will be trained by the evaluation team to maximize reliability. GPRA data will be entered into CSAT’s GPRA Data Entry and Reporting system via the internet within 7 business days of the forms being completed. Data will be entered by project staff, with supervision by the program director and technical assistance of the evaluation team. The evaluation team will collect the quantitative data from the GPRA site. The data will be analyzed and reported in detail to the project team and to CSAT as required. The evaluation team will produce reports on 1) project demographics, substance-abuse history, HIV risk behaviors, and other characteristics of interest, and 2) service amount and patterns.

**Process evaluation.** The process evaluation will track the implementation of the project components and document the project activities, barriers encountered and how they were overcome, and services delivered. The process evaluation will give an exact count of the number of persons served by the project and their demographics, as well as the quantitative process objectives (Table 5, page 10). This will enable the project to identify and solve implementation problems and track the quantity of services provided. Close attention to demographics will help ensure that the program is providing services to the whole range of the target population; investigation of outcomes by demographic characteristics will also be a check on the cultural competence of the project. The evaluation will provide regular feedback to the project to improve services. The evaluation team will produce semi-annual reports on 1) the project demographics, substance abuse, HIV risk behaviors, and other characteristics of interest, 2) service amount and patterns, including referral patterns, and 3) outcomes as related to project objectives. The data will also support investigation into correlations of outcomes by service type and amount, and other characteristics.

**Assessment of implementation.** The process evaluation will assess how closely project implementation matched the project plan in the application, what types of deviation from the plan occurred, what led to the deviations, and what effect the deviations had on the planned intervention and evaluation. The evaluation team will interview project staff, attend project team meetings, and review other project documents. This will enable the evaluation to document, through narrative report, the development and implementation of the services and the evidence-based practice. Process evaluation reports will also describe barriers encountered in project implementation and delivery of services and how they were overcome.

**Outcome evaluation.** The outcome evaluation will assess the effects of the outpatient substance-abuse treatment services and motivational interviewing in terms of clients’ substance-abuse and HIV risk behaviors, as well as employment, housing status, health/behavioral/social consequences of substance use, social connectedness, and criminal justice status. The outcome evaluation will also assess the program/contextual factors that are associated with the outcomes, and the individual factors associated with outcomes. Durability of effects will be assessed by analyzing change from baseline to discharge and 6-month follow-up.

**Assessment of individual outcomes.** The outcome evaluation will assess individual outcomes using the GPRA tool, the Addiction Severity Index, and clinical review of client charts. The primary outcomes, as expressed in the objectives, are changes in substance abuse (abstinence) and changes in HIV risk behaviors. Outcomes will be assessed at discharge and 6-month follow-up and analyzed by comparing discharge/follow-up data to baseline data to determine achievement of the outcome objectives, and to analyze individual outcomes by other variables such as client characteristics (demographics, diagnosis, primary drugs of abuse, etc.), and length of receiving services.

Treatment effectiveness. The outcome evaluation will assess treatment effectiveness using GPRA and ASI tools, and confirming quantitative data by interviews with project staff and chart review. The primary outcome objective will be reduced alcohol and drug use, but the outcome evaluation will also examine data with regard to changes in physical and mental health status, changes in self-sufficiency including employment, legal income, and public assistance status, and changes in social support or functioning including family and social relationships, living arrangements, and legal status.

**Treatment efficiency.** The outcome evaluation will assess treatment efficiency using the GPRA and ASI, and project records. Treatment efficiency will be evaluated by analyzing client data with regard to services utilization, retention in treatment, and treatment completion.

**Ability to conduct the assessment.** AHP staff are familiar with the GPRA and ASI instruments and have experience administering them. They also have experience conducting follow-up interviews and data collection, and entering GPRA data on the GPRA web site. As noted above under *Ability to collect and report on the required performance measures*, the AHP has previous successful experience in collecting, entering, and reporting GPRA data. The evaluators also have extensive experience conducting performance assessments for other CSAT grantees using the GPRA tool. Allen and Loeb were the evaluators on the AHP’s ACM grant, and now serve as evaluators on Door to Treatment, a CSAT HIV TCE in San Mateo County that outreaches, engages, and treats Latinos and African Americans at risk of HIV.

**Per-person unit cost of the project.** Per the instructions in the announcement, the per-person cost is calculated as the total support requested for the life of the project multiplied by .8 (.2 is the allowance for GPRA reporting requirements) and the resulting amount is then divided by the number of persons to be served over the life of the project. The total 5-year budget is $2,499,960; 80 percent of that amount is $1,999,968. Dividing 80 percent of the total 5-year budget by 410, the minimum number of clients to be served over 5 years, yields a per-person cost of $4,878. This is within the reasonable range as stated in the announcement for the Outpatient treatment modality – $1,000 to $5,000. Given the complex treatment needs of the target population and the intensive services that will be provided by the counselors, this per-person cost is reasonable.

**Section F: Literature Citations**

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**Section G: Budget Justification, Existing Resources, Other Support**

Year One Budget

|  |  |
| --- | --- |
| Personnel | 247,483 |
| Fringe Benefits (27%) | 66,820 |
| Travel | 4,000 |
| Equipment | 3,600 |
| Supplies | 6,975 |
| Contractual | 39,960 |
| Other | 27,975 |
| Total Direct Costs | 396,813 |
| Indirect (26% of direct) | 103,171 |
| TOTAL | $499,984 |

###### PERSONNEL

|  |  |  |  |
| --- | --- | --- | --- |
| Job Title | Name | % Time | Salary |
| Project Director | James W. Dilley, MD | 5% | In Kind |
| Medical Director | Malcolm John, MD | 5% | In Kind |
| Team Psychiatrist | George Harrison, MD | 10% | $16,600 |
| Program Director | Ramón Matos, MA | 75% | $53,955 |
| Substance-Abuse Counselor | Erric White | 100% | $46,436 |
| Substance-Abuse Counselor | Claudia Figallo | 100% | $46,436 |
| Substance-Abuse Counselor | TBH | 100% | $46,436 |
| Substance-Abuse Counselor | TBH | 50% | $21,283 |
| Receptionist | Chantal Salkey | 50% | $16,337 |
| Salary subtotal |  |  | $247,483 |
| Fringe @ 27% |  |  | $ 66,820 |
| Total personnel |  |  | 247,483 |

**Fringe Benefits:** The University sets the fringe rate for staff at 27 percent of salary.

##### James W. Dilley, MD — Project Director

Dr. Dilley is the executive director of the UCSF AIDS Health Project. For the proposed project, Dr. Dilley will assume overall responsibility for the clinical and scientific performance of the project. In this capacity, he will coordinate the development and overall program design; oversee the collection, analysis and interpretation of project data; and assist in the dissemination of the project findings. He will oversee all aspects of the project, including the finalization of the assessment measures, recruitment of clients and provision of services, data analysis strategies, and preparation of manuscripts. He will also maintain the liaison relationship with SAMHSA. No salary is requested for Dr. Dilley’s efforts, which are provided in kind. Dr. Dilley will devote 5 percent of his effort to the project.

Malcolm John, MD — Medical Advisor

Dr. John is the medical director of the Men Of Color program of the UCSF Positive Health Project. He will provide medical consultation regarding patients of the Men of Color program who are referred to the ASAP+ project, including weekly case conferences at the Men Of Color program and conferences via phone or e-mail. No salary is requested for Dr. John’s efforts, which are provided in kind. Dr. John will devote 5 percent of his effort to the project. Dr. John is African-American.

Ramón Matos, MA — Program Director

Mr. Matos is a master’s level social worker with the AIDS Health Project and has worked on clinical service projects delivering services for patients/clients with triple diagnosis, HIV, substance, and mental health disorders. He will work with Dr. Dilley in developing clinical protocols and will be responsible for the day-to day-operation of the Behavioral Health Case Management Program and supervision of the counselors/case managers. Mr. Matos will devote 75 percent effort to the project. Mr. Matos is Latino.

George Harrison, MD — Team Psychiatrist

Dr. Harrisonwill serve as psychiatrist for the project. Dr. Harrison is a board-certified psychiatrist with a specialty in HIV issues. Dr. Harrison is the medical director of UCSF AIDS Health Project. For the proposed project, his duties will include psychiatric assessment, medication management and clinical consultation. His level of effort will be 10 percent.

Erric White\_— Substance-Abuse Counselor

Mr. White will provide substance-abuse counseling utilizing Motivational Interviewing, along with service planning, linkage to needed services, and intake and follow-up data collection. Mr. White will administer the GPRA and other instruments. Mr. White will begin his efforts (100 percent) in month one of the project and continue for the duration of the project. Mr. White has been an ASAP counselor and a case manager at AHP since March of 2000. He has received extensive training at AHP in cultural competence, case management, Cognitive Behavioral Therapy, and Motivational Interviewing. Prior to coming to AHP he was a counselor, substance-abuse counselor, and program coordinator at Ferguson Place, a residential facility for people with substance-abuse problems and HIV. Mr. White is African-American.

Claudia Figallo\_— Substance-Abuse Counselor

Ms. Figallo will provide substance-abuse counseling utilizing Motivational Interviewing, along with service planning, linkage to needed services, and intake and follow-up data collection. She will administer the GPRA and other instruments. Ms. Figallo is bicultural and is fluent in English and Spanish. She has been providing substance-abuse counseling and case management to multiply diagnosed individuals at AHP since 2003. She has received extensive training at AHP in cultural competence, Cognitive Behavioral Therapy, and Motivational Interviewing. Ms. Figallo has considerable experience providing services for substance abusers, especially IDUs, and working in programs for children and women. Ms. Figallo will begin her efforts (100 percent) in month one of the project and continue for the duration of the project. Ms. Figallo is Latina.

Substance-Abuse Counselor — to be hired

This position will provide substance-abuse counseling utilizing Motivational Interviewing, along with service planning, linkage to needed services, and intake and follow-up data collection, and will administer the GPRA and other instruments. The counselor will be 100 percent time and begin in month one of the project and continue for the duration of the project.

Substance-Abuse Counselor — to be hired

This position will provide substance-abuse counseling utilizing Motivational Interviewing, along with service planning, linkage to needed services, and intake and follow-up data collection, and will administer the GPRA and other instruments. The counselor will be 50 percent time and begin in month two of the project and continue for the duration of the project.

Receptionist/Data Entry Clerk — Chantal Salkey

Ms. Salkey will be responsible for greeting clients and assisting clients in getting to the AHP Services Center and connecting clients with their counselors. The receptionist assists clients in speaking with their counselor in person whenever possible, thus decreasing the likelihood of client drop out. Ms. Salkey will also provide administrative support for the project and will work closely with the program director to assure that GPRA forms are distributed, collected and input in a timely manner. Ms. Salkey will devote 50 percent effort in each year of the project. Ms. Salkey is African-American.

OPERATING EXPENSES

**Travel.** Funds are allocated for the program director, and program director to attend annual CSAT mandatory meetings. Allocations in the travel category include round-trip airfare, per diem, overnight accommodations and ground transportation, projected as $2000 per person per trip (round trip airfare SFO to Washington DC - $900, 4 nights lodging - $800, four days meal/per diem - $200, ground transportation - $100). We are requesting $4,000 in year one, increasing to $6,000 in years two through five to allow for an additional staff person to attend each year.

##### **Equipment.** Desktop computers are necessary for data entry, client record keeping, project communication, and general office procedures. Three Dell PCs, a printer, and Windows XT software @ $1,200 per unit = $3,600 will be required in year one.

**Supplies.** Routine office and computer supplies will be purchased including program specific office expenses such as paper, desk and file supplies, clerical pool expense, miscellaneous publications, business cards/stationery, office equipment, printing, preparation of slides for presentations, purchase of journal article reprints and other related expenses. Program expenses will also include materials and food and beverages for client focus groups. Postage will be necessary to communicate with clients as well as with other interested groups. Educational supplies and software upgrades will also be purchased. Other required supplies include a file cabinet for the storage of data and the rental fees of office equipment. Photocopying can be performed at the AIDS Health Project. We are requesting $6,975 in each year of the project (general office supplies - $2,850, equipment rental - $1,675, postage - $1,050, program expenses - $1,400).

**Contractual.**

Program Evaluation. The evaluation will be conducted by an outside evaluator, Allen/Loeb Associates. Their staff will be Tim Allen and Peter Loeb, who have extensive experience evaluating SAMHSA projects, including other CSAT-funded projects for African American and Latino substance abusers at-risk for HIV. Cost of the evaluation is figured at an average of 37hours per month at $90 per hour = $39,960 per year. Evaluator's travel is covered as part of the annual cost.

**Other**

###### Occupancy (Rent and Utilities): This project requires office space for the project staff. Due to severe space limitations new UCSF projects are housed off-campus. Thus, space rental is a direct cost. Included is rental of office space, utilities (not telephone), building maintenance, and other occupancy expenses. Staff will be housed at the AHP Services Center. Costs are allocated by square foot usage per program. The site is near clients and has private offices available for interviews as well as a reception area and room suitable for daily group meetings. Occupancy costs are calculated as $3500 per FTE. Total compensated FTE’s are 4.85 x $3,500 = $16,975 for occupancy in each year of the grant.

Telephone: We are requesting dedicated telephone lines for the program director, the receptionist, and the counselors. Telephone expenses include installation fees, long-distance costs, voicemail-related charges and dedicated phone lines for staff to assist them in doing client work. Telephone costs are projected as $2,750 per year.

Staff training. Project staff will receive will receive training in GPRA data collection, Motivational Interviewing, and other professional development trainings. The year one budget for training is projected as $2,250; ongoing staff training is allocated $1,000 in each of years two through five.

Honoraria. Community Advisory Board members will receive honoraria of $75 per meeting. Five meetings are projected in year one — a project kickoff meeting and four quarterly meetings, with quarterly meetings though years two to five. Eight Community Advisory Board members at five meetings = $3,000 in year one; eight members and four meetings = $2,400 in years two through five.

GPRA Data Collection Incentives. Participating in follow-up evaluation requires a substantial time commitment and reimbursement has been shown to be an effective measure in securing completion of program evaluation instruments. The reimbursement schedule will provide $20 worth of fast food or grocery certificates for the completion of the evaluation instruments, including GPRA, at six month follow-up and discharge. These funds are projected as $3,000 in year one (75 clients x $40) and $4,000 in years two through five (100 clients x $4,000).

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| OTHER | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
| Occupancy  | 16,975 | 16,975 | 16,975 | 16,975 | 16,975 |
| Telephone | 2,750 | 2,750 | 2,750 | 2,750 | 2,750 |
| Staff training | 2,250 | 1,000 | 1,000 | 1,000 | 1,000 |
| Honoraria | 3,000 | 2,400 | 2,400 | 2,400 | 2,400 |
| GPRA incentives | 3,000 | 4,000 | 4,000 | 4,000 | 4,000 |
| TOTAL OTHER | 27,975 | 27,125 | 27,125 | 27,125 | 27,125 |

###### **Indirect.** The approved University of California “other sponsored project” rate is 26 percent of all direct costs. This amount is $103,171 in year one and $103,173 in years two through five.

**Five-year budget for entire project.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
| Personnel | 247,483 | 249,418 | 249,418 | 249,418 | 249,418 |
| Fringe Benefits | 66,820 | 67,343 | 67,343 | 67,343 | 67,343 |
| Travel | 4,000 | 6,000 | 6,000 | 6,000 | 6,000 |
| Equipment | 3,600 | 0 | 0 | 0 | 0 |
| Supplies | 6,975 | 6,975 | 6,975 | 6,975 | 6,975 |
| Contractual | 39,960 | 39,960 | 39,960 | 39,960 | 39,960 |
| Other | 27,975 | 27,125 | 27,125 | 27,125 | 27,125 |
| Total Direct Costs | 396,813 | 396,821 | 396,821 | 396,821 | 396,821 |
| Indirect | 103,171 | 103,173 | 103,173 | 103,173 | 103,173 |
| TOTAL Direct and Indirect | $499,984 | 499,994 | 499,994 | 499,994 | 499,994 |

**Section H: Biographical Sketches and Job Descriptions.**

Job Description

**Project Director at .05 % FTE:** James W. Dilley, MD

Dr. Dilley will provide oversight for all project activities. In this capacity, he will coordinate the development and conduct of the proposed work, supervise the collection, analysis, and interpretation of the project’s data, and assure the dissemination of the study’s findings to the professional and scientific community. He will work closely with the program director to ensure all facets of the project are completed according to Request for Applications (RFA) requirements. Dr. Dilley will attend the mandatory annual technical assistance meeting and present the results of the project.

• Will oversee the design and maintenance of a database to collect and store program evaluation and case specific data.

• Will provide leadership and oversight in writing and publishing the findings from data gathering and evaluation activities.

* Will assure contractual obligations are met and work with the evaluators to disseminate findings.
* Will provide leadership and oversight in presenting findings from data gathering and evaluation activities at conferences, in collaboration with other members of the team.
* Will also maintain the liaison relationship with SAMHSA Center for Substance Abuse Treatment.
* Will be a board-certified psychiatrist with the state of California.
* Will have five years clinical experience in an HIV mental health and substance-abuse treatment environment.

## Job Description

**Program Director at 75% FTE:** Ramón Matos, MA.

The program director isbilingual/bicultural Spanish speaker with extensive administrative and clinical experience. He has worked with HIV infected people with substance abuse and mental health concerns since 1987.

• Will manage all day-to-day activities of the AIDS and Substance Abuse Program for African Americans and Latinos with HIV (ASAP+) project.

• Will supervise and provide ongoing training for the counselors. Mr. Matos will assist with diagnosis and treatment planning.

• Will assure data is collected in a manner prescribed by the program evaluation team.

• Will have a Master’s degree in social work or psychology as well as extensive experience in HIV, mental health, and substance-abuse treatment.

• Will have demonstrated ability to work effectively with the diverse groups that make up the target population.

## Job Descriptions

**Substance-Abuse Counselors at 100% FTE:** Claudia Figallo, Erric White, TBH

The substance-abuse counselors include a bilingual/bicultural Spanish-speaker and an African-American, and 1.5 FTE To Be Hired.

The substance-abuse counselors:

• Will provide assessments, treatment planning, counseling, referral to needed services, tracking, and follow-up.

• Will administer the GPRA and other instruments.

• Will have Bachelor’s-level degrees in social work or a closely related field, and/or equivalent education, experience, and certification.

• Will have demonstrated ability to work effectively with the diverse groups that make up the target population.

• Will have three years demonstrated competence in working with substance abusing populations as well as people of color and people with mental health disorders.

## Job Description

**Team Psychiatrist at 10% FTE:** George Harrison, MD

• Will serve as psychiatrist for the project.

• Will function as the medical director and be responsible for the clinical supervision of the service.

• Will provide crisis intervention, and triage services as required.

• Will prescribe and help manage psychiatric medications, assist in assessment and diagnosis, and consult on treatment planning and crisis amelioration. His level of effort will be 10 percent time.

* Will be board-certified psychiatrist in the state of California.
* Will have five years clinical experience in an HIV mental health environment.

Reception/Data Entry Clerk at 50% FTE: Chantal Salkey

* Will be responsible for greeting clients and assisting clients in getting to the AHP Services Center and/or connecting clients with their counselors.
* Will work closely with the program manager to assure that GPRA forms are distributed, collected and input in a timely manner.
* Will have high school diploma or GED and three years of related administrative/clerical experience, or equivalent combination of education and experience; experience with MS Word, Excel, and/or other software programs; excellent organizational, communication and listening skills; ability to manage multiple tasks simultaneously.

**Section I: Confidentiality and SAMHSA Participant Protection/Human Subjects**

1. Protect Clients and Staff from Potential Risks

The project will provide services specifically developed for the needs of the target population. The medical, physical, psychological, social, legal and other risks to participants in the proposed project will be minimal. There are no high or unusual risks to participants as a result of participation in the project that they would not experience without the project. The major risk would seem to be to participants’ confidentiality. Risks to confidentiality will be protected through vigilant enforcement of confidentiality requirements. When needed, the applicant will seek the advice and consultation of professionals such as doctors, psychiatrists, lawyers and others.

Whenever confidential data is obtained, there may be some risk of confidentiality being breached. Therefore, continual vigilance is necessary. Procedures to protect confidentiality are already in place at the AIDS Health Project, and will be maintained during the proposed project. Client records are and will be kept under lock and key, and access restricted to staff who are trained in professional ethics and supervised. All participant identifying information, including services received and evaluation data, will be protected in accordance with confidentiality regulations.

1. Fair Selection of Participants

The target population for the proposed project is homeless people with HIV and who have substance abuse and/or mental illness. The criterion for inclusion in the project is being a member of the target population. Participants will be recruited by the case managers.

1. Absence of Coercion

Participation in the project is voluntary. At the time of intake/baseline data collection, participants will be informed that their participation is wholly voluntary and that they are free to decline at any time; services will not be withheld from those who decline to complete data collection instruments. Clients will be offered $20 certificates for groceries for completion of follow-up data collection, regardless of whether they participate in treatment. Clients will be told that they may receive services even if they do not participate in or complete the data collection component of the project.

1. Data Collection

Outcome and participant descriptive data will be obtained for evaluation purposes and will be collected directly from project participants through interviews and self-report instruments. Maximum use will be made of existing records or data, wherever possible. Participant-specific data will be maintained by participant number and entered into a database, where the data can be aggregated by age, grade, gender, ethnicity, or other heading. Access to the database will be limited to appropriate project staff. Copies of proposed data collection instruments are included in Appendix 2, “Data Collection Instruments/Interview Protocols.”

1. Privacy and Confidentiality

All project participants will be assured that the confidentiality of information they provide will be protected and that no information will be released to any agency or individual without the participant’s specific written consent. Exceptions to this policy will be cases of suspected child or elder abuse, which staff are required to report under California law. The applicant will undertake to resist in judicial proceedings any effort to obtain access to information pertaining to project participants. Identifying information will be removed from data files entered into the database and participants will instead be identified by number. The name/number match will be kept in locked files. Interim reports will not include any identifying information. The applicant agrees to maintain the confidentiality of participant records in accordance with the provisions of Title 42 of the Code of Federal Regulations, Part 2 (42 CFR, Part 2).

1. Adequate Consent Procedures

The project, its potential risks and benefits, procedures to protect against risks, the voluntary nature of participation, the right to withdraw at any time, the nature and use of the data to be collected, and procedures for maintaining confidentiality will be explained to participants in lay language. Potential risks, though they appear to be insignificant, will also be explained in lay language. Consent for non-English speaking participants will be obtained by a staff person who speaks the participant’s language, with written materials in the participant’s language. Data collection personnel will explain procedures and obtain signed, written informed consent for data collection. A sample consent form for data collection is included in Appendix 3, entitled “Sample Consent Forms.” It is not anticipated that separate consents will need to be obtained for different data collection instruments. Consent for the collection of evaluation data will not be required for participation in any programs.

1. Risk/Benefit Discussion

Given the minimal risks created by the project, these risks are reasonable in relation to the anticipated benefits to the participants of provision of the proposed services and in relation to the knowledge about effective services for the target population that is expected to result from the project.

**Appendix 1:**

**(1) Identification of at least one experienced, licensed service provider organization.**

The organization that will conduct the project is the UCSF AIDS Health Project. It is an experienced and licensed service provider organization.

**(2) a list of all direct service provider organizations that have agreed to participate in the proposed project, including the applicant agency, if it is a treatment service provider organization;**

The UCSF AIDS Health Project is the only direct service provider organization that will participate in the project. Other community–based agencies will collaborate by making referrals to the project or accepting referrals, but will not be participants in the sense that they will be supported by grant funds.

**(3) Statement of Assurance**

Next page.

**(4) Letters of commitment/support.**

Following pages.

### Statement of Assurance

As the authorized representative of the applicant organization, I assure SAMHSA that if the UCSF AIDS Health Project application is within the funding range for a grant award, the organization will provide the SAMHSA Government Project Officer (GPO) with the following documents. I understand that if this documentation is not received by the GPO within the specified timeframe, the application will be removed from consideration for an award and the funds will be provided to another applicant meeting these requirements.

* a letter of commitment that specifies the nature of the participation and what service(s) will be provided from every service provider organization listed in Appendix 1 of the application, that has agreed to participate in the project;
* official documentation that all service provider organizations participating in the project have been providing relevant services for a minimum of 2 years prior to the date of the application in the area(s) in which services are to be provided. Official documents must definitively establish that the organization has provided relevant services for the last 2 years; and
* official documentation that all participating service provider organizations are in compliance with all local (city, county) and State/tribal requirements for licensing, accreditation, and certification or official documentation from the appropriate agency of the applicable State/tribal, county, or other governmental unit that licensing, accreditation, and certification requirements do not exist. (Official documentation is a copy of each service provider organization’s license, accreditation, and certification. Documentation of accreditation will not be accepted in lieu of an organization’s license. A statement by, or letter from, the applicant organization or from a provider organization attesting to compliance with licensing, accreditation and certification or that no licensing, accreditation, certification requirements exist does not constitute adequate documentation.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Authorized Representative Date

**Appendix 2: Data Collection Instruments/Interview Protocols**

**Appendix 3: Sample Consent Forms**

UCSF AIDS Health Project

AIDS and Substance Abuse Plus (ASAP+)

Evaluation Data Collection Consent Form

We are asking for your consent to provide us information about yourself by being interviewed now, about 6 months from now, when you leave the program.

This information is being collected by the AIDS and Substance Abuse Plus (ASAP+) project of the UCSF AIDS Health Project. It is funded by a grant from the federal Substance Abuse and Mental Health Services Administration. To find out how well the program is helping people, we are asking those who receive services from the program to provide us with information about themselves.

You are free to say no to this request, now or at any future time. If you decide not to give this information, you can still receive services from the project.

Some of the questions ask about alcohol and drug use, criminal activity, and other personal matters. Your answers to these questions will be kept confidential. Reports or articles may be written about this project, but your name will never be associated with the information. Your individual answers will not be released to anyone and will be kept secure by our coding system. Completed forms will be kept in locked files.

Your participation in providing this information will help us know more about how to help people who are homeless and who have HIV and have mental health and alcohol and other drug problems.

If you have any questions about the project or this form, please feel free to ask them.

*I have read and understand the above information regarding providing information about myself for the purpose of project evaluation, and I give my consent to collect this information.*

Signature Date

 Print Name

**Appendix 4: Letter to the SSA**

February 27, 2007

Ms. Kathryn Jett

Director

Department of Alcohol and Drug Programs

1700 K Street, Fifth Floor

Executive Office

Sacramento, California 95814-4037

Dear Ms. Jett:

The UCSF AIDS Health Project is applying to the Substance Abuse and Mental Health Services Administration (SAMHSA) in response to its Targeted Capacity Expansion Program for Substance Abuse Treatment and HIV/AIDS announcement. A copy of the application face page and an abstract are attached.

As the Single State Agency, you are invited to provide comments directly to SAMHSA. Comments must be submitted within 60 days of the application deadline, which is February 28, 2007.

Comments should be addressed to:

Crystal Saunders, Director of Grant Review

Office of Program Services

Substance Abuse and Mental Health Services Administration

Room 3-1044

1 Choke Cherry Road

Rockville, MD **20857**

ATTN: SSA – Funding Announcement No. TI-07-004

Thank you,

Joan Kaiser

Contracts and Grants Officer

 SMA 170

01/2003

ONLY FOR APPLICANTS APPLYING FOR GRANTS THAT FUND SUBSTANCE-ABUSE TREATMENT OR PREVENTION SERVICES

# ASSURANCE

# Of Compliance with SAMHSA Charitable Choice

**Statutes and Regulations**

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| --- |
| SAMHSA’s two Charitable Choice provisions [Sections 581-584 and Section 1955 of the Public Health Service (PHS) Act, 42 USC 290k, et seq., and 42 USC 300x-65 et seq., respectively] allow religious organizations to provide SAMHSA-funded substance-abuse services without impairing their religious character and without diminishing the religious freedom of those who receive their services. These provisions contain important protections both for religious organizations that receive SAMHSA funding and for the individuals who receive their services, and apply to religious organizations and to State and local governments that provide substance-abuse prevention and treatment services under SAMHSA grants. |

As the duly authorized representative of the applicant, I certify that the applicant:

Will comply, as applicable, with the Substance Abuse and Mental Health Services Administration's (SAMHSA) Charitable Choice statutes codified at sections 581‑584 and 1955 of the Public Health Service Act (42 U.S.C. ''290kk, et seq., and 300x‑65) and their governing regulations at 42 C.F.R. part 54 and 54a respectively.

|  |  |
| --- | --- |
| SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL | TITLEContracts & Grants Officer |

|  |  |
| --- | --- |
| APPLICANT ORGANIZATIONUniversity of California San Francisco | DATE SUBMITTEDFebruary 27, 2007 |

