Procedure: 6.2 STOP Program overview and case study
Approval date: January 10, 2025
Approved by: Director, MB HIV Program

PURPOSE

This document provides additional information about the British Columbia's Centre for Excellence (BCCFE) in HIV/AIDS Seek and Treat for Optimal Prevention of HIV/AIDS® (STOP HIV/AIDS®) program.

BACKGROUND

The Program to Access Treatment for HIV and Support (PATHS) is an outreach model of care that has been adapted from the BCCFE STOP program. The following program overview and case study provides additional information about the STOP team and how it operates. While these documents can be helpful to provide greater context, there remains key differences between STOP and PATHS. In Manitoba, the focus of the PATHS outreach teams will remain "Treatment as Prevention" (TasP) for clients diagnosed with HIV.

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STOP Outreach Team

March 28, 2013

Vancouver STOP Project

Introduction

"We take a community-wide approach to caring for people."

"I'm pounding the pavement on outreach and I'm just trying to connect with my 30 clients as much as I can," Jacey Larochelle, a registered nurse with the STOP Outreach Team, says of her typical workday.

She's not alone. The interdisciplinary team of nurses, nurse educators, social workers, outreach workers and peers, all working with the support of a physician, was established in 2010 by the Vancouver Seek and Treat for Optimal Prevention of HIV/AIDS (STOP) Project to improve

engagement in and linkage to HIV testing, care and support, and treatment. The STOP Outreach Team has proven to be one of the most important initiatives of the Vancouver STOP Project because it has facilitated an integrated system of care across the city for some of Vancouver's most marginalized people.

The team focuses on four key areas. The first three are: expanding routine and rapid HIV testing in targeted settings; providing public health follow-up for partners of people who test positive; and educating and building capacity among service providers. The team is perhaps best known for its fourth focus: engaging and linking to care people who are newly diagnosed or who have been lost to care since their diagnosis.

"We aim to thread clinical services together to strengthen the continuum of care," says Miranda Compton, the team's manager. Through its engagement and linkage to services, the team attempts to fill in the cracks in the HIV continuum of care for people most likely to fall through them. "If a person's needs are straightforward, then they are probably the wrong person for the team," she adds. The team's mandate is to offer short-term intensive case management as it links the most vulnerable people to the appropriate longer-term services in the community.

Because the team works exclusively on outreach, its members have the flexibility to be innovative with the strategies they use to engage clients. The outreach workers labour tirelessly to meet people wherever they are. The team's physician does home visits for clients who cannot make it to a clinic, and the nurses are able to spend time building relationships and engaging clients. The team's social workers address any barriers clients identify to their care, including housing, food security, social assistance benefits and immigration status.
The team's greatest challenges are structural: a lack of adequate housing in Vancouver; wait lists for detox and recovery programs; and limited mental health services tailored to people with active addictions. But they are also individual: clients who don't trust the healthcare system; clients with complex mental health and addictions; and clients who, understandably, are concerned with survival rather than addressing their HIV infection.
Despite the challenges, says Larochelle, "I think we are actually reaching a demographic that would otherwise not be getting healthcare."

What is the Program?
The STOP Outreach Team is an interdisciplinary team of nurses, nurse educators, outreach workers, social workers, administrative support workers and peers all working with the part-time support of a physician. The team's mandate is to expand low-barrier HIV testing services and to improve engagement in HIV treatment, care and support for some of the most marginalized people in Vancouver. Importantly, through their flexible, intensive case

management approach, this clinical outreach team is a bridge to established HIV services across the city of Vancouver rather than the final destination for clients. While HIV testing and diagnosis volumes, treatment adherence and suppressed viral load are some of the key markers of success, the team uses a holistic model of care, which includes a person's physical, mental and social needs.

This approach means that the STOP Outreach Team works not only on the HIV-specific needs of its clients. The team also addresses psychosocial and other medical barriers before addressing a client's HIV, and does so by supporting the client to prioritize their own needs. Taking a broad approach to achieving what is essentially a biomedical goal (preventing HIV transmission, diagnosing people early in their infection and supporting people living with HIV to be on treatment and achieve a suppressed viral load) has allowed the team to address the broader social determinants of health. These determinants affect their clients' ability to prevent HIV, to access testing, to engage and link to care, and adhere to their medications once on treatment. Engagement with the team addresses these determinants and improves the likelihood that clients will remain engaged in prevention, testing, care and treatment.

The team focuses on four key areas:

1. providing education and capacity-building opportunities to community agencies, healthcare practitioners and peers to improve or expand services;
2. expanding rapid and routine HIV testing in targeted settings, such as mental health and addictions services, in First Nations communities in the Vancouver Coastal Health region, in gay bathhouses, in the justice system, in supported housing, and in abortion and youth clinics;
3. providing public health follow-up for partners and other contacts of people who test positive (in collaboration with Vancouver Coastal Health Communicable Disease Control); and
4. engaging and linking people to care who are newly diagnosed or who have been previously diagnosed and lost to care and who require support to link to existing HIV and psychosocial services.

The team improves linkages between services that already exist in the community by offering intensive case management for clients to help them navigate the system. This support may only last a few weeks and includes referrals and accompaniment to culturally appropriate services (for example, clinics that specialize in the health of gay men), or it may last longer and provide intensive case management for people with complex barriers to accessing healthcare. Services for these individuals typically last between four and six months, and clients can return to the team's caseload should they need the added individualized support.

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The STOP Outreach Team also has nurses, outreach workers and case managers embedded in other programs in Vancouver. The focus of this case study is, however, on the staff whose primary work site is the STOP Outreach Team office and does not cover the work of team members who are embedded at other sites. For more information on programs hosting embedded staff, please see the Maximally Assisted Therapy Program case study.

Why Was the Program Developed?

The goal of the provincial STOP Project is to expand HIV testing, treatment and support services to clinically eligible people. However, even with the extensive services available in Vancouver, some people have not been linking effectively to, or staying engaged in, care. The Vancouver STOP Project, a partnership between Vancouver Coastal Health and Providence Health Care, developed the STOP Outreach Team to expand low-barrier HIV testing and diagnosis services and significantly enhance linkage to, and engagement in, HIV and related services for some of the most marginalized people in Vancouver.

Part of the vision for this team was to provide clinical, intensive case management to people newly diagnosed with HIV and to HIV-positive people aware of their status but not engaged in care as a way to improve linkage and retention in care. The vision included a commitment to doing this through outreach, which filled a gap in the existing system of engagement and linkage in the city, particularly outside of the densely serviced Downtown Eastside.

How Does the Program Work?

The Vancouver STOP Project has expended significant energy on improving engagement and linkage services across Vancouver. The breadth and depth of its services, and its ability to reach the most vulnerable with HIV testing, treatment, and care and support, has made it integral to the new way that HIV services are being delivered in Vancouver since the start of the Vancouver STOP Project.

While the STOP Outreach Team provides discrete services, team members work closely together, developing individualized care plans for clients, meeting daily in the STOP Outreach Team office before heading out for the day, and supporting each other to provide the best possible care to clients.

Education for service providers

The team has HIV specialist nurse educators whose role is to provide training and support to service providers who want to offer routine or rapid HIV testing services in their practices. This sub-team within the STOP Outreach Team is known as the Targeted Testing Team. This team trains clinicians to offer testing and diagnosis in primary care clinics, in mental health and addictions services, in supportive housing, in First Nations communities in the Vancouver

Coastal Health (VCH) catchment area, in the justice system where VCH is contracted to offer healthcare, and in youth and abortion clinics.

While the Vancouver STOP Project is currently training physicians in family practice and acute care to routinely offer HIV testing in their practice, these capacity-building initiatives are not initiated by the STOP Outreach Team's nurse educators. For more information on the nurse educators' role in expanding testing services in Vancouver, please see the Expanded Rapid and Routine Testing Case Study. For more information on other testing initiatives in Vancouver, see the Peer Testing Project, the HIV Testing in Family Practice, the HIV Testing in Dental Clinics and the HIV Testing in Acute Care case studies.

24-hour telephone line for clients and service providers
The STOP Outreach Team also runs a 24-hour telephone line for clients who are experiencing an urgent health issue, or service providers seeking support for clients. The purpose of the line is to ensure that the team is able to assess and respond to the needs of clients as they emerge. This is particularly important for a transient population of people who may frequently be in hospital or involved in the justice system. Ultimately, having the telephone line strengthens continuity of care by providing a round-the-clock resource for clients.

In addition, the line is also available for service providers looking for information. This includes information on how to diagnose an individual with HIV, how to access a client's HIV test results, where to fill an emergency antiretroviral prescription for a client who has run out of ARVs or to ask for help in referring someone to psychosocial services. Service providers also call the line to report that a person for whom the team has been searching has resurfaced. In these instances, the STOP Outreach Team will make arrangements to meet the client at a certain time and place to connect with them.

HIV and STI testing
The team's nurses organize and deliver testing clinics in a variety of settings including community organizations, in single room occupancy hotels, and at AIDS service organizations that serve highly vulnerable populations. They often use point-of-care (POC) tests to do this, which yield results in minutes and do not require individuals to return for their results. This is especially important in settings where people seeking testing experience significant and complex barriers to healthcare, and live in or frequent neighbourhoods with a high prevalence of HIV. These testing events are also opportunities to link people who are newly diagnosed to care and to reconnect people to care who know they are HIV-positive but have been lost to care.

In this regard, testing clinics are about more than just testing. These clinics provide low-barrier healthcare for the most marginalized people by bringing healthcare to the spaces most familiar to them and shifting the logistical burden of healthcare from the patient to the provider.

In addition, the team has increased efforts to provide low-barrier HIV testing to gay men and other men who have sex with men. They have done so through bathhouse testing, in which STOP Outreach Team nurses conduct HIV and STI screening in three of Vancouver's bathhouses. Through close partnerships with the owners and management, a room in each bathhouse has been renovated into a clinical space and nurses offer HIV and STI testing and treatment there.

In July 2012, **YouthCO** and the STOP Outreach Team also launched *Know on the Go*, a mobile outreach service that offers HIV testing for gay men and other men who have sex with men in outdoor sex venues, such as parks. In the summer of 2012, this project provided HIV and STI screening during gay pride celebrations and, since the fall of 2012, the service has been available outside gay events, clubs and venues.

Like their other testing initiatives, the STOP Outreach Team's gay men's HIV testing programs aim to expand testing options for a group at high risk for HIV. In both of these models, a mix of point-of-care testing and standard lab testing is performed. For more information on these initiatives, please see the Mobile and Bathhouse HIV Testing Project Program Element.

Finally, the team's nurse educators offer HIV testing at public events frequented by the general population, including events at the University of British Columbia and at Simon Fraser University. These are seen less as testing events by the team (though they do perform tests) and more as awareness-raising events about HIV and HIV testing. The goal of these events is to contribute to the normalization of the testing experience and to reduce stigma associated with HIV.

Public health follow-up

The team's four public health-designated nurses can also assist the Vancouver Coastal Health Communicable Disease Control (VCHCDC) program with partner notification, contact tracing and referral services for people who are newly diagnosed with HIV. The VCHCDC is responsible for all public health follow-up after HIV testing in the region, and has nurses who specialize in offering this follow-up and supporting clients through the difficult process of diagnosis, partner notification and linkage with care. However, in rare instances where the VCHCDC nurses anticipate that a client will be particularly hard to find or engage, the STOP Outreach Team offers this service, using its knowledge of the community to locate them. This integration between the two teams allows for greater flexibility in public health follow-up and supportive, client-centred work with the client and their contacts.

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Engagement and linkage through intensive case management
The team is best known for its engagement and linkage services. It provides these services both to people who are newly diagnosed and to people who know their HIV-positive status, but are not linked to care. The team does this through intensive case management.

This case-management service is voluntary. It can last a few weeks, for people who experience some barriers to accessing HIV-specific services but who are generally able to self-manage their healthcare. Alternatively, it can be an ongoing process, especially for people who experience more complex, intersecting barriers to accessing HIV-specific services and who need additional help accessing healthcare.

First contact with the STOP Outreach Team
While some clients connect with intensive case management services through their HIV diagnosis by a STOP Outreach Team nurse at the various testing clinics the team organizes, most clients first become known to the team through a referral. Referrals for case management come from various services and programs around Vancouver. For people who are newly diagnosed, referrals can come from family doctors and acute care facilities, and mental health and addictions services.

Referrals also come to the STOP Outreach Team for people who already know their HIV status but have been lost to care. These referrals are often made by physicians at community health clinics in the Downtown Eastside, from the Immunodeficiency Clinic at St. Paul's Hospital, from Vancouver Coastal Health's Primary Outreach Services, from AIDS service organizations and from other agencies working in the neighbourhood.

Typically, these people are referred to the team because they are challenged by HIV medication adherence, have stopped taking their medications altogether, or they have not been seen by their primary care provider in months or even years. Referrals to the team are usually made through a referral form, though referrals are also made over the phone. The outreach workers act as intake workers for new referrals to the team.
Initial engagement with the STOP Outreach Team

Referrals to the team are assessed each morning at a team meeting known as the huddle. During the huddle, team members discuss new clients' needs. If those needs are primarily medical, a nurse will take the lead in the client's care. If they are psychosocial, a social worker will lead the team's efforts. In most cases, the nurse or social worker will pair with an outreach worker, and the outreach worker will play a central role in executing the care plan, through

initial engagement with the client and through accompaniment to appointments. Each client is assigned to two members of the team to ensure continuity of care.
The huddle is also an opportunity for team members to discuss case management clients in general, coordinate activities and divide responsibilities. It also gives team members a chance to share their daily schedules with one another.

Locating and engaging potential clients
Following a referral and initial discussion about connecting with a potential client, the team member(s) assigned to the person will try to locate them in the community to introduce them to the team and its services. Sometimes, potential clients are very easy to locate, as they are already known to the team or their healthcare provider knows where they can be found. However, some other clients are harder to find.

Those clients who are more challenging to connect with tend to be people who require longer-term intensive case management. In these cases, one of the outreach workers takes the lead. Outreach workers use VCH's health records systems to locate a person, sifting through recent entries in their health files to find a last known address. The outreach workers also contact prisons and jails to determine if the person is currently involved in the criminal justice system. Often, outreach workers leave messages for clients with the Ministry of Social Development, asking that the message be delivered to the client when they collect their social assistance cheque. The team also leaves notes with agencies where the client is known to hang out. Any inquiries into the whereabouts of a client respect the client's confidentiality and simply say that someone is trying to contact them on behalf of their healthcare provider. No mention of HIV is made.

Once a person has been located, the team's lead for the client establishes a connection with them. In many cases, this takes flexibility and persistence. Because the team works largely on outreach, members are free to be innovative with their strategies. This includes taking the person to lunch or for coffee, or spending a few hours with them to allow the new client to become comfortable with them. When a person refuses support, team members always leave the option to connect at a later date. The team often returns to the same client several times in order to establish a connection.

Once a client has accepted the team's help, it is the team's role to inform clients of all their options, provide education about HIV and HIV treatment and care, and discuss with clients all the different services the team can help them access. The client is always at the centre of the care and support offered to them. Team members follow the client's lead in establishing priorities and making the appropriate linkages to services.

Short-term engagement with case management
Clients who are engaged on a short-term basis with the STOP Outreach Team tend to be more independent, better able to self-manage their healthcare and usually experience fewer barriers to engagement in healthcare than other clients of the STOP Outreach Team's case management service.

The team's involvement with these people usually lasts a few weeks and can include support with accepting a diagnosis, disclosure to family and friends, help finding a primary care provider and accompaniment to the first few appointments, or help re-engaging in care if the individual is not newly diagnosed. It can also include connecting the client with a peer navigator from Positive Living BC who can provide more long-term support. For more information on peer navigators, please see the Peer Navigator Program Case Study.

The team can ensure that clients who need it are receiving their full social assistance benefit, that they have adequate housing and have access to food banks and meal programs. Whenever possible, referrals to culturally appropriate services are made. Gay men, for example, are referred to medical and psychosocial services that specialize in LGBTQ communities.

Longer-term engagement with case management
For other clients, engagement with the team takes longer and more intensive case management is required. Typically, these clients have multiple and intersecting barriers to healthcare, including episodic homelessness, involvement in the criminal justice system, and mental health and addictions challenges. Although the average length of engagement is between four and six months, some clients have been on the team's caseload for more than two years.

Clients who engage with the team for a longer period of time are often in need of more in-depth psychosocial and health support and management. This can include supporting applications for full disability benefits, for immigration status and for the Canadian Pension Plan. The team also makes referrals for better housing or for a shelter bed, and to meal programs. The team facilitates linkages between longer-term case management programs, such as programs at AIDS Vancouver and Positive Living BC. These organizations also have access to services that may not be offered by the team, such as food banks.

Dealing with psychosocial barriers to medical care is a key step for clients as they re-engage in HIV care. This process allows the team to build rapport and trust and improves clients' capacity to address their healthcare needs by stabilizing income, housing and food security.

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When a relationship has been established and a person's psychosocial needs have been addressed, then the team can discuss healthcare with them and encourage them to start HIV treatment. Nurses and outreach workers spend their days connecting with clients, talking to them about treatment options, accompanying them to their medical appointments, providing daily medication support, and connecting clients with methadone and mental health and addictions services if they want them.

The role of the physician

The clinical work of the team is supported by a physician who spends three half days per week with the team. The physician's role is to provide clinical support to the nurses as they care for their clients. He is responsible for reviewing all lab work ordered and is available by telephone to answer any questions nurses may have about their clients' medical needs.
The physician is not involved in the care of all of the STOP Outreach Team's clients. He usually sees clients whose needs are immediate or clients the nurses believe are unlikely to thrive under the care of another physician. Mostly, the physician sees patients at the community clinic at which he is based, though he does see about 10-20 percent of people requiring physician care at home or in the community.

The physician also acts as an educational resource for the team. The physician offers support and advice for their practice to allow nurses to provide the care their clients need. Biweekly, the physician meets with the team to review cases and relate learning points.

Discharge

Typically, clients are not discharged until their psychosocial needs are met and they have begun antiretroviral therapy, are well-established on their regimen and are seeing the benefits of treatment (reduced viral load or virologic suppression, and increased CD4 count). The team ensures that there is strong engagement and strong capacity to provide the kinds of support clients need before they are discharged from the team's caseload. Depending on the client's needs, they are discharged to a variety of primary care practices and enhanced services around Vancouver.

About 75 percent of the team's clients need further intensive case management. If these clients live in supportive housing, they will often be discharged to the care of onsite nurses and social workers. Others are discharged to intensive adherence support programs such as the Maximally Assisted Therapy Program at the Downtown Community Health Centre. For more information on this program, please see the Maximally Assisted Therapy Case Study.

Clients who are more independent are discharged to the Immunodeficiency Clinic at St. Paul's Hospital or one of Vancouver Coastal Health's community health clinics, all of which have HIV-trained physicians on staff. These clients are better prepared for self-management and do not need intensive case management or outreach to continue their engagement in treatment, care and support. For more information on the system of care provided by the Immunodeficiency Clinic, please see the IDC Case Study.

Next steps
In planning for the team's future after March 2013, VCH is considering a model in which interdisciplinary teams that include a combination of nurses, social workers and outreach workers are embedded in pods in existing primary care programs and services around the city. In this model, pods may be responsible for specific populations and/or specific geographic areas.

This model builds on the work of team members already embedded in other programs. Such teams currently exist at the Maximally Assisted Therapy Program, the Downtown Eastside Women's Centre and the PHS Community Services Society. Such a model would reduce overextension of staff and improve communication and collaboration between service providers and the team.

Required Resources

Human resources
An interdisciplinary team of nurses, nurse educators, social workers, outreach workers, administrators and peers, all of whom are supported by a physician, is key to establishing a clinical outreach team such as this. The experience of the STOP Outreach Team has demonstrated that staff should be innovative with their approaches to care and support and that they must be dedicated and willing to serve clients with compassion and without judgment.

Challenges

1. Lack of pre-existing model. With no precedent for the team's structure, management has shifted and altered the team's makeup to find an optimal operating structure and staff complement. Work continues to be done to find the right staff configuration, with the right roles and in the right settings.
2. Structural barriers. Mental health and addictions services are challenged to meet the needs of the most complex clients. Waitlists and transitions among service settings provide structural barriers to engaging and maintaining some of these clients in ongoing HIV care.

3. Social workers. With a primary focus on biomedical interventions and outcomes as associated with treatment as prevention, social workers and other clinicians often struggle to prioritize issues that can be more immediate and important for daily survival. This, combined with the lack of obvious measures of success relating to the social determinants of health has challenged social workers to understand the relative value of their practice.
4. Limited resources. While the STOP pilot was well funded, there were many priorities that led to pressures and some unmet needs. The STOP team could have provided more care and even greater improvements to access with more resources such as physician sessions. Additionally, the mandate to provide both expanded testing and treatment support services has overextended some team members. In addition, developing individual and effective care plans for each client is time-consuming, as is meeting the needs of dozens of clients to execute these plans.
5. Collaboration with other service providers. It has been a challenge at times for the team to integrate its work with the work of other agencies in a neighbourhood with a many providers. Improved coordination of service delivery would result in greater efficiency and outcomes.
6. Communication with the criminal justice system and other jurisdictions. Challenging communication with the federal justice system and other health authorities can have a negative health impact on clients who experience episodic incarceration, or who are transient, and who need strong continuity of care.
7. Cheque day. Provincial income assistance cheques are issued monthly, giving clients access to hundreds of dollars at a time. To reduce the negative impact this can have on clients' lives, the team encourages clients to have cheques issued weekly or biweekly, and have rent withdrawn directly from their accounts. For clients who want it, the team will match them with a peer navigator that will support them to do something positive with the money.
8. Weekend services. The team does not offer weekend service to clients though it does have a 24-hour telephone line for clients and service providers needing support or information.
9. Transitions and discharge. Many of the team's clients rely on outreach or require a tailored clinical service to remain engaged in care. There are limited spaces in long-term programs that have the capacity to do this. Despite limited capacity in the community, discharge must take place as there is a steady flow of referrals to the team.

Evaluation

Since its inception, the team has kept data on the number of testing clinics it holds, the number of tests conducted, the number of new positives yielded and the number of people living with HIV linked to care. These data are collected to determine the clinics' effectiveness. Between

November 2010 and July 2012, the team performed 1622 tests and diagnosed 33 new clients with HIV. This represents a two percent positivity yield.

The team also tracks the health indicators of clients, including housing and income status, health status and stability, ARV starts, and viral loads to determine if engagement with the team improves health outcomes for clients.

As of February 2013, the team has over engaged 404 HIV-positive clients with intensive case management and antiretroviral adherence support. Eight-nine percent of people referred were linked to an HIV primary care provider when they transitioned from the STOP Outreach Team to a less intensive care setting. In addition, frequent users of the city's emergency departments (people who used the emergency room more than nine times in six months) experienced a 47 percent decrease in total number of emergency department visits six months after their referral to the STOP Outreach Team when compared to the six months before their referral. This suggests that the team is improving the health outcomes of clients through stronger connections to HIV primary care. Between November 2010 and June 2012, the team also helped 97 clients improve their housing status.

Finally, the team was the subject of the fall 2012 Community Engagement Report, a publication that the Vancouver STOP Project releases quarterly. Based on surveys of and interviews with clients, the report found that the team's intensive case management and peer support work improved clients' connection to medical care, nurtured client independence and provided clients a reason to find hope for change in their lives. This comment, by one of the team's clients, illustrates the effectiveness of the integrated care the team provides: "My doctor, my housing worker, the case managers -- they are connecting together. They see I've made a difference to better myself and my health, and I keep pushing, keep fighting for my life. They are helping me, and I push too – I want a long life."

Lessons Learned

1. "An already developed infrastructure." In order for a team such as this to be effective, a strong network of pre-existing and effective HIV treatment, care and support services, housing, food security and mental health and addictions services needs to be available.
2. "Our role is to provide a bridge for clients to link back into the existing system of care." The STOP Outreach Team provides an option to help re-engage clients who are lost to care and engage newly diagnosed people in services. By offering complementary services, the team can reduce the cracks in the system through which the most vulnerable may fall.
3. "Easy to penetrate and easy to navigate." The team operates as a full-service primary care team. The team removes the logistical barriers to care by shifting those burdens

from the patient to the clinical team, including the requirement to come to the clinic for care.

4. "We take our services to our clients wherever they are." The fact that the team works exclusively on outreach for its engagement and linkage component is key to its success in supporting clients. It provides the team the flexibility to spend extra time with clients to build strong therapeutic relationships and link them to long-term supports.
5. "We are able to meet clients where they are and guide them on the journey toward health." The team provides non-judgemental services tailored to the needs of its clients. This client-centred approach allows clients to determine their own priorities with team members acting as facilitators.
6. "We take a community-wide approach to caring for people." While collaboration with other service providers has been challenging, the team's ability to collaborate is also a strength. The team works closely with peers, clinicians, hospitals and community organizations to coordinate services and develop a discharge plan.
7. "One phone line." The outreach team has a 24-hour phone line for clients and service providers that allows them to access after-hours support. This allows clients to contact the team when they require assistance and allows the team to assess and respond to clients' needs immediately. The line also allows service providers to contact the team when their clients have re-appeared after having been unreachable, when their clients have run out of medications or when they need information about how to connect with other services.
8. "A group of passionate people who want to do this work." The team consists of dedicated and competent individuals with a desire to provide the best service in an autonomous and often complex environment.
9. "Things all changed at the same time." The success of the team in supporting clients to engage in care has been, in part, due to the scaling up of an already developed treatment, care and support infrastructure that happened simultaneously with the creation of the team. This provides the team with options when trying to link clients to necessary services and programs. This investment in the system has had a direct impact on the successes observed in clients.

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BC CENTRE FOR EXCELLENCE IN HIV/AIDS

CASE STUDY

WITH SUPPORT FROM STOP HIV/AIDS TEAM, CLIENT ABLE TO REACH UNDETECTABLE VIRAL LOAD

NOVEMBER 2015

BACKGROUND

Seek and Treat for Optimal Prevention of HIV/AIDS (STOP HIV/AIDS®), a program conceptualized by the BC Centre for Excellence in HIV/AIDS (BC-CfE), aims to expand access to HIV treatment, care and medications among hard-to-reach and vulnerable populations. The STOP Outreach Team involves collaboration between nurses, health care professionals, social workers and others in order to provide for the broad spectrum of needs of their clients living with HIV. In 2012, based on its success, the BC provincial government announced $19.9 million in funding for the provincial Health Authorities towards the program's growth.

STOP Outreach Team members across the province work with vulnerable populations who have suffered trauma and lack trust in traditional health care systems. Many of their clients are simultaneously facing addiction and homelessness problems, while dealing with access to HIV treatment and care. STOP Outreach Nurses work with approximately 35-40 clients at a time.

The success stories from the STOP program show the resilience that exists within vulnerable communities, as well as the importance of holistic support systems to address a broad spectrum of health, social and economic needs.

This case study provides an example of a success story. A client, through the services provided by the STOP Outreach Team, was able to achieve stability and improved health. The client's name has been changed for privacy concerns.

CASE STUDY

"Ross" met with the STOP Outreach Team in Vancouver while at a STOP Team HIV testing event in March 2012. At intake, the 40-year-old individual's CD4

counts were alarmingly low at <10 and his viral load measured at over 200,000/mL. Ross struggled with severe opioid and methamphetamine IV addiction, required support with food security and housing, and faced multiple challenges to restarting his HIV antiretroviral medications (ART).

The program STOP Outreach Team in Vancouver, under Vancouver Coastal Health, supported Ross in getting into three different residences and placed in several shelters. However, he faced multiple evictions and incarcerations. He was connected to the John Ruedy Immunodeficiency Clinic (IDC) at St. Paul's Hospital. There, he re-started methadone treatment and became engaged in his medical care. He also became a member of The Dr. Peter's Centre Day Health Program for meals and additional nursing support.

During this time, the client struggled and was on and off methadone. He failed many attempts to restart HIV treatment. He required a significant amount of support to stay on methadone, as he would lose his dosing prescription on the way from the clinic to the pharmacy. He had multiple hospital admissions in relation to AIDS-related illnesses and often left the hospital against medical advice.

In addition to these physical health issues, he struggled with suicidal ideation and hopelessness. He required a great deal of support to accomplish day-to-day tasks as his life was very chaotic and he was often intoxicated.

A turning point finally came in 2015 when Ross became stabilized at a detox centre, after many failed attempts at detox over the years. He then restarted on ART and was transferred to a treatment centre. He eventually left the treatment centre after facing stigma and abuse due to his HIV status. The STOP staff supported and encouraged Ross to reintegrate into the centre. He returned and completed his treatment program before moving into a recovery house.

Ross eventually moved to independent sober housing and began attending appointments independently. His CD4 count increased to 150 and his viral load reached undetectable levels, making likelihood of transmission negligible.

At this time, Ross hopes to become a mentor to assist others in facing their addiction and in growing towards wellness.