

# AHEAD

Social Work Research at the University of Michigan

## PROJECT ICI



COLLABORATING  
WITH COMMUNITIES  
TO END THE  
HIV EPIDEMIC



SCHOOL OF SOCIAL WORK  
UNIVERSITY OF MICHIGAN

# welcome



It is with great pleasure that I introduce *Ahead*, a magazine focusing on social work research at the University of Michigan.

Often we read of a research project in a scientific journal and are left with questions: How long did it take to collect the data? How did the research team decide on the sample? How were the findings disseminated? *Ahead* will highlight the effort, and the beauty, behind what happens in each phase of the research cycle.

This debut issue showcases the New York City–based Project ICI (Interagency Collaboration Implementation), of which I am the principal investigator, funded by the National Institute of Mental Health (NIMH) (R01MH095676). In particular, we focus on the Project ICI Dissemination Symposium, held May 4, 2017, in New York City. We started Project ICI in 2012, when I was teaching at the Columbia University School of Social Work. The project continued successfully under my leadership when I came to the University of Michigan in 2015.

Project ICI seeks to develop best practices for collaboration among health and social service practitioners who bring evidence-based services to those at risk for or living with HIV. We seek to narrow the research-to-practice gap by addressing barriers to client participation in the HIV “continuum of care”—testing, primary care, and adherence

to antiretroviral treatments. Social workers, public-health educators, nurses, and others in HIV prevention are the focus of Project ICI.

The project is grounded in principles of community-based participatory research (CBPR) and was conceived and conducted in collaboration with its Implementation Community Collaborative Board (ICCB), a group of community stakeholders, practitioners, and service consumers. I would like to thank the ICCB, the participating agencies, and all the others who have made Project ICI successful in New York, and ultimately, as we note below, in Michigan and beyond.

I am pleased to share Project ICI with you, and I look forward to presenting more in-depth views of social work research in future issues of *Ahead*.

*Rogério M. Pinto*

**Rogério M. Pinto, PhD**

Associate Professor

University of Michigan School of Social Work

*Project ICI's Implementation Community Collaborative Board (ICCB) and friends at the May 4, 2017 symposium*



# Collaborating with Communities To End The HIV Epidemic



Project ICI (2012–17) is a longitudinal, mixed-method study, focused on understanding the role of collaboration among New York City organizations providing evidence-based HIV-prevention services. We surveyed social workers, public health educators, nurses, and many other services providers (“providers”) employed by 36 New York City community-based agencies, health clinics, and hospitals. We collected baseline data from 379 of these providers and, for the 12- and 24-month follow-ups, we collected from 250 providers. To help spark collaboration among participants, we offered trainings in interagency and transdisciplinary collaboration (see page 22) to 226 providers between their baseline and 12-month follow-up. We also collected in-depth interview data from 20 participants to obtain a deeper understanding of the impact of collaboration (both barriers and facilitators) on providers’ abilities to help at-risk individuals both prevent and treat HIV infection. **M**

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**INTERPROFESSIONAL  
COLLABORATION LAB**



**SCHOOL OF SOCIAL WORK**  
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University of Michigan**

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# THE PROJECT ICI SYMPOSIUM

## RESEARCH TO PRACTICE

Research findings are commonly shared through peer-reviewed publications, rarely reaching beyond academia to communities. To bridge this gap between research and practice, between academia and communities, Project ICI, at the end of its final year, hosted a dissemination symposium at Columbia University, bringing together nearly 60 of its participants, along with community members, administrators, and researchers. ICI participants who attended the symposium represented all 36 agencies participating in the study. Administrators in every participating agency and all providers who participated in Project ICI will receive a copy of this issue of *Ahead*. This is our way to say “thank you” and to keep our promise to share the key results of Project ICI.

The day began with breakfast, introductions, and an overview of the project. Keynote addresses came from Dr. Christopher Gordon, chief of the HIV Treatment and Translational Science Branch at the Division of AIDS Research at the NIMH, and Dr. Julie Myers, Director of HIV Prevention at the New York City Department of Health and Mental Hygiene. Both discussed the importance of research in combating HIV. Participants

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*This event uniquely engaged and helped community members and providers.*

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heard from and engaged with a panel of administrators, providers, and researchers who discussed and analyzed the Project ICI findings. Team members led small-group discussions on collaboration, self-care, research involvement, and future research.

This event uniquely engaged and helped community members and providers—offering continuing education credit, multimedia modes for participation, networking opportunities, and space to focus on wellness and each person’s unique experience.

Symposium participants were grateful to meet others who represented a cross-section of HIV-prevention and treatment professionals in New York City. The event allowed effective sharing of research results. Researchers were able to tackle difficult questions with providers, explore their experiences, and learn about the areas of greatest impact for future research. Participants had their opinions and experiences validated by peers. By uniting the worlds of research and practice in one place, we helped discover true understanding and made progress together. **M**

*Opposite page, at the Project ICI Symposium: Top: Rogério M. Pinto, PhD, Principal Investigator; Prema L. Filippone, MSW, Project Director. Bottom Left: Leslie-Ann Lezama, symposium performer and study participant, After Hours Project. Bottom Right: ICCB member Charles Sanky*

# The Questions We Asked, The Answers We Heard

PREMA L. FILIPPONE, LMSW, PROJECT ICI DIRECTOR

*Project ICI's director, Prema L. Filippone, LMSW, welcomed participants to our Project ICI Dissemination Symposium in New York City. The audience included representatives of the 36 NYC service agencies that participated in Project ICI over the past five years, along with special guests.*

Project ICI allows us to hear your perspectives on collaboration and on HIV care. Often we focus on clients and forget to ask, How well are we collaborating? Are we linking enough people to care they need? What facilitates and what hinders interagency collaboration? How has your ability to collaborate and link clients to care increased or decreased? When the Centers for Disease Control (CDC) deemphasized DEBIs (Diffusion of Effective Behavioral Interventions), what happened at agencies? Some programs shut down or downsized. Organizations merged. It was an organic process as you worked to give your clients what they needed.

Project ICI looks at how you've been offering behavioral interventions or linked people to evidence-based services such as mental health, HIV testing, PrEP (Pre-Exposure Prophylaxis), and PEP (Post-Exposure Prophylaxis). We collected data from 379 providers at 36 agencies on providers' experiences with collaboration and referral-making, focusing on which evidence-based services you used to link clients to care. We offered the Interagency Transdisciplinary Collaboration training, highlighting



Prema L. Filippone, Project Director

provider collaboration skills and helping create a professional network of providers from this study.

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*Often we focus on clients  
and forget to ask, How well  
are we collaborating?*

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We collected data at two more points, 12 and 24 months after the baseline, in order to see what had changed for you. We had some attrition, but we successfully retained 250 providers for each data point. Follow-up interviews allowed us to study your work-related stressors and

personal life experiences, capturing changes that affect provider collaboration and the linking of clients to care. Finally, we conducted in-depth interviews with a randomly selected group of 20 providers from participating agencies. These interviews allowed us to better understand barriers and facilitators to collaboration and links to care.

All of what I have described was possible because of the longstanding commitment of the individual providers and the community-based organizations in this study. We thank you all! **M**





## ICI PARTICIPATING AGENCIES

### MANHATTAN

African Services Committee  
Ali Forney Center  
APICHA Community Health Center  
Bailey House  
Care for the Homeless  
Exponents  
Foundation for Research on Sexually Transmitted Diseases (FROST'D)  
Gay Men's Health Crisis  
Harlem United  
Iris House  
Latino Commission on AIDS  
Lesbian, Gay, Bisexual & Transgender Community Center  
New York Harm Reduction Educators  
Partnership for the Homeless  
Project Renewal  
Safe Horizon  
Urban Pathways  
Washington Heights CORNER Project

### BRONX

BOOM!!Health (Formerly Bronx AIDS Services; merged with CitiWide Harm Reduction)  
Services for the Underserved (formerly Palladia)  
Vocational Instruction Project Services

### BROOKLYN

After Hours Project  
Bridging Access to Care  
Brookdale University Medical Center  
Center for Community Alternatives  
Gay Men of African Descent  
Housing Works  
Turning Point  
Urban Neighborhood Services  
Wyckoff Hospital

### QUEENS

AIDS Center of Queens County  
Fortune Society  
Reality House

# “I believe that community and research are the same”

SUSAN S. WITTE, PhD, PROJECT ICI CO-INVESTIGATOR



Susan S. Witte, PhD, Co-Investigator

*At the symposium, Project ICI co-investigator Susan Witte, PhD, spoke about the importance of community-based participatory research.*

**I** am going to talk about community-based participatory research, or CBPR, since Project ICI is a CBPR study.

Many of us in this room have been doing this work for 10, 20, even 30 years! Fighting HIV has defined our professional and even our personal lives. I have worked in HIV prevention since I graduated from college in 1986. In 1988 I became a volunteer at AIDS-Related Community Services in the Hudson Valley. I left ARCS and began conducting HIV-prevention research at Columbia because, as a

practitioner, I was frustrated by how researchers thought and spoke about the work I did. They did not understand how to ask the questions to which we needed answers.

ARCS now has a new name: Hudson Valley Community Services. I am back as a member of the board. The name reflects the progress we have made in three decades. With HIV, we are now talking about the continuum of care and about ending the epidemic, and our work encompasses other chronic diseases. Similarly, Project ICI asks key questions to move us toward success with the continuum of care. All this is because of community.

I believe that community and research are the same. You cannot do research outside the community

affected. Findings will not reach the people “in whose name or purpose” the research is being conducted. I am proud to be a part of this community and this research team. To be here today with members of this community who provide the daily care, treatment, and prevention services to the community is a privilege.

CBPR enhances the meaning and validity of research findings. Communities help us interpret our findings and make use of them. CBPR builds community capacity; what comes from the community goes back to the community. CBPR must promote systems change. We are fortunate today to have the NYC Department of Health and the National Institutes of Health with us, as well as all of you, who define the HIV system of care. In our current political context, we are talking about how funding might end; we know the work will not end.

We can use CBPR to eliminate health disparities. We will continue to work toward that goal for the rest of our lives.

After 25 years as an HIV-prevention researcher, this is the first time that I am spending a day with individuals who are participants in a research project in dialogue about the findings. That says a lot about where the field needs to be. It needs to be here. You are making it happen; you are making meaning of what we are learning so we can end the epidemic. **M**



# “We focused on the questions you were asking.”

ROGÉRIO M. PINTO, PhD, PROJECT ICI PRINCIPAL INVESTIGATOR



*At the symposium, Principal Investigator Rogério M. Pinto, PhD, spoke about how CBPR helps respond to policy changes and shifts in service priorities.*

In 2004, as a postdoctoral fellow at the HIV Center for Clinical Studies at the New York State Psychiatric Institute, I asked agency practitioners—including people from agencies now in Project ICI—what I should be studying. This gave rise to the research questions that I have been pursuing for many years now, including those asked by Project ICI.

By following community-based participatory research (CBPR) principles, Project ICI has been open to environmental changes; since the project started in 2012, we adjusted expectations and updated our research questions based on community needs. Ms. Filippone mentioned DEBs—scripted behavioral interventions on which much research has focused in the past two decades. But since 2012, when we found that antiretroviral medications can help prevent HIV transmission by lowering the viral load in the bloodstream, we have also pursued research to understand the HIV continuum of care—testing, accessing primary care, and adhering to antiretroviral regimens.

Without leaving our original questions, we focused on questions you were asking: How can I best help my clients to access HIV testing and primary care? How can I address barriers to adherence to HIV medication? I am sure you noticed a change from our baseline to our follow-up survey questions. We changed and updated questions so that we could learn how shifts in HIV policies had shaped current practices. In doing this, we adhered to CBPR.

**We went to the community and asked you what we should be studying, what might be helpful to the community, and then we tracked your concerns over time.**

CBPR allowed us to develop deep human connections. We engaged 36 agencies and 379 providers at baseline. We trained 226 practitioners. Imagine how often we have been in touch to make this happen! There are many connections behind those numbers—connections that could not have been made without funding to conduct Project ICI. **M**



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**KEYNOTE**


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# “Getting what we know works into the hands of those who need it.”

CHRISTOPHER GORDON, PhD, NATIONAL INSTITUTE OF MENTAL HEALTH

Dr. Gordon is chief of the HIV Treatment and Translational Science Branch at the Division of AIDS Research at the National Institute of Mental Health. His primary responsibilities involve development of new programmatic initiatives, administration of currently funded research, and building scientific collaborations among other institutes, agencies, and community/clinical sites. Dr. Gordon coordinates the Division of AIDS Research activities in dissemination and implementation research.

Dr. Gordon beamed in from his office at the NIMH in Washington, DC, where, he modestly joked, “no magic happens.” (But hard work, yes, as he acknowledged the work of all participants many times over the next 20 minutes.) Dr. Pinto introduced Dr. Gordon as “a champion of the work we do, without whom we would not be here today.” Dr. Gordon returned the kudos and remarked on his steady, heartfelt support of Project ICI over the years. He praised the messages of Drs. Pinto and Witte and Ms. Filippone, thanked the symposium attendees for all their work, and stated how important it was for this particular group to gather and “take time to celebrate what has been accomplished.”

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*“This is cutting-edge science,” Dr. Gordon declared, and he stated that the most important task of his office over the next ten to fifteen years will be “getting what we know works into the hands of those who need it.”*

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Dr. Gordon spoke about how Project ICI responded to policy shifts and service priorities over its five years, and asserted that one of the strengths of implementation science is its ability to “move with the field.” While the ICI mission remained the same, the content changed as prevention and treatment strategies changed. “This is cutting-edge science,” Dr. Gordon declared, and he

stated that the most important task of his office over the next ten to fifteen years will be “getting what we know works into the hands of those who need it.”

The group reviewed with Dr. Gordon some slides he provided for their packets, which reinforced the commitment of the National Institutes of Health (NIH) and the NIMH to implementation science; showed a timeline of NIH/NIMH activities in this area; and pointed out the critical importance of researchers partnering with communities and implementers to closing the gap between research and practice. “We want to hear from the people actually making decisions about risk. Neither medications nor technology will solve all problems,” Dr. Gordon said, “unless they are put into the hands of those using them in the best way possible.”



Christopher Gordon, PhD

“We’ve come a long way,” Dr. Gordon concluded, “but there’s a lot of work to be done.” He invited anyone present to be in touch with him, and Dr. Pinto promised that, once the day’s activities and discussions had determined next steps, he and his colleagues would indeed communicate them to Washington. **M**



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**KEYNOTE**


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# Ending the HIV Epidemic: “We can do this through collaborative work.”

JULIE MYERS, MD, MPH, NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

*Dr. Myers is the Director of HIV Prevention in the Bureau of HIV/AIDS Prevention and Control of the New York City Department of Health and Mental Hygiene. She leads the department's efforts to implement PrEP and PEP citywide. She works as an HIV primary-care physician at Columbia University Medical Center and is an instructor in the College of Physicians and Surgeons. Dr. Myers received her MD from Cornell and her master's in public health from Columbia. She started in HIV prevention as a volunteer with the Lower East Side Needle Exchange Program.*

**D**r. Myers acknowledged many colleagues present, noting that the New York City Department of Health (NYCDOH) has supported many initiatives created by Project ICI partner agencies represented in the room.

She then announced her galvanizing theme: HIV/AIDS activism, political will, and science are coming together to end the AIDS epidemic. This will happen officially when annual rates of new AIDS infections drop below that of deaths. For New York City, the target year is 2020.

Dr. Myers traced the history of HIV/AIDS in the city, from the worst days of the 1980s through the introduction of antiretroviral therapy in the 1990s, leading to a 58% reduction in new diagnoses between 2001 and 2017.

She pointed out that new AIDS diagnoses today are unequally distributed, the majority being of young black and Latino men living under the federal poverty level. “We must work together,” Dr. Myers asserted—a message embodied by Project ICI—“because so many neighborhoods are affected.” She praised NYCDOH commissioner Mary Bassett for looking at the epidemic through a “health equity lens,” making a deliberate effort to pinpoint health disparities and address them in creative ways.

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**“We must raise our voices.  
There is resistance work  
to be done.”**

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Dr. Myers cited many initiatives in place to help end the epidemic, including community activism, increasing access to PrEP and PEP, the NYCDOH's Undetectable=Uninfected campaign, and the announcement by Bill de Blasio, New York City's mayor, on World AIDS Day, 2015, that the city would put \$23 million toward ending the epidemic.

Dr. Myers reviewed the foundational elements of ending the epidemic: identification of those undiagnosed, retention in treatment of those diagnosed, and access to PrEP for those testing negative. This, broadly



Julie Myers, MD, MPH

speaking, constitutes the HIV continuum of care—not linear, but rather a continuous cycle of reengagement with each individual.

“This is a critical time,” Dr. Myers told the room, calling for advocacy and collaborative approaches such as those studied by Project ICI. “We must raise our voices together. There is resistance work to be done right now.”

As for ending the epidemic by 2020, Dr. Myers said, “We are well on our way. We can do this through collaborative work and through resistance and activism and advocacy. We are motivated by the health disparities and by social justice. This is what important research looks at.” **M**

# Longitudinal Design: “Having snapshots isn’t enough.”

MELANIE M. WALL, PhD, PROJECT ICI CO-INVESTIGATOR



Melanie M. Wall, PhD, Co-Investigator

*At the symposium, Project ICI co-investigator Melanie M. Wall, PhD, spoke about the uses of data and the importance of this being a longitudinal study.*

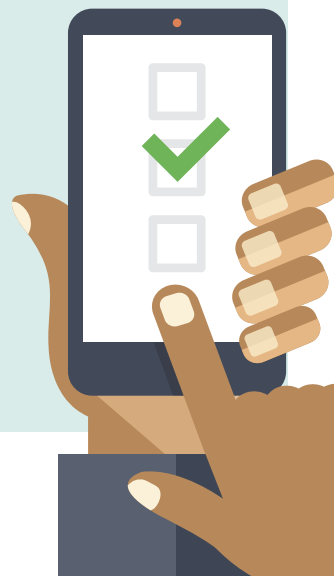
All the responses that providers gave to the questions we asked went into a huge database. Our goal was then to make some sense of it all. It's important to realize from the quantitative perspective—and I know that the qualitative work done on this project is important, too—that there is an idea that, if you can't measure it, you can't improve it. So with the quantitative data we were trying to develop a measurable way of understanding what's out there and, more importantly, draw connections between what we think are important factors, such as how collaborative people are and how many referrals they are making. By linking the data we are able to answer research questions that all of us are asking. For example, “Does collaboration matter?” Well, now we can look at data, look at those associations, and come up with an answer to those questions. So I guess I am saying: data are important. And we do our best to take very good care of the data!

But perhaps the most important aspect of this study is its longitudinal nature. Dr. Gordon spoke about the changing environment that we're in. Well, the fact that Dr. Pinto

had the guts to push the project to be extended across three points of data collection is really just unheard of in the agency environment. The first response we had from reviewers was, “There's no way you are going to be able to do this. You're not going to be able to follow people in this environment even for three months.” We pushed back. We asserted that it was necessary to design the study to look at your work across a much longer period of time, in order to get an idea of what the real world is like and how it is changing. Having just snapshots isn't enough. The longitudinal aspect of this data structure lets us address questions that are really critical to the field of implementation science. **M**

## TECHNOLOGY ENHANCES ENGAGEMENT

Consistent with our commitment to CBPR, we sought to engage symposium participants throughout the event. Symposium attendees had the opportunity to participate by texting their questions and thoughts via Poll Everywhere, a digital tool for live, interactive audience participation. The event organizers displayed questions and prompts and collected data in a matter of minutes. When participants texted their answers, these responses showed up on the screen anonymously. We taught participants how to use this tool at the start of the day, asking, “How are you feeling right now?” Responses allowed us to gauge the emotional states of participants while introducing this technology. We polled participants later to get responses to our fishbowl panel discussion, small-group discussions, and end-of-day debriefings. Poll Everywhere was a powerful and practical way for us to gather group feedback quickly. Symposium attendees were able to interact and contribute to our discussions in a way that validated their voices in an academic space.







**379**  
PROVIDERS



**36**  
SOCIAL / HEALTH  
SERVICES AGENCIES



**5**  
YEARS

## Project ICI Participants and Procedures

Our findings come from baseline data from 379 providers in 36 social and public-health services agencies in New York City. In order to recruit a variety of agencies, our Implementation Community Collaborative Board (ICCB) held provider recruitment breakfasts in 2012. We included agencies with earmarked funding for services for those most at risk for primary and secondary HIV infection. The first 36 agencies that accepted our terms became the basis for the study. Incentives to participate included one laptop computer per agency and gift cards for individual providers.

An average of 10 staff members per agency participated. ICCB members implemented computer-assisted, face-to-face interviews with providers at their agencies. Data were uploaded and safely managed by using DatStat software, to which only relevant personnel had access. Provider interviews lasted from 45 to 60 minutes.

### Service agency sample

All 36 agencies were nonprofit organizations providing medical HIV-related services (e.g., HIV testing, HIV medical care) and myriad social services. Twelve agencies had budgets above \$10 million; 10 had budgets between \$5 million and \$10 million; 10 had budgets between \$1 million and \$5 million; and four had budgets below \$1 million. Eight agencies employed more than 100 providers of direct clinical and/or case-management services; four agencies employed 50 to 100 such providers; and 24 employed fewer than 50.

### Provider sample

Sixty-two percent of providers were women. The sample was diverse ethnically and racially: 64% identified as Hispanic/Latino. Racially they identified as 51% black or African American; 27% white; 17% more than one race; and 5% Hawaiian native, Asian, American Indian, or Alaskan native. The mean age of the sample was 41 years. The sample included case managers, counseling staff members (e.g., social workers), education/outreach workers, health navigators, supervisors (e.g., of counselors, case managers, educators, and/or outreach staff members), and program administrators. The largest proportion of the sample had bachelor's and master's degrees.

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*Our findings come from baseline data from 379 providers in 36 social and public-health services agencies in New York City.*

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### Retention and Attrition

Of all participants in Project ICI, 104 (about 35%) changed organizations. We were unable to follow up with 86 providers who changed jobs, moved out of state, or went on medical leave. Three of our providers passed away. Two smaller agencies had to close, agencies merged with other agencies, and small and large agencies had to address funding losses. Perception of competition among agencies seemed to intensify. **M**

# Collaborating to End HIV/AIDS

## What We Found

**W**e have begun the analysis of all the data we have collected in the past five years. Using baseline data, we have conducted analyses to shed light on three key points of interest. Using survey data we have studied (1) the degree to which Project ICI participants who were exposed to behavioral HIV-prevention interventions before 2012 were more likely to link their clients to HIV testing and primary care; and (2) what facilitates integration of HIV and substance-treatment services. Using in-depth interview data, we have (3) identified key factors that influence how and how often participants link their clients to HIV testing and primary care.

But before we can interpret our findings, we need to note that in 2012, when Project ICI was launched, the landscape of service provision changed dramatically; starting in 2012, treatment with antiretroviral medication became the major HIV-prevention strategy worldwide, and the CDC began to de-emphasize many of its behavioral HIV-prevention interventions. Our findings reflect the new landscape that requires providers to identify appropriate behavioral interventions for their clients, link their clients to HIV testing and primary care, and help them stay on prescribed medication regimens. Linkage-making behaviors were explored in both our surveys and in-depth interviews with providers.

As Project ICI was funded at the precise time these changes began to occur in 2012, our results provide insight into whether or not exposure to CDC Effective Behavioral Interventions (EBIs) influenced providers' linkage-making behaviors regarding HIV testing and primary care. Our findings show that out of 379 providers, 142

(37%) were not exposed to EBIs, meaning the agencies for which they worked were not funded to provide such interventions. Nonetheless, those who were exposed to EBIs are now more likely to make linkages to HIV, HEP-C and STI testing, to primary care, and to drug-treatment and mental health services.

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*In 2012, when Project ICI was launched, the landscape of HIV service provision changed dramatically.*

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Project ICI also shed light on what factors may help improve integration of HIV-prevention services with substance-using clients. We found that HIV-prevention training, training in evidence-based practices, staff collaboration, and job satisfaction were all associated with increased staff use of the following evidence-based practices: sexual-risk assessments, risk-reduction counseling, condom demonstration, and referrals to HIV testing—or a combination of two, three, or four of these services.

Our in-depth interviews with 20 randomly selected ICI participants revealed that various factors may help improve providers' linkage-making to HIV continuum-of-care services, such as HIV testing and primary care. Data analysis revealed key facilitators of and barriers to linkage-making. For example, providers who had made linkages on behalf of family members, friends, or themselves seemed more likely to link their clients to similar services. **M**



*Fishbowl participants, left to right: Pinto, Witte, Ruffins, Etienne, Shack, Josepher.*

## The Community Reacts

We are committed to bringing the Project ICI study results back to the community. At the symposium, we did this in real time, not just announcing results or showing slides, but bringing community collaborators onstage in a “fishbowl” to discuss those results while others observed. The full room then had the opportunity to discuss both the project’s results and the issues raised by the fishbowl participants.

Fishbowl participants included: HIV/AIDS activist Elder Antionette Etienne of Iris House (ICI participating agency); Howard Josepher, LCSW, co-founder and President of Exponents (ICI participating agency); Frederick Shack, LMSW, Executive Director of Urban Pathways (ICI participating agency); and, from the Project’s ICCB, Drs. Pinto and Witte and Jeannette Ruffins.

### **Contrasts across small and large agencies**

Fishbowl participants discussed the importance of supporting smaller community-based agencies, which, with little funding, provide lifesaving services to populations at risk. Panelist Howard Josepher from Exponents said, “Will we ever learn the lesson that the bigger you get the more out of touch you get?” This comment reflected our results; it appears that in small agencies, providers may be more knowledgeable about the culture and current issues in the communities they serve than their bigger-agency counterparts.

Another participant remarked, “Larger corporate organizations are so culturally removed from our population.” In contrast, members of the community lead community-based agencies and can establish more intimate relationships with clients, even if they are able to offer fewer services. This does not mean that providers in larger agencies are not aware of these issues; it simply suggests that providers are not a homogeneous group. There are myriad differences among providers across agencies of all sizes and capacities. As agencies merge, they often lose the decades of work, trust, and relationships they have built. Structural racism and classism are undoubtedly important considerations in this trend.

### **Integrating HIV prevention into substance-misuse treatment**

Significant reductions in new HIV infections have occurred in the past several years, but incidences remain disproportionately high for clients who use



alcohol, drugs, or both. In the United States, 2.6 million American adults receive substance-use treatment in community-based programs each year. Substance users are at heightened risk for HIV infection through sexual contact and needle-sharing practices. Social and public-health service providers have an opportunity to offer HIV prevention to individuals at risk, including substance-using clients, as is widely recommended.

Our fishbowl panel was not surprised that factors uncovered by Project ICI may improve integration of HIV-prevention services with clients who use or misuse substances. They stressed that staff collaboration and job satisfaction were associated with increased use of myriad evidence-based HIV-prevention practices. They contended that these findings made sense in that providers who are treated well by their agencies will likely perform at a higher level. A symposium attendee furthered this conversation by discussing the importance of developing relationships with clients. Using Poll Everywhere, she texted that establishing this trust and personalizing interventions become difficult in the absence of job satisfaction and staff collaboration.

### **Making Linkages**

Because smaller agencies are often grant-based and faced intense pressure to retain clients, they may be resistant to collaborating. They may fear that clients will not return after being referred to another agency. Collaboration is an important solution to these issues,

as all of these agencies can benefit from working together, developing relationships with clients, and learning evidence-based practices while retaining close relationships with those they serve.

For example, in discussing our findings regarding providers' exposure to EBIs, fishbowl panelist Jeannette Ruffins of Bailey House suggested that some providers may work for agencies that offer different types of EBIs and still not realize that the interventions their agencies carry out are actually EBIs. Some agencies may be so large and have departments that are physically so far apart that information about EBIs may not travel so easily as we may wish it did.

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### *Panelists agreed on the critical role of collaboration in helping clients.*

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We know from Project ICI findings that those providers who were exposed to EBIs are now more likely to make linkages to HIV, HEP-C, and STI testing, to primary care, and to drug-treatment and mental health services. Ms. Ruffins interpreted this finding as suggesting that providers who are exposed to one type of evidence-based practice (EBP) targeting myriad health-promotion behaviors may become more knowledgeable about and develop more positive attitudes toward them, and thus become more likely to adopt other EBPs, such as HIV-prevention EBIs.

*Jeannette Ruffins, Elder Antionettea Etienne, and Frederick Shack in the fishbowl.*





Left to right: ICCB member Rosa Bramble Weed asks a question of the fishbowl participants; ICCB member Karen L. Baird

The panelists also discussed the qualitative findings indicating that forces at the personal, job, agency, and community levels affect providers and the provision of care. A provider who is negatively affected in any of these spheres has a decreased ability to operate effectively in other spheres. Fishbowl participant Frederick Shack, from Urban Pathways, explained, “A lot of this work is about relationships—having a lived experience.” Work-related factors such as physical space, promotions, and increased responsibilities appear to influence the amount and frequency of linkage-making. On the other hand, in the current competitive environment, pressures to retain clients and fear of losing clients to other agencies may negatively influence linkage-making behaviors. Panelists agreed on the critical role of interprofessional collaboration in helping clients access services and stay in care.

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*“A lot of this work is about relationships—  
having a lived experience.”*

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Our findings have been written up in scientific papers that are now under review by several peer-reviewed journals. For the next several years, we will continue to analyze and integrate both qualitative and quantitative data. We will identify longitudinal patterns of linkage-making and many other behaviors that guide HIV-prevention practice. In the spirit of collaborative research, we plan to write and publish papers in collaboration with ICCB members, and colleagues and PhD students at the University of Michigan and across the country. **M**

Symposium attendees enjoy the fishbowl.



# Keeping Our Balance: Fighting Compassion Fatigue and Burnout

Our findings showed that a large portion of ICI participants have faced various challenges, including compassion fatigue, vicarious trauma, mental health concerns, and burnout. Institutionalizing what self-care and wellness mean within organizations is an important step in addressing this issue uncovered by Project ICI.

We wished to honor these results by providing symposium participants with inspiration for how they might begin to develop self-care strategies. ICCB members Wendy Whitman, MA, LAc, an acupuncturist, and Angela Ghesquiere, PhD, a social work researcher and Reiki practitioner, provided a mini-workshop on self-care. Wendy explained the self-care materials we had distributed to the group: pamphlets on coping with stress; guided meditation exercises; dark chocolate (which has calming antioxidant properties); herbal tea (chosen for its relaxing properties); sachets filled with lavender, the scent of which reduces anxiety and aids sleep; and stress balls and guidelines on hand acupressure. Ms. Whitman demonstrated how to press the fingers and palm into the stress balls to relax different parts of the body. She also demonstrated two mudras—finger positions that harmonize the body using the nervous system and acupuncture meridians in the fingers. Participants held the second mudra while Dr. Ghesquiere explained Reiki, a the Japanese system of energy healing and anxiety reduction. She then practiced Reiki on the entire room for several

minutes. (Reiki may be practiced over short or long distances, as well as through direct touch.) Both women emphasized the importance of the attendees continuing their self-care, especially in midst of their often stressful work environments.

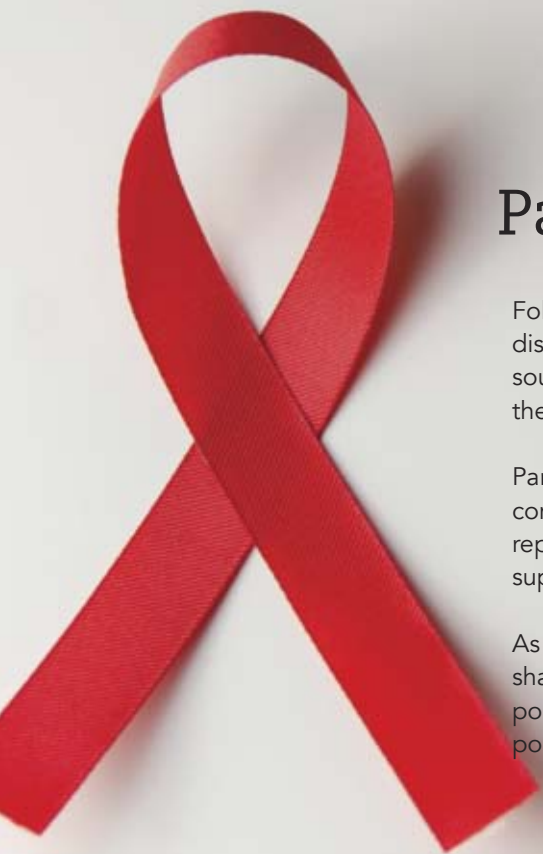
ICCB member Rosa Bramble Weed also spoke on the issue of self-care, specifically in agency work: “In our busy work lives and agencies we lose sight of the resources we have to help achieve balance in our lives. It is important to be attentive to the world through our senses, helping us find comfort, pleasure, and balance. The music we heard at lunchtime helped us pause, breathe, and listen to sounds and lyrics.\* The beat of percussion and guitar connected us with our breathing, which is how we regulate ourselves when we are stressed. No wonder we smiled, felt relaxed, and connected with each other! There was spontaneity and laughter—signs of relaxation and reenergizing. Music and movement are part of self-care—our ability to function effectively in the world while meeting the challenges of daily life with energy, vitality, and confidence. We aim for balance within work life and between home and work, including the physical, psychological, emotional, and spiritual domains.” **M**

*\*Music was provided by: Leslie-Ann Lezama and the Unique Band (Ms. Lezama is a study participant, from the After Hours Project); and Paul Chang (Columbia College class of 2019).*

*Wendy Whitman and Angela Ghesquiere help participants relieve stress!*







## Participants' Recommendations

Following our wellness activities, symposium attendees participated in small-group discussions at their tables. Facilitated by trained ICCB members, these discussions sought to further engage everyone in reflection about the Project ICI findings and their experiences.

Participants were happy to share their thoughts and felt validated when able to contribute their voices to the larger conversations of the symposium. Each small group represented a cross-section of all those involved, spanning researchers, administrators, supervisors, direct service providers, and health department officials.

As a result, the conversations were rich and allowed for a variety of perspectives to be shared. Conversations were focused on four main questions. Here we summarize key points made by small-group participants as they considered the specific questions we posed to them.

### *What are the barriers to self-care, and how can your agency help?*

Most groups cited having intense workloads and being overworked as major barriers to self-care. Providers have limited time to interact with clients, and mentioned dealing with a lot of unnecessary bureaucratic tasks and paperwork that interfered with service provision and self-care. With the limited funding that agencies face and frequent vacancies in staffing, providers are often overworked. Some reported giving up breaks and lunchtime to accomplish daily tasks. Many groups noted that agencies could distribute responsibilities more evenly and protect providers' breaks and lunchtimes. Most symposium attendees also commented on the importance of setting aside space and time for self-care activities such as meditation and yoga, as well as music rooms and break rooms. They also suggested wellness workshops and mindfulness training, self-care or behavioral-health days, check-ins with teams and supervisors, organizational commitment to advocacy and social justice, and attention to team dynamics and responsibilities. They said that supervisors could model self-care to providers, highlighting the importance of wellness in an agency. Attention to agency wellness improves client wellness, as providers also model self-care to their clients. Elder Antionette Etienne of Iris House stated during the fishbowl panel discussion, "We have to stay as one."

#### SUMMARY OF RECOMMENDATIONS

Agencies can:

- ✓ Distribute responsibilities more evenly
- ✓ Invest in management, supervision, and teamwork improvement
- ✓ Model self-care for providers, who will in turn model self-care for their clients
- ✓ Bring in massage therapists, host events, create spaces and times for self-care
- ✓ Create support from supervisors and managers to create a culture of self-care
- ✓ Build meditation, yoga, and other self-care sessions into the day

## *What do we need to do to better retain providers in research?*

Small-group members commented on how a lack of available staff and intense workloads foster the perception that research participation interferes with workflow. They also described how historically, research has taken advantage of vulnerable populations, creating a lasting feeling of distrust. Symposium attendees suggested finding strategies to build trust between researchers and community agencies. By offering educational “crash courses” in research methodology and institutional review board (IRB) protocols, investigators could facilitate agency and provider participation. Offering incentives to administrators and providers as well as sharing research findings could also serve as motivating forces.

### SUMMARY OF RECOMMENDATIONS

Researchers ought to:

- ✓ Clarify IRB rules and protocols for behavioral and social research
- ✓ Educate agency administrators about the value of research
- ✓ Provide results to agencies so they recognize value from participating
- ✓ Provide incentives that would make agency participation worthwhile
- ✓ Provide educational sessions/crash courses on research methodology and significance

## *What might facilitate collaboration across agencies?*

In their small-group discussions, symposium attendees cited a lack of communication and competition for resources and clients as major barriers to interagency collaboration. A few participants remarked that memoranda of understanding (MOUs) are often drawn up by upper management, but these do not necessarily mean collaboration is occurring. True collaboration more likely happens through middle management and direct-care providers, so those people should be more involved in the process. Grants offering incentives for collaboration and reduced competition might also help improve interagency and interprofessional collaboration.

### SUMMARY OF RECOMMENDATIONS

Collaboration can be improved by:

- ✓ Monthly meetings of agencies hosted by different agencies.
- ✓ Grants that incentivize collaboration
- ✓ Involving middle management and direct care providers in creating MOUs

## *What should we research next?*

Participants recommended:

- ✓ Develop and test training models to help providers with self-care and building resilience
- ✓ Continue longitudinal examination of interprofessional collaboration with the same cohort
- ✓ Develop and test collaborative models to improve client participation in the HIV Continuum of Care
- ✓ Study the effects of healthcare legislation on provider abilities to help clients
- ✓ Discover how to build trust between academia and community workers
- ✓ Investigate effectiveness of building relationships with colleagues and clients

# “The Fruits of Our Labor”

STUDY PARTICIPANTS REFLECT ON THE PROJECT AND THE DAY



“To see so many community partners in one room, talking about how to make our services better as a community, was so inspiring. **To see that we are collaborating to serve our clients more than ever shows that we are in a new time in service provision in NYC.** Thanks, Project ICI team, for the work you’ve done, and for bringing us all together to see the fruits of our labor.”

JOEY LOPEZ, ALI FORNEY CENTER

“It is outstanding to have more than 30 organizations participating in this study. It highlights the dedication and passion we have for our professions, the clients we serve, and the communities involved. At the symposium, we were able to meet others in the field and learn about the challenges, failures, and successes we all have experienced, allowing us to feel part of a brotherhood and sisterhood helping those with HIV/AIDS and highlighting the importance of collaborating with other organizations. **Thank you for sharing the results of the ICI study and allowing us to celebrate the work we do each and every day.**”

ANDREW K. FRAZIER,  
GAY MEN’S HEALTH CRISIS



“The Project ICI dissemination symposium was a great experience. To understand how collaborations work and thrive in our field is essential. I was especially grateful to have an opportunity to network and develop relationships with new colleagues, enhancing current collaborations. **Having the opportunity to gather with my peers and work together to address the ICI findings as well as next steps was inspiring.** I feel connected to my colleagues and this work in a whole new way, and look forward to our continued work in the future.”

LYNETTE VERGES,  
CARE FOR THE HOMELESS

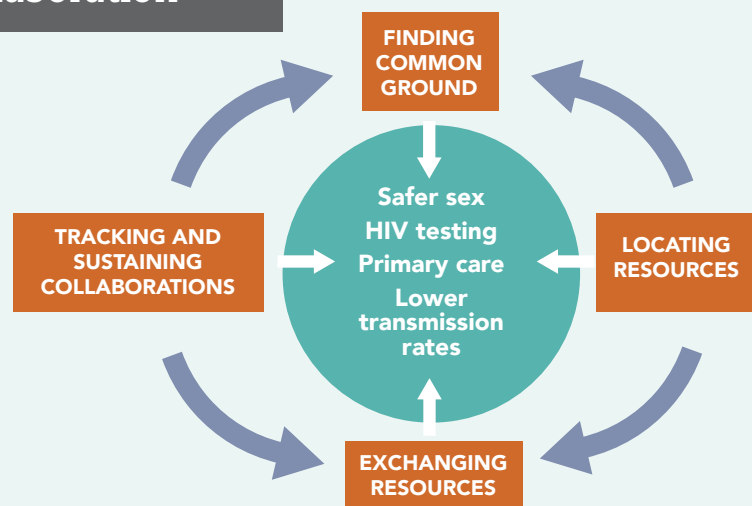


# Interprofessional Collaboration: We can always do better!

One key element of Project ICI has been to offer the space, time, and structure for providers to come together, share their experiences, and advance collaboration methods. Long before the symposium, as part of a longitudinal study, we offered training in interagency and interprofessional collaboration to more than 200 providers between the baseline and the 12-month follow-up.

## Four Stage Interagency and Transdisciplinary Collaboration

We designed the interagency and transdisciplinary collaboration (ITC) training to help providers acquire knowledge, attitudes, efficacy, and subjective norms conducive to collaboration in linking their clients to HIV-related services without fear of losing those clients. This was a one-day training that included skill-building exercises and opportunities to practice ITC components through group activities and discussions. Participants were trained using a four-step model.



### 1 FIND COMMON GROUND

Identify service users' needs, challenges and solutions, and comprehensive intake and ongoing needs assessments over time.

### 2 LOCATE RESOURCES

Find where services/ resources are, within and outside one's own agency, then match these services/resources with the consumer's demographic information and needs.

### 3 EXCHANGE RESOURCES

Create new services, evaluate services, apply for grants, and make mutual referrals

### 4 TRACK AND SUSTAIN

Track collaboration and sustain new services, evaluation of services, grant applications and mutual referrals.

**By the end of this training, participants demonstrated a renewed intention to collaborate with colleagues across agencies. In order to lower HIV transmission rates, the ultimate goal of collaboration among providers is to help their clients find access to safer-sex interventions, HIV testing, and primary care.**

# Expanding Project ICI

Following the project's success in New York, Dr. Pinto and his team have expanded their research on interprofessional collaboration to Michigan, New Jersey, Brazil, and Spain. We have so far collected cross-sectional data from practitioners in each of those locations, allowing us to compare, in domestic and international environments, practitioners' knowledge, attitudes, social norms, and HIV behavioral and medical interventions. These efforts, grounded in our previous research in New York, will allow us to study the influence of interprofessional collaboration on referral-making behavior in myriad sociocultural contexts.




## THE INTERPROFESSIONAL COLLABORATION LAB University of Michigan School of Social Work

The Interprofessional Collaboration Lab at the University of Michigan School of Social Work is led by Dr. Pinto. With funding from the National Institute of Mental Health and several other sources, our research examines how practitioners may better deliver evidence-based services to high-risk populations in the United States (New York City, NY; Newark, NJ; Michigan); Brazil (Rio de Janeiro, RJ; Santa Luzia, MG; Birigüí, SP); and Spain (Madrid). Our work is fully grounded in community-engaged research involving community members, practitioners, and stakeholders.

Relying on social work research, practices, and values, we conduct applied research and produce scholarship with "real world" implications. By improving delivery of science-based services to those affected by serious health problems, our research helps fulfill social work's primary mission, and it responds to calls for interprofessional research and for strategies to close the research-to-practice gap. Our research is guided by community-based participatory research principles in partnership with practitioners and service consumers (e.g., racial-, ethnic-, and sexual-minority women), and is based in service agencies in communities affected by health disparities. Diffusion-of-innovations theory generally guides this research. We use a variety of mixed methods, an NIH priority with the potential to enhance service delivery.

Our key areas of interest include the dissemination and implementation of evidence-based HIV-prevention and substance-misuse-treatment interventions. We also study the roles that interprofessional collaboration may play when different types of service providers work together to deliver evidence-based services. This research includes studies that examine factors influencing the participation of racial-, ethnic-, and sexual-minority women in research and in healthcare systems.

Our research has shown that practitioners who have been involved in scientific research are more willing to use research findings in their day-to-day practice. An organizational culture that values research can help enhance providers' intentions to partner with researchers in developing better services for clients. Providers with favorable attitudes toward evidence-based research and those reporting a sense of satisfaction with their jobs are more willing to use EBPs.

Our research will continue to explore myriad factors that can affect how research findings and evidence-based practices can best be translated into community practice and service delivery in the United States, Brazil, and Spain. 

# Piloting Project ICI in Michigan

In 2016, the University of Michigan School of Social Work Vivian A. and James L. Curtis Center provided funding to collect in Michigan the same type of data we collected in New York. Special thanks to our associate dean, Joe Himle, for his assistance. This expansion would not have been possible without the Michigan Department of Health and Human Services, particularly Mary Roach, MPH, CHES, program evaluator for the department's HIV-Prevention Unit, and members of the Michigan HIV/AIDS Council, of which Dr. Pinto is a member.



Working with master's and doctoral students, Dr. Pinto launched the Interprofessional Collaboration (IPC) Lab at the University of Michigan School of Social Work. These students have assisted in several phases of the research cycle and in the management of two grants. Dr. Pinto has provided mentoring and trained them in CBPR and qualitative and quantitative methods. **M**

**Pei Ni Ong** is a research associate at the IPC Lab. She has been involved in developing and evaluating programs and services for families in poverty. Her interests include international and cross-cultural adaptation and implementation of programs.

**Kathryn Berringer** is a PhD student in the joint program in anthropology and social work at the University of Michigan and a research assistant at the IPC Lab. She has several years of experience as a practitioner and researcher in the field of HIV treatment and prevention.

**Kiela Crabtree** is a third-year doctoral student in the University of Michigan's department of political science and a candidate for a master's degree in social work from the university's School of Social Work. Her research interests broadly encompass political oppression and political erasure in the context of the United States.

**Rashun Miles** is a first-year master of social work student at the University of Michigan. He is a graduate research assistant at the IPC Lab, where he investigates practitioners' roles in providing evidence-based services to high-risk populations.



*Pei Ni Ong; Kathryn Berringer; Kiela Crabtree; Rashun Miles*





**56**  
**PROVIDERS**



**13**  
**SOCIAL / HEALTH  
SERVICES AGENCIES**



**10**  
**CITIES AND TOWNS**

## Preliminary Findings

Project ICI in Michigan has interviewed 56 providers in 10 Michigan towns. We recruited community agencies and Health Departments that are supported by the Michigan Department of Health and Human Services. Our provider sample included social workers, health educators, care navigators, and others. We administered a modified version of the survey used in the New York City Project ICI, and we also conducted two focus groups. Of the providers who filled out our survey, 36 were female and 20 male. Twenty-seven identified as White providers, 23 as African-American, five as mixed-race, and one as Asian-American. Focus groups included four female and five male providers, and five African-Americans; three White; and one mixed-race.

Our research in Michigan includes collection of data concerning providers' referral-making behaviors and implementation of different types of services, such as HIV-prevention and treatment, disability, rehabilitation, grief services, and other behavioral interventions. We also learned about provider well-being in Michigan. Many Michigan cities are weathering political changes. Threats to natural resources and employment, and traumatic public and private events have affected social work and public health practice. We hope to show that threats to well-being (resulting in, for example, compassion fatigue and anxiety) have an impact on Michigan practitioners and their ability to collaborate, make referrals, and implement interventions.

Our preliminary survey findings show that a sizeable portion of the providers we interviewed experience compassion fatigue and anxiety. One focus group participant noted, "I've got a lot of clients with a lot of different things going on. There are times where I wake up in the morning and I don't really feel ready to run to work and get started."

These findings and the extant literature suggest that such psychological symptoms may have an impact on Michigan providers' ability to practice. For example, we found that providers who linked 15 or fewer clients to HIV testing in the prior six months reported higher levels of anxiety than those who linked 16 or more clients. These findings suggest that mental health issues, for example compassion fatigue, may also be related to lower numbers of client linkages to HIV testing. HIV testing is the first step of the care continuum; skipping this step can profoundly affect clients' access to HIV care and life-saving medications.

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*We must ensure that our health workers have the tools they need to take care of themselves so that they can care for others.*

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Anxiety may affect other areas of job performance, including the referral of clients to other health and mental health services, and so there is an urgent need to address providers' well-being. We hope to develop and test training interventions for providers that will specifically address well-being, and we also hope to develop organizational and environmental interventions to address issues that may threaten providers' well-being, such as low incomes and lack of resources to help clients.

The providers we interviewed are passionate about what they do and the quality of care they provide their clients. But, like health workers anywhere, they lead stressful professional lives, often working long hours and carrying large caseloads. We must ensure that our health workers have the tools they need to take care of themselves so that they can care for others. We are excited to work with researchers and practitioners in Michigan to help them address quality of life issues. **M**

# IMPLEMENTATION COMMUNITY COLLABORATIVE BOARD (ICCB)

Project ICI was developed and conducted by its ICCB, composed of providers, managers, and consumers whose contributions include practice expertise, delivery of behavioral interventions, and intervention facilitation. ICCB members are trained in community-based participatory research, protection of human participants, cultural competence, survey development, recruitment scripts, and data collection and analysis. The ICCB uses group dynamics and processes as described in peer-reviewed publications—dialectic processes, mutual support, problem-solving, and procedural triangulation—to facilitate the implementation of research methods and respond to challenges that arise in the research cycle.

**Rogério M. Pinto, PhD**, is a Brazilian-born psychiatric social work researcher with more than a decade of clinical and community practice. He is an expert in community-based participatory research and mixed-methods research. He is the principal investigator on an NIMH K01 Career Development Award (2007–12) and NIMH R01 (2012–17). In the United States, Brazil, and Spain, Dr. Pinto has examined how transdisciplinary collaboration and practitioners' involvement in research improve delivery of evidence-based services.

**Susan S. Witte, PhD**, is an associate professor at the Columbia University School of Social Work. She has worked with Columbia's Social Intervention Group since 1993, and she joined the Global Health Research Center for Central Asia at its inception in 2007. Dr. Witte's research supports the evolution of efficient, effective, evidence-based program implementation in communities. Her practice experience includes work in agencies providing support to survivors of sexual violence and agencies providing HIV/AIDS prevention, education, and treatment.

**Melanie M. Wall, PhD**, is the director of the Division of Biostatistics at the New York State Psychiatric Institute and the Columbia University psychiatry department, working mostly on NIH-funded research. She has modeled complex multilevel and multimodal data on research questions in clinical studies and large epidemiologic studies. She received her PhD from the department of statistics at Iowa State University and served on the biostatistics faculty at the University of Minnesota School of Public Health.

**Prema L. Filippone, LMSW**, is the project director of Project ICI. She has over 10 years' experience in research management and has supervised several federal NIMH grants. She served as program director for Girls' Educational and Mentoring Services, a service provider for child victims of commercial sexual exploitation and domestic sex trafficking. She holds dual bachelor of arts degrees in psychology and sociology from Rutgers University and a master of science in social work from Columbia University.

**Karen L. Baird, PhD**, is an associate professor of political science at Purchase College of the State University of New York. Her main area of research is the politics of women's health, focusing on women and HIV/AIDS. She also co-chairs the Women and Society University Seminar at Columbia University. From 2007 to 2014, she served on the Executive Council of the New York City HIV-Prevention Planning Group. She also served on the New York City PrEP for NYC Task Force. She has published work on women and HIV-prevention programs and on issues of gender, justice, and health.

**Rosa Bramble Weed, LCSW-R, CASAC**, is a mental health practitioner with a private practice in clinical and forensic psychosocial services in New York City. She treats individuals, families, and couples, specializing in the impact of trauma. She has helped clients cope with and heal from traumatic stress disorders, depression, anxiety, and the effects of interpersonal violence.



*Project ICI's Implementation Community Collaborative Board (ICCB) and friends at the May 4, 2017 symposium*

**Angela Ghesquiere, PhD**, is a program manager at the Brookdale Center for Healthy Aging of Hunter College of the City University of New York. Her areas of scholarship are services and implementation science, hospice and palliative care, trauma, bereavement, and mental health practice. Her current research focuses on service-use disparities in older adults with bereavement-related mental health disorders and on increasing access to and quality of mental health care in hospice and palliative-care settings. Dr. Ghesquiere received her PhD in social work from Columbia University.

**Jeannette Ruffins, MSW**, is vice president of housing resources and development at Bailey House, one

of the oldest AIDS housing organizations in the country. She oversees direct services to clients, building operations, and client advocacy. She has over 25 years of experience providing services to and designing interventions for vulnerable and at-risk populations. Prior to joining Bailey House, she worked as the executive director for HELP USA.

**Charles Sanky** graduated in 2016 from Columbia University with degrees in psychology and business management. He led many student organizations and initiatives, tackling mental health policy, curricular reform, and sexual violence. He has worked as an emergency medical technician, has health policy experience at the local, state, and federal

levels, and is an award-winning researcher. He attends the Icahn School of Medicine at Mount Sinai Hospital.

**Wendy Whitman, MA, LAc**, is a licensed acupuncturist and anthropologist. She has provided therapeutic services at many community-based organizations, some of which participate in Project ICI. She focuses her practice on underserved populations. As an anthropologist, she specializes in the collection and analysis of ethnographic data. She received an MA in cultural anthropology from Hunter College and studied acupuncture at the Florida Institute of Traditional Chinese Medicine. [M](#)



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