Resilience and Innovation to End the HIV Epidemic in the U.S.

2021 Ryan White HIV/AIDS Program Highlights

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Foreword

Resilience and Innovation to End the HIV Epidemic in the U.S.: 2021 Ryan White HIV/AIDS Program Highlights

For more than 30 years, the Health Resources and Services Administration (HRSA) Ryan White HIV/AIDS Program (RWHAP) has provided a comprehensive system of HIV medical care, medication, and essential support services for low-income people with HIV. In August 2020, HRSA celebrated the 30th anniversary of the historic legislation that created the RWHAP. Since its passage, the guiding principles of the RWHAP have been achieving health equity, stopping stigma, and reducing health disparities.

> *In 2019, nearly 568,000 people received services through the RWHAP. Without RWHAP services, many of our nation's populations with the greatest health disparities.*

In 2019, nearly 568,000 people received services through the RWHAP. Without RWHAP services, many of our nation's populations with the greatest health disparities—including people with HIV who are from racial/ethnic minority populations, men who have sex with men, women, transgender individuals, older adults, and youth—would not receive HIV care and life-extending medication with antiretroviral therapy (ART). Thirty years ago, many people with HIV had shortened lifespans. Now, people with HIV who take HIV medication as prescribed are able to reach and maintain an undetectable viral load, allowing them to lead longer, healthier lives, and have effectively no risk of sexually transmitting the virus to an HIV-negative partner.

HRSA's RWHAP recipients have demonstrated true dedication to providing care and treatment to people with HIV and meeting RWHAP clients and patients where they are, despite facing unimaginable challenges over the last two years. The program is leading the nation in achieving undetectable viral loads or viral suppression among its clients. Thanks to the efforts of RWHAP providers, approximately 88.1 percent of clients receiving RWHAP HIV medical care were virally suppressed in 2019,[1] compared to the national viral suppression average of 66 percent.[2]

Reaching viral suppression is a key component of *Ending the HIV Epidemic in the U.S. (EHE)*, the federal initiative to reduce new HIV infections in the United States by 90 percent by 2030.[3] HRSA's RWHAP has been supporting the EHE initiative since its inception by continuing to ensure that all people with HIV are diagnosed and receive essential HIV care, treatment, and support services to help them become virally suppressed. RWHAP recipients—including those located in EHE priority jurisdictions where new HIV diagnoses are high—have been planning and implementing local EHE initiatives and leveraging other innovative approaches to engage with people with HIV and retain them in care. Coincidentally, just before the RWHAP celebrated its 30-year anniversary and recipients started adopting strategies to help end the HIV epidemic in the United States, a new challenge emerged with coronavirus disease 2019 (COVID-19). Although the COVID-19 pandemic changed the way HIV care could be delivered

to RWHAP clients as a result of quarantine, social distancing, and other safety measures, RWHAP recipients across the country rose to the challenge. With help from fiscal year (FY) 2020 Coronavirus Aid, Relief, and Economic Security (CARES) Act funding, RWHAP recipients and providers have demonstrated their resilience by finding opportunities to create and implement new, innovative approaches to HIV care and client engagement.

This biennial report, *Resilience and Innovation to End the HIV Epidemic in the U.S.*, highlights the many accomplishments and successes of HRSA's RWHAP during the last two years in achieving HRSA's goals to end the HIV epidemic in the United States. The report features seven recipients selected by HRSA that have implemented successful strategies and innovative approaches to HIV care—including a jurisdictional approach to EHE planning, linking care to incarcerated people with HIV, telehealth and telepsychiatry services, peer navigation services, housing and employment services, technology to provide clinician education, and a Community-Based Dental Partnership Program. These and other recipients of HRSA's RWHAP provide inspiration for ending the HIV epidemic in the U.S. and ensuring resilience during the COVID-19 pandemic.

In the sections that follow, program highlights from HRSA's RWHAP are presented, along with a summary of the innovative approaches used by recipients and their respective success stories.

Highlights of the Virtual 2020 National Ryan White Conference on HIV Care & Treatment

For the first time, as a result of the COVID-19 pandemic, HRSA's HIV/AIDS Bureau (HAB) hosted its 2020 National Ryan White Conference on HIV Care & Treatment virtually. The biennial event was held August 11–14, 2020, with approximately 7,400 attendees, including HRSA's RWHAP recipients and subrecipients, HIV health care providers, partners, national and local stakeholders, people with HIV, and members of the general public. The 2020 National Ryan White Conference theme, "30 Years of Innovating Care, Optimizing Public Health, Ending the HIV Epidemic," celebrated the contributions and successes made by HRSA's RWHAP in providing care and treatment to people with HIV and leveraging powerful tools to end the HIV epidemic in the United States. The biennial conference provided a forum for attendees to learn about and share innovative models of care and best-practice strategies to reduce new HIV infections and HIV-related health disparities.

> *Six thematic tracks at the conference served as the foundation for four plenary sessions, 290 workshops, 41 virtual exhibits, and 160 poster sessions.*

Six thematic tracks at the conference served as the foundation for four plenary sessions, 290 workshops, 41 virtual exhibits, and 160 poster sessions. Conference workshops and sessions focused on developing new and innovative ways to engage with the community and serve specific populations—such as youth transitioning to adult care, transgender people,

clients who are homeless or unstably housed, and many others. In addition, many of the presentations demonstrated how RWHAP recipients have adapted their services to provide HIV treatment and care to people with HIV during the COVID-19 pandemic. The continued implementation of these effective models and strategies supports the goal of HRSA's RWHAP to end the HIV epidemic. Visit TargetHIV for a recap of the conference, as well as the presentation slides.

Ryan White HIV/AIDS Program Annual Client-Level Data Report, 2019

HRSA's *Ryan White HIV/AIDS Program Annual Client-Level Data Report, 2019* provides program data about clients served by RWHAP Parts A, B, C, and D during calendar years 2015–2019, regardless of the source of RWHAP funding. The report offers an in-depth look at the data on demographic and socioeconomic factors among RWHAP clients, such as age, race/ethnicity, transmission risk category, federal poverty level, health care coverage, and housing status. Annual client-level data allow HRSA to assess and support the progress that RWHAP recipients are making to improve HIV care, treatment, and health outcomes—such as viral suppression among people with HIV—and toward achieving the goals of the EHE initiative.

The **BY THE NUMBERS** infographic on the next page shows selected highlights of the *Ryan White HIV/AIDS Program Annual Client-Level Data Report, 2019*. Of particular note is that 88.1 percent of RWHAP clients receiving HIV medical care reached viral suppression in 2019. This achievement reflects the ongoing commitment and dedication of recipients of HRSA's RWHAP to reduce health disparities among people they have not yet successfully maintained in care and to provide high-quality comprehensive services to their clients.

HRSA'S Ryan White HIV/AIDS Program

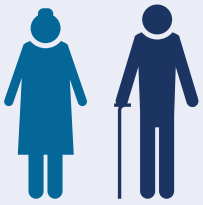
By the Numbers: 2019

SERVED **567,803** clients in **2019**

MORE THAN **50%** of people with **diagnosed HIV in the United States**

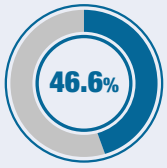
88.1% of clients receiving HIV medical care

reached viral suppression* in 2019

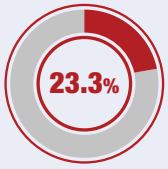


46.8% of clients were **aged 50 years and older**

73.4% of clients were **racial/ethnic minorities****



of clients identified as **Black/African American**



of clients identified as **Hispanic/Latino**

60.7% of clients were

living at or below **100%** of the **Federal Poverty Level**

* Viral suppression is based on data for people with HIV who had at least one outpatient ambulatory health services visit and at least one viral load test during the measurement year and whose most recent viral load test result was less than 200 copies/mL.

** Clients self-identified as 26.6% White and less than 2% each American Indian/Alaska Native, Asian, Native Hawaiian/Pacific Islander, and persons of multiple races. Hispanics/Latinos can be of any race.

Data sourced from 2019 Ryan White HIV/AIDS Program Annual Client-Level Data Report.

HRSA
Ryan White HIV/AIDS Program

Ending the HIV Epidemic in the U.S.

The federal EHE initiative aims to reduce the number of new HIV infections in the United States by at least 90 percent by 2030, with the goal of decreasing the number of new HIV infections to fewer than 3,000 per year. Reducing new infections to this level essentially means that HIV transmissions would be rare and meet the definition of ending the epidemic.

The EHE initiative, which began in FY 2020, is leveraging scientific advances in HIV prevention, diagnosis, treatment, and care by coordinating the highly successful programs, resources, and infrastructure of HRSA, the Centers for Disease Control and Prevention (CDC), National Institutes of Health, Substance Abuse and Mental Health Services Administration, and Indian Health Service. The HHS Office of the Assistant Secretary for Health is coordinating this cross-agency initiative.

HRSA's RWHAP and the Health Center Program have a leading role in helping diagnose, treat, prevent, and respond to efforts to end the HIV epidemic. Over the last year, HRSA's HAB has implemented the EHE effort by funding RWHAP Parts A and B jurisdictions. Recipients used innovative strategies to link people who are either newly diagnosed with HIV or diagnosed but currently not in care to essential HIV care, treatment, and support services. These services reduce transmission by helping people with HIV access the care and treatment needed to reach HIV viral suppression. HRSA's HAB also has collected data about these RWHAP EHE efforts.

During the first six months of this effort, great progress was achieved by the funded jurisdictions, as demonstrated by HRSA's RWHAP EHE data. Of the 10,000 people who received EHE services, 6,300 were new to the RWHAP and an additional 3,600 were re-engaged in EHE care and treatment services. These nearly 10,000 people are a promising sign of progress toward meeting the year one goal of 18,000 people newly engaged or re-engaged in RWHAP care and treatment services through EHE.

Community engagement is critical to EHE. HRSA's leadership has been holding listening sessions with RWHAP recipients, Health Center Programs, state and county leaders, HIV community partners, and people with lived experience. In 2019–2020, HRSA visited 23 EHE-funded jurisdictions. In 2021, HRSA is hosting virtual public health leader and community listening sessions in all 10 regions of the country to learn about their programs and identify ways to support them. HRSA also has been holding webinars with RWHAP recipients to share select innovative programs and practices. Visit HRSA's EHE webpage for additional information about HRSA's role in the initiative.

HIV National Strategic Plan

The recently released *HIV National Strategic Plan: A Roadmap to End the HIV Epidemic for the United States 2021–2025* is the nation's third consecutive five-year national HIV strategy. The new HIV Plan builds on the work of the *HIV/AIDS Strategy for the United States: Updated to 2020* with a 10-year goal of reducing new HIV infections by 90 percent by 2030. The HIV Plan aligns closely with the EHE initiative and was developed in collaboration with six federal government departments and 12 HHS agencies and offices through a process led by the HHS Office of the Assistant Secretary for Health and its Office of Infectious Disease and HIV/AIDS Policy. Community input was gathered throughout the development process to inform and refine the HIV Plan.

The HIV Plan focuses on four goals:

1. Prevent new HIV infections.
2. Improve HIV-related health outcomes of people with HIV.
3. Reduce HIV-related disparities and health inequities.
4. Achieve integrated and coordinated efforts that address the HIV epidemic among all partners and stakeholders.

For stakeholders across the nation, the HIV Plan articulates objectives and strategies for each goal; identifies priority populations disproportionately affected by HIV so that federal agencies and other stakeholders can focus efforts and resources to achieve the greatest impact; and sets forth eight core indicators to monitor progress, as well as a disparity indicator to measure progress toward reducing significant HIV-related disparities.

FY 2020 Coronavirus Aid, Relief, and Economic Security Act Funding

The COVID-19 pandemic presented significant challenges and opportunities for RWHAP recipients to provide innovative care and treatment to people with HIV. To assist RWHAP providers with the capacity to respond to the pandemic, HRSA awarded $90 million of FY 2020 CARES Act funding to support 581 RWHAP recipients across the country—including city or county health departments, health clinics, community-based organizations, state health departments, and AIDS Education and Training Centers—in their efforts to prevent or minimize the impact of this pandemic on people with HIV.

Specifically, FY 2020 CARES Act funding enabled RWHAP providers to prevent, prepare for, and respond to COVID-19 by promoting practices to reduce the transmission of COVID-19; bolstering provider capacity to test for and treat COVID-19 among RWHAP clients and their family members; maintaining existing HIV care and services in an environment drastically altered by the pandemic; extending operational hours and increasing staffing hours; purchasing additional equipment; enhancing workforce training and capacity development; and providing critical services to people with HIV, such as home-delivered meals, emergency housing, and transportation.

FY 2020 CARES Act funding gave RWHAP recipients the flexibility to meet evolving needs in their respective communities during this unprecedented time. In order to monitor and report on RWHAP FY 2020 CARES Act-funded activities, HRSA developed the COVID-19 Data Report (CDR) system to collect monthly, aggregate-level data on the types of services provided and number of people served by RWHAP FY 2020 CARES Act–funded recipient and subrecipient service providers. In June 2021, HRSA released the *Ryan White HIV/AIDS Program (RWHAP) COVID-19 Data Report, January 20, 2020 through December 31, 2020*, which was HRSA's first publication of national RWHAP aggregate-level data submitted through the CDR.

Summary of Innovative Approaches

Summary of the Innovative Approaches Used by Featured Recipients

The seven HRSA RWHAP recipients featured in this report have implemented a variety of innovative approaches to deliver HIV care, treatment, and education to clients and the communities they serve. A common thread in the planning and delivery of these approaches is the desire to engage with and retain clients in HIV care and help them reach and maintain viral suppression, with the ultimate goal of ending the HIV epidemic in the United States. Several of the recipients have been engaged in developing and implementing local plans to end the HIV epidemic by collaborating with jurisdictional partners and providers. All seven showed remarkable resilience in adjusting their approaches and programs to continue vital services and to expand such services as telehealth and virtual meetings as the COVID-19 pandemic emerged in early 2020.

The seven featured recipients are listed here, and a summary of their approaches follows:

- New Haven Health Department (NHHD), New Haven, Connecticut (Part A)
- Kentucky Department for Public Health (KDPH), Cabinet for Health and Family Services (CHFS), Frankfort, Kentucky (Part B)
- AIDS Arms Network/Prism Health North Texas (PHNTX), Dallas, Texas (Part C)
- Medical College of Wisconsin (MCW), Milwaukee, Wisconsin (Part D)
- City of Kansas City, Missouri Health Department (KCHD), Kansas City, Missouri (Part F: Special Projects of National Significance [SPNS] Program)
- MidAtlantic AIDS Education and Training Center (MAAETC), Pittsburgh, Pennsylvania (Part F: AIDS Education and Training Center [AETC] Program)
- Rutgers School of Dental Medicine (RSDM) Community-Based Dental Partnership Program (CBDPP), Newark, New Jersey (Part F: Dental Program)

NHHD, an RWHAP Part A recipient, provides core medical and support services for people with HIV in the eligible metropolitan area (EMA) of New Haven and Fairfield Counties, Connecticut. NHHD has been collaborating with key stakeholders in the Greater Hartford transitional grant area (TGA)—which covers Hartford, Tolland, and Middlesex Counties—to develop a comprehensive, community-driven initiative to end the HIV epidemic in Connecticut by 2030. This initiative, *In It to End It*: *Our Plan to End the HIV Epidemic*, engages community leaders involved in HIV care at the local and state levels in facilitated planning sessions and workshops to discuss what it would take to end the HIV epidemic. Likewise, NHHD has actively engaged people with HIV in group discussions and interviews about sexual health, HIV stigma and discrimination, and ending the HIV epidemic. NHHD has employed a unique

> *Like NHHD's initiative, the development of the KDPH strategic plan involved the participation of key local and Commonwealth-wide stakeholder groups.*

approach to capturing discussion feedback from this audience by utilizing "graphic facilitators," who create vivid graphics of the stories, themes, and comments that arise during discussions.

KDPH, a Part B recipient, supports community-based medical and nonmedical support services for people with HIV throughout the Commonwealth of Kentucky. At the end of 2020, KDPH released its *Kentucky Ending the HIV Epidemic Strategic Plan for 2021–2026*. Like NHHD's initiative, the development of the KDPH strategic plan involved the participation of key local and Commonwealth-wide stakeholder groups. To address the strategic plan's emphasis on linkage-to-care activities for incarcerated populations, KDPH began providing core medical and support services for people with HIV who are incarcerated or involved in the criminal justice system when these became allowable RWHAP services. To facilitate care retention, KDPH is providing linkage navigation services for incarcerated people with HIV prior to their release from detention to ensure that they continue to receive HIV care.

PHNTX, located in Dallas, Texas, uses its RWHAP Part C funding to provide people with HIV with personalized, integrated, and equitable HIV medical care and support services in Dallas County and eight surrounding counties. One of the many innovative programs that PHNTX offers to its patients is telehealth and telepsychiatry. Although planning for these programs was underway before the COVID-19 pandemic began, their implementation was accelerated to ensure that patients had access to medical and behavioral health care visits during the pandemic through a computer, laptop, smartphone, or tablet with a webcam. PHNTX sends patients a text message with a link to initiate telehealth video sessions. The telehealth system has backup capabilities to offer users technical assistance, and it can add a translator to telehealth visits for non-English-speaking patients.

MCW planned a peer navigator program with its RWHAP Part D supplemental capacity-building funding to address the unique challenges young people with HIV face as they transition to adult care in Milwaukee, Wisconsin. The program offers a bridge from pediatric care to adult HIV care by using peer navigators to help youth stay in care and get the treatment and services they need to reach and maintain viral suppression. MCW partnered with the Wisconsin Department of Health Services and Diverse & Resilient, a community-based organization with strong connections to the LGBTQ+ community, to recruit clients and deliver peer navigation services to them.

> *The program offers a bridge from pediatric care to adult HIV care by using peer navigators to help youth stay in care.*

> *The three-year initiative provided supportive services to clients who were transitionally housed, homeless, or unstably housed.*

KCHD was awarded RWHAP Part F funding for its KC Life 360 initiative as part of the SPNS initiative Improving HIV Health Outcomes Through the Coordination of Supportive Employment and Housing Services. The three-year initiative provided supportive services to clients who were transitionally housed, homeless, or unstably housed. KC Life 360 focused on building skills to ensure that clients were capable of obtaining and maintaining employment, earned income, and economic mobility, with the goal of securing subsidized or unsubsidized permanent housing. KC Life 360 initiated several innovative programs, such as emergency hotel gap or short-term lodging with hotel vouchers to keep clients out of shelters or from living on the street; cellphones and monthly payment plans to ensure clients could communicate with health care and service providers, employers, and landlords; and a bicycle program in which bicycles were offered to clients to help them to travel more easily to health care and case management appointments and to their workplaces.

MAAETC, an RWHAP Part F funding recipient located at the University of Pittsburgh, provides critical clinical education and training to RWHAP health care providers about HIV transmission, prevention, treatment, and care. MAAETC developed the Learner Education and Practice Portal (LEAPP) for its own use, as well as use by regional partners and other AETCs, to monitor, support, and improve the quality of their HIV education and support services. The LEAPP platform initially was developed as a data collection tool for accessing MAAETC data on the number and types of providers trained and the impact of trainings. MAAETC currently uses LEAPP to convene communities of practice and facilitate interaction among health care providers at practice transformation clinics, partner organizations, and other agencies and programs.

> *RSDM's CBDPP has uniquely integrated trauma-informed care into dental practices and services.*

RSDM, an RWHAP Part F recipient based in Newark, New Jersey, provides comprehensive oral health care services to its RWHAP clients in southern New Jersey through its CBDPP. The program is training the next generation of dental providers to care for patients with HIV through its didactic and community-based service-learning experiences for predoctoral and postdoctoral students. RSDM's CBDPP has uniquely integrated trauma-informed care (TIC) into dental practices and services to engage people with HIV in dental care to improve their health outcomes. The TIC approach focuses on the patient and incorporates such elements as respecting the individual, alleviating fear and anxiety, and providing a supportive environment before dental work is initiated; coordinating and integrating care with other providers; and offering information and education to patients.

Success Stories

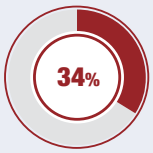
Counterclockwise from top left: PHNTX's Deanna Rogers, Clinical Research Project Manager, giving a COVID-19 vaccine to Karin Ndahui; Susan Winters, MAAETC Data Manager; group photo of KCHD's Debbie Adams, Employment Support Specialist, Dr. Joey Lightner, Evaluation Coordinator, Jamie Shank, Quality and Housing Manager, and Kate Murphy, Housing Employment Specialist; Corey Clark, Diverse & Resilient Peer Navigator; Rutgers School of Dental Medicine.

Conversation board from discussions with the Trans Youth Group, a peer support group for young transgender individuals.

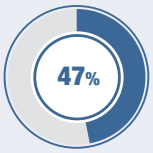
Engaging the Community to End the HIV Epidemic in Connecticut: New Haven Health Department (Part A)

As an RWHAP Part A–funded recipient, the New Haven Health Department (NHHD) provides core medical and support services for people with HIV in the EMA of New Haven and Fairfield Counties, Connecticut, and its five subregions—Bridgeport, Danbury, New Haven, Stamford/Norwalk, and Waterbury/Meriden. The New Haven/Fairfield Counties HIV Ryan White Planning Council determines the allocation of Part A funds, based on the proportion of HIV cases in each region. Members of the Council are appointed by the Mayor of New Haven and include people with HIV, community-based organizations working in HIV, and individuals with HIV expertise; they also are diverse in terms of gender, race/ethnicity, and sexual orientation. In addition to allocating funding to the EMA, the Council's role is to conduct needs assessments and collect other data to establish service priorities for each fiscal year and determine funding amounts for each service.[4]

The RWHAP serves more than 2,000 clients in the EMA, primarily people of color (47% Black/African American and 34% Hispanic/Latino). NHHD's RWHAP goals focus on ensuring that people with HIV are linked to and retained in



of New Haven RWHAP clients are **Hispanic/Latino**



of New Haven RWHAP clients are primarily **Black/African American**

Thomas Butcher, NHHD Project Director, RWHAP Part A Program.

care. According to NHHD Project Director Thomas Butcher, NHHD's RWHAP implemented the Intensive Medical Case Management (IMCM) program to increase viral suppression rates among key client groups. The IMCM program replaced Early Intervention Services Program to move recently diagnosed people with HIV and those who have fallen out of care into the HIV care system. The IMCM is population based and focuses on three priority groups—Black women, young men who have sex with men (MSM) of color, and transgender women—who have been experiencing an increase in HIV diagnoses. Butcher explained, "The IMCM was the Planning Council's first foray into drilling down within a population group rather than generically saying, 'We take care of all people with HIV." To provide clients with more focused and personalized care, case managers have no more than 20 clients. In addition to populations with increased rates of HIV diagnosis, NHHD prioritizes clients who have not reached viral suppression, often individuals who have fallen out of care, by reviewing demographic data and developing strategies to engage them and get them into HIV care.

In It to End It: Our Plan to End the HIV Epidemic

NHHD recently embarked on a community-driven initiative to end the HIV epidemic in Connecticut by 2030. This initiative, *In It to End It: Our Plan to End the HIV Epidemic*, is a collaboration between the New Haven and Fairfield Counties EMA and the Greater Hartford TGA.[5] The initiative supports the federal *Ending the HIV Epidemic in the U.S.* initiative and is built on an earlier *Getting to Zero* campaign with Hartford's RWHAP to respond to the area's growing incidence of HIV in MSM of color, Black women, and transgender women. According to Butcher, the initiative was made possible in 2019 when the New Haven/Fairfield Counties Ryan White Part A Program became one of just 10 jurisdictions to be awarded HRSA RWHAP funding to develop a comprehensive, community-driven plan to end the local HIV epidemic. Early on, Butcher reached out to the Greater Hartford TGA with an invitation to collaborate on the initiative: "If we, in our Part A jurisdiction, and you [Hartford] can get to zero or make inroads, we really will start to end this epidemic."

John Sapero, Director of Ending the HIV Epidemic Initiatives for Collaborative Research.

To spearhead the plan's development, Butcher engaged John Sapero, Director of Ending the HIV Epidemic Initiatives for Collaborative Research, LLC, to coordinate planning activities, which included assessing current HIV care and engaging community stakeholders to obtain their input on ways to improve care. Sapero also is responsible for developing interim plans and the final plan. Developing the plan has followed a ground-up, collaborative process that involves obtaining input from "a mix of

Conversation board from discussions with participants in Chat for Change, a group for MSM aged 18 to 30 who are at risk for acquiring HIV.

people with HIV; people that could benefit from HIV-related services, whether it's prevention or care; the community; planning body members; as well as other state-and staff level stakeholders," shared Butcher. Initially, NHHD expected that each region participating in the initiative would have distinct directions and strategies for its local plans and would want to form individual planning bodies. However, "What we've found," Butcher explained, "is that there are many consistencies in the needs and activities that have been identified among the regions. There's also been clear community guidance that people don't want to establish another planning body for the *In It to End It* plan." As a result, the *In It to End It* initiative planning efforts are collaborative and not directed by a single planning body. The end product of *In It to End It* planning efforts is a five-year plan with an initial two-year implementation strategy submitted to HRSA on June 30, 2021, and shared with the community in July 2021. Full implementation of the *In It to End It* plan begins in summer 2021.

Engaging Stakeholders in the Planning Process

The *In It to End It: Our Plan to End the HIV Epidemic* initiative began with an assessment of current HIV care in Connecticut. According to Sapero, "We didn't want to duplicate existing work. Going into the project, there was already a lot of information I reviewed from focus groups and community meetings conducted by the Connecticut HIV Planning Consortium, particularly around prevention initiatives." In addition, Sapero reviewed state and jurisdictional priorities, strategies, and plans for ending the HIV epidemic to obtain an understanding of the HIV landscape in Connecticut.

Sapero and his team then conducted more than 25 interviews with a variety of HIV community leaders in each region, local planning body leaders, HIV prevention and care program leads, pharmaceutical company representatives, community-based organizations, NHHD's RWHAP staff, and others who had been identified during the interviews. Several of these initial interviewees became members of the *In It to End It* Leadership Team.

Following the interviews, a series of facilitated planning sessions and workshops was held with a variety of stakeholders to envision what needs to occur to end the HIV epidemic in their communities. As explained by Sapero, *In It to End It* planning efforts involve people who "don't typically have a voice in HIV planning, … everyone from the case managers who are providing services to the person who is at the front door greeting folks as they walk in. They all have passion, knowledge, expertise. … It's really about getting those unique voices to help inform the plan." Butcher added, "We recognize that there are people who are doing work who also represent the very communities that are engaged in our care system who are

> *The more information we have from diverse people and populations, the more we will be able to build a stronger, comprehensive plan.*

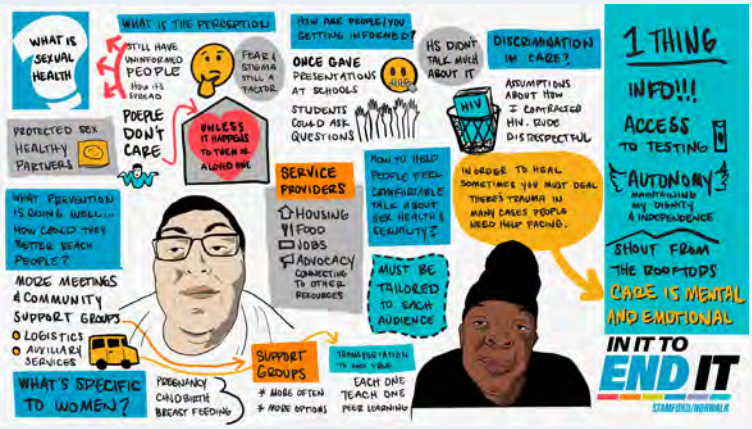
also identified as needing prevention services. The more information we have from diverse people and populations, the more we will be able to build a stronger, comprehensive plan."

To create an aspirational focus for the plan during planning sessions, the program created a new process to actively engage stakeholders and capture their organizational and individual perspectives on what is needed to end the HIV epidemic. The objective was to inspire stakeholders during workshop sessions by actively generating ideas using individual, two-person team, and large-group work. An example was the "Dream Big" workshop session organized by Butcher in January 2021. This workshop was held to obtain input and recommendations from state disease intervention specialists, prevention and surveillance program staff, and RWHAP medical case managers and intensive case managers on how to get newly diagnosed people with HIV into care. Participants were asked to provide input on how to get people who are lost to care back into the care system. Butcher hopes that the input from the "Dream Big" workshop will lead to the development of a Memorandum of Understanding among HIV providers to "move participant recommendations forward to reduce new HIV infections, get people tested and into the care system, and find those folks that had fallen out of care."

Obtaining Input From People With HIV

Engaging people with HIV in group discussions about sexual health, community perceptions of HIV, stigma and discrimination, and ending the HIV epidemic is another important component in developing the *In It to End It* plan. Stakeholders and partners have been helping identify people with HIV, including those clients in the initiative's priority populations. According to Sapero, "We've been reaching out to organizations regardless of whether they receive RWHAP funding for their services to allow their clients to provide some feedback to us. And that's both from a prevention standpoint and care standpoint."

Instead of using focus groups and other traditional methods to obtain feedback from the HIV client community, the *In It to End It* team used a new, innovative approach to actively engage participants during feedback sessions. As Sapero explained, the *In It to End It* plan is meant to be "an aspirational plan, but also one that is very actionable for the community to implement." The approach involves focused discussions and interviews led by graphic facilitators. The facilitators create vivid graphics of the stories, themes, and comments that arise during discussions. The final art (conversation boards) provides a visceral, captivating record of each engagement session, conveying emotion and intent in greater ways than a written report. Sapero explained that people who initially provide input often find written results to be challenging to review and absorb. After attending workshops on graphic facilitation, Sapero found the approach to be more intimate and engaging. Butcher added that the conversation boards are more accessible to a larger audience than written reports. "It draws you in. It



Conversation board from discussions with people with HIV who receive medical care through the Mid-Fairfield AIDS Project, a nonprofit service organization.

summarizes things well. There's always a filter, but these are more unfiltered than taking executive summary notes. So, you get a sense of the community's voice."

Demonstrating Resilience During the COVID-19 Pandemic

NHHD has had to overcome many challenges to maintain its high level of HIV support service and high rates of viral suppression throughout the COVID-19 pandemic. Butcher noted that Connecticut was aggressive in shutting down the state at the beginning of the pandemic, so NHHD had to adjust quickly. Butcher's first step in responding to the pandemic was to implement a virtual meeting with regional providers to determine how service delivery was being affected, what was changing, and what steps providers were taking to mitigate the effects of the pandemic. He found that providers had implemented new policies and procedures, which affected certain services more than others. The hardest-hit services were mental health, dental, and residential and inpatient substance treatment services. Despite these challenges, NHHD's RWHAP services stayed resilient throughout the pandemic through the use of telehealth, improved communication with recipients, strengthened partnerships, and the expanded provision of support services. When the pandemic first hit, most providers rapidly implemented telehealth visits to ensure continuation of care. NHHD worked with partner organizations to provide laptops so that all of its RWHAP clients could engage in telehealth visits and virtual support groups.

When in-person visits were necessary, NHHD's RWHAP staff worked with providers to ensure that clients did not risk their health by taking public transportation. NHHD provided client transportation via Uber Medical and Lyft. As of January 2021, NHHD had implemented a hybrid of in-person and telehealth services for case management.

FY 2020 CARES Act funding further enhanced NHHD's resilience during the pandemic by allowing the RWHAP to provide for clients' basic needs so they could remain in care. The NHHD RWHAP Planning Council conducted a survey of client needs to determine how best to spend the COVID-19 funds. The survey revealed that the primary client needs were food and housing support. In response to these findings, NHHD divided the funds between food and rental assistance. The program allocated funds to different geographic areas based on the number of COVID-19 cases and the impact of the coronavirus in the area. NHHD is conducting another survey of 300 clients regarding COVID-19 vaccination. According to Butcher, the survey will focus on communities of color and ask about people's intentions to get vaccinated. Findings from the survey will be shared with the local health department responsible for COVID-19 vaccination.

Key Successes and Lessons Learned

Over the past few years, NHHD has achieved several successes, despite the COVID-19 pandemic and other challenges. Across the New Haven/Fairfield County EMA, NHHD has reached an overall viral suppression rate of approximately 90 percent. The NHHD continues to work toward increasing viral suppression rates by focusing on populations with increasing numbers of HIV cases, such as young MSM, Black women of all ages, and transgender women.

New Haven Health Department

of NHHD RWHAP clients have **reached viral suppresion**

The New Haven/Fairfield Counties HIV Ryan White Part A Planning Council played a crucial role in engaging the diverse group of community members and partners involved in the *In It to End It* planning efforts. According to Thomas Butcher, the "Planning Council and the [recipients] have worked really well and very closely for many years," which has created a seamless process for effective outreach to the community. According to John Sapero, the NHHD RWHAP Part A Planning Council could serve as a model for other RWHAP Part A planning councils across the United States because of the unique relationship between members and the recipient. "The relationship is unique with regard to the collaborative approach, the respect that members and [recipients] have developed for one another, common goals, engagement, and innovation," explained Sapero.

As a result of the Planning Council's collaboration with recipients, NHHD's RWHAP experienced few difficulties in engaging other organizations and forming partnerships, including the crucial partnership with the Hartford TGA. According to Sapero, the Hartford RWHAP Part A Planning Council "latched on to the [*In It to End It*] project right away." Outreach to other partners also was relatively easy once staff at these organizations were convinced that they had a role in the planning effort and understood what that role was. "I can't think of anybody who's been resistant," said Sapero. "The Connecticut HIV Planning Consortium, on board right away; the Positive Prevention group, on board right away. What little resistance I've received is from folks who really don't see themselves as having a role in HIV planning. This is a great opportunity to tell them, 'Well, you really do. You're part of the community, and you have knowledge and experience, and your agency serves these clients. Just because you haven't been involved doesn't mean you can't be involved now.'"

Continued on page 20

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The process of engaging the community and obtaining their feedback was another successful aspect of the *In It to End It* initiative, particularly the graphic facilitation process. Butcher recommended incorporating the graphic facilitation approach into other RWHAP planning efforts when relevant, because it captures everybody's imagination. To date, more than 175 stakeholders and community members with HIV or at risk for HIV have participated in NHHD's engagement activities. For many participants, it was the first time they had been formally asked to take part in the HIV planning process.

In responding to the challenges posed by the COVID-19 pandemic and in implementing the *In It to End It* initiative, NHHD has learned several important lessons. Butcher emphasized that one important lesson was the resilience of the RWHAP. "Even through pandemics, we can do the work. The twin epidemics of COVID-19 and HIV presented more challenges but also created more unforeseen possibilities in terms of efficiency." For example, NHHD has learned how to take advantage of telehealth and the benefits of this approach to reduce barriers to service delivery. Specifically, more people received HIV care, and because clients did not have to go to a physical location, the program experienced fewer missed appointments due to such barriers as stigma and lack of transportation. Butcher shared a story of a client who had fallen out of care because she did not want to be seen going to the clinic. This client was brought back into care because telehealth visits were an option that allowed her to receive care in the privacy of her own space. NHHD may continue to use telehealth after the pandemic is over to deliver mental health, case management, and medical consultation services more efficiently.

The lessons learned by NHHD during the pandemic have been positive and even revealed ways to improve RWHAP services. For example, NHHD has begun using the input obtained from HIV stakeholders to develop plans for new programs. According to Sapero, health departments and programs could improve HIV services by responding to the HIV epidemic the way they responded to COVID-19: "The great thing that has come out of this is that the RWHAP at the federal level responded very quickly and gave the flexibility for jurisdictions to respond quickly and innovatively." This response helped change how staff thought about the HIV service delivery system and gave them permission to innovate services to respond to the needs of that community. According to Butcher, the goal was to "change the system to make it safer for people with HIV during this pandemic, … but we didn't do it in a vacuum. We did it with provider input." All in all, Butcher concluded, the pandemic has been "a pretty amazing time in making connections to keep the system moving and advancing. Communicating what we're doing together makes a big difference."

(L to R) Front row: Kristy Perry, KADAP Coordinator; Gloria Dennis, Part B Federal Program Specialist/Supervisor; Tiffany Bivins, KY HIV Care Coordinator Program Administrator (KHCCP). (L to R) Back row: Todd Hurst, KADAP Administrator; Erin Larmour, KY Health Insurance Continuation Program Coordinator (KHICP). March 2018.

Ending the HIV Epidemic in Kentucky Through Community Engagement: The Kentucky Department for Public Health, Cabinet for Health and Family Services (Part B)

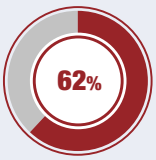
The Kentucky Department for Public Health (KDPH), Cabinet for Health and Family Services, a HRSA RWHAP Part B recipient, supports community-based medical and nonmedical support services for people with HIV throughout the Commonwealth of Kentucky. Currently, the KDPH RWHAP and its nine subrecipients serve 5,363 people with HIV in Kentucky (about 71% of all HIV cases in the Commonwealth). Approximately 62 percent of KDPH RWHAP clients are White, and about 34 percent are primarily Black/African American. Among KDPH RWHAP clients, about 84 percent are virally suppressed, compared with a viral suppression rate of 55 percent for non-RWHAP clients in Kentucky. People with HIV in Kentucky experience several barriers to obtaining HIV care

The Kentucky Department for Public Health, Cabinet for Health and Family Services

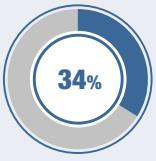
84% of KDPH RWHAP clients **are virally suppressed**

Compared to

55% of non-RWHAP clients in Kentucky



of KDPH RWHAP clients are **White**



of KDPH RWHAP clients are primarily **Black/African American**

and staying in care, making it challenging for them to reach viral suppression. These barriers include long travel distances between home and clinic, coupled with difficulty accessing reliable transportation; unstable housing; mental health and substance use challenges; and HIV-related stigma.

Kentucky Ending the HIV Epidemic Strategic Plan for 2021–2026

In 2019, Kentucky was one of seven states with a substantial number of HIV diagnoses in rural areas to be designated a priority jurisdiction in the federal *Ending the HIV Epidemic in the U.S.* initiative. Kentucky's priority jurisdiction status, along with additional HRSA RWHAP funding, led KDPH to develop an ending the HIV epidemic strategic plan for the Commonwealth of Kentucky. According to Dr. Tisha Johnson, HIV/AIDS Medical Director at KDPH, the process to develop Kentucky's ending the HIV epidemic strategic plan began with a survey of HIV stakeholders—including providers, educators, people with HIV, and people at risk for acquiring HIV—to provide feedback on HIV prevention and care services in Kentucky. Stakeholders were "asked questions to help identify strengths and opportunities and ways to improve HIV prevention and services," said Johnson.

> *[Stakeholders were] asked questions to help identify strengths and opportunities and ways to improve HIV prevention and services...*

To develop the strategic plan, KDPH formed six regional stakeholder groups and one Commonwealth-wide stakeholder group composed of representatives from the regional groups. Stakeholder group members represented a wide variety of organizations invested in HIV care, including individuals who completed the strategic plan survey, local health departments, local and state education agencies, law enforcement agencies, Kentucky's HIV/AIDS Prevention Program, community organizations, mental and behavioral health centers, clinics, universities, pharmacies, and people with HIV. Regional stakeholder groups held multiple virtual meetings to discuss ideas, perspectives, and strategies for ending the HIV epidemic, and their recommendations were presented to the Commonwealth-wide group for consideration. The Commonwealth-wide group worked with KDPH to compile input from the stakeholder meetings and survey, review regional stakeholder group recommendations, and draft and finalize the strategic plan.

In December 2020, KDPH released the *Kentucky Ending the HIV Epidemic Strategic Plan for 2021–2026* with the overarching goal of reducing new HIV infections by 75 percent in the first five years of the strategic plan and by 90 percent in the first 10 years.[6] The strategic plan was organized around the four pillars addressed in the HHS *Ending the HIV Epidemic in the U.S.* initiative. Kentucky's goal for the first pillar, Diagnose, is to increase the diagnosis of HIV cases in Kentucky by 42 percent over the next five years. Goals for the second pillar, Treat, are (1) engaging in care the 1,500 Kentuckians with HIV who are not currently in care

over the next five years and (2) increasing viral suppression to 90 percent across all KDPH RWHAP–supported programs and community programs. Kentucky's goals for the third pillar, Prevent, are (1) increasing the number of sites delivering PrEP by 100 percent in five years and (2) expanding preventive services provided at Syringe Services Programs (SSPs). The goal of the fourth pillar, Respond, is increasing KDPH's capacity to identify and investigate active HIV transmission clusters and respond to HIV outbreaks within one year of implementing the Plan.

> *We have a lot of on-the-ground outreach efforts in the Commonwealth.*

KDPH currently is engaged in outreach efforts to disseminate the strategic plan to HIV stakeholders throughout the Commonwealth, communicate the goals and objectives of the plan, and engage relevant health and service organizations in the implementation of the strategic plan. Kentucky's HIV/AIDS Prevention Program and several of KDPH's RWHAP subrecipients are collaborating with KDPH in these outreach efforts. According to Johnson, "We have a lot of on-the-ground outreach efforts in the Commonwealth."

Some of the strategies identified in the strategic plan currently are being implemented with the support of two new grants awarded by the CDC and HRSA. One of these strategies is increased linkage-to-care activities to ensure that clients receive and are retained in HIV care. As explained by Johnson, through the KDPH RWHAP Linkage Navigator program, "If a client falls out of care or misses an appointment, the medical case manager is responsible for reaching out to a linkage navigator to locate and get the client back into care." In addition, KDPH's RWHAP Data To Care (D2C) program generates a list of clients who have fallen out of care using Commonwealth surveillance and HRSA CAREWare data to help subrecipients identify and re-engage clients in HIV care. Another strategy that has been implemented is increased linkage to care for incarcerated people with HIV.

Bringing RWHAP to Incarcerated People With HIV

The *Kentucky Ending the HIV Epidemic Strategic Plan for 2021–2026* specifically describes linkage-to-care activities focusing on incarcerated populations and collaborating with the criminal justice system to increase HIV treatment for incarcerated people using RWHAP services. The strategic plan also includes a review of the linkage-to-care and case management process for incarcerated people with HIV, with the goal of increasing efficiency and timeliness of services when possible. In addition, the strategic plan indicates that KDPH will strive to ensure linkage navigation services for incarcerated people with HIV prior to their release from local jails and Commonwealth prisons to ensure that they continue to receive HIV care.

Johnson explained that KDPH's RWHAP program has long recognized the need for improved HIV care services for incarcerated people in Kentucky. Although required by law to provide HIV care to inmates with HIV, local detention centers frequently lack the funds to provide

sufficient care. Todd Hurst, Kentucky AIDS Drug Assistance Program (KADAP) Administrator, explained, "We would have clients in care, and then they would maybe become incarcerated and not have access to sufficient care and medications, so that prompted us to reach out to our project officer." To facilitate care for incarcerated people with HIV, HRSA released a Policy Clarification Notice in November 2018 (PCN 18-02),[7] providing guidance on how recipients may use program funds for core medical and support services for people with HIV who are incarcerated or otherwise involved in the criminal justice system. "I think HRSA looked at that policy and really heard the need that we were identifying, because we were getting letters from family members [and] medical case managers who were concerned about a client that had been incarcerated and was not receiving adequate care," said Hurst. "When we saw the change and the policy clarification notice, we really jumped on it and tried to get something implemented as soon as possible." After obtaining input from legal counsel and the HRSA project officer, KDPH developed and implemented a new Commonwealth policy in July 2019 allowing detention centers to collaborate with the RWHAP to provide HIV care on a short-term and transitional basis to incarcerated people in local detention centers throughout Kentucky. The new policy then was shared with KDPH RWHAP Part B subrecipients and the Kentucky Jailers Association. According to Johnson, "The policy was very well received, and people were very excited about it. I feel like the uptake has been very quick for this new program."

Since the new policy has been implemented in Kentucky, approximately 60 local or county detention centers across the Commonwealth have formed agreements with the KDPH RWHAP to provide short-term and transitional HIV care services for incarcerated people with HIV. The KDPH RWHAP currently serves 59 incarcerated individuals with HIV at the various detention centers.

> *"We want to make sure that any person with HIV who is incarcerated has access to adequate HIV care."*

Hurst explained, "We want to make sure that any person with HIV who is incarcerated has access to adequate HIV care. Where there is a shortfall in a facility, we want to be able to step in and work with that facility to make sure that we're supporting them with whatever—whether it be case management … or medical care and medication for those who have already tested positive." Hurst encourages subrecipients who work directly with local jails to come to an agreement of what can they provide and what they cannot provide, especially because different facilities have different budgets. "It's really a collaboration between those local subrecipients and that local facility to make sure that they're meeting the needs of those folks [with HIV]."

Engaging People With HIV Through Other KDPH RWHAP Programs

KDPH CHFS supports several other RWHAP programs, including KADAP, which provides all eligible Kentuckians with HIV medication assistance and formulary medications through a mail-order pharmacy service offered by the Kentucky Clinic Pharmacy. RWHAP Part B

funds also support a contract with a Commonwealth-wide oral health provider that delivers services to RWHAP clients. In addition, KDPH RWHAP supports the Kentucky Health Insurance Continuation Program, which pays for continuation of health insurance benefits for eligible individuals at risk of losing their employment-related or private health insurance. Other services provided to people with HIV by the KDPH RWHAP include mental health care, housing, nutrition services, and transportation assistance.

Demonstrating Resilience During the COVID-19 Pandemic

The COVID-19 pandemic emerged just as work on the strategic plan began. As a result, KDPH had to adapt its efforts to ensure that the plan was released on schedule. "We were planning on doing a lot of in-person meetings," explained Johnson, "but with the pandemic, we did it virtually, … and I think we actually may have had better participation because people didn't have to travel; they could be in the comfort of their homes." KDPH HIV Prevention provided smartphones to community participants to ensure that they were able to continue participating in the planning process throughout the pandemic. Johnson elaborated, "We didn't want there to be a financial barrier; we were able to provide smartphones so that they could see the plan and participate."

> *"We were planning on doing a lot of in-person meetings… but with the pandemic, we did it virtually."*

KDPH employed several approaches to ensure that quality HIV care was provided to clients during the COVID-19 pandemic. The use of telehealth for service delivery was a key approach that kept the program resilient throughout the pandemic. Gloria Dennis, Kentucky Ryan White Part B Program Manager, noted that telehealth has worked well for KDPH RWHAP clients because it eliminates the need for them to travel to a clinic. Dennis noted, "Transportation has always been a barrier for our clients," particularly in rural areas. Telehealth has allowed KDPH RWHAP clients to "get to their appointments and get the services they need" during the pandemic.

Dennis also emphasized the importance of RWHAP staff availability to clients, including case managers, which was critical to keeping clients in care and identifying nonmedical needs during the pandemic. Johnson explained, "[Program staff make themselves] available to our clients, to listen, to hear from them the difficulties that they're having, and then find solutions to those barriers so that they continue to receive the care and the treatment that they need, whether that be through support services or health care." For example, one subrecipient provided cellphones to medical case managers working at home so that clients could easily reach them, and case managers could have all client telephone numbers on hand.

Another strategy employed by KDPH to prevent clients from falling out of care during the pandemic is providing a secure list of new clients to all subrecipients, following established protocols and procedures. RWHAP staff follow up with the subrecipients to determine

how the program can assist in getting these new clients into care or recertified and integrated into the Kentucky RWHAP system. RWHAP ADAP also supported clients by providing reliable access to HIV medications during the pandemic. According to Hurst, "Early on in the pandemic, our governor made an executive order to allow us to fill extra doses of medication … making sure [clients] had an adequate supply of medication." The contract with a single pharmacy—Kentucky Clinic Pharmacy—that serves the entire Commonwealth has helped. "They do a lot of mail orders, and clients really like that and are already using mail orders, so that worked well. When the pandemic came up, I think access to medication was not as much of a barrier because of the systems we already had in place," said Hurst.

> *Early on in the pandemic, our governor made an executive order to allow us to fill extra doses of medication...*

One way that KDPH's RWHAP subrecipients have been meeting the care needs of incarcerated people with HIV during the pandemic is through the use of telehealth. For example, one subrecipient, LivWell Community Health Services, has been able to provide all 13 incarcerated patients it serves with at least one telehealth appointment from April 2020 to June 2021. Another subrecipient, Bluegrass Care Clinic, initially scheduled in-person appointments for incarcerated people with HIV but rescheduled those appointments because of concerns of risks associated with the COVID-19 pandemic. The subrecipient has been using telehealth appointments to deliver care to incarcerated people with HIV since that time.

In addition, FY 2020 CARES Act funding allowed KDPH to successfully continue to meet the nonmedical needs of clients during the pandemic. For example, this funding was used to form a partnership with a community organization that provides housing to clients with HIV experiencing homelessness. Dennis explained, "We even assisted with hotel and motel vouchers as emergency assistance due to the situation with COVID-19 … to keep people warm instead of being out in the cold." KDPH also used FY 2020 CARES Act funding to provide emergency financial assistance for RWHAP clients who lost jobs during the pandemic to help them pay utility bills and buy groceries. Johnson noted, "With COVID-19, we recognized that people were going to be having difficulties financially," adding that Dennis collaborated with various organizations to identify and meet housing, food, and other basic needs of KDPH's RWHAP clients during the pandemic.

Key Successes and Lessons Learned

The strategic planning process to develop the *Kentucky Ending the HIV Epidemic Strategic Plan for 2021–2026* was essential to moving HIV care and treatment forward in Kentucky. The diversity of HIV stakeholders engaged in the process ensured that the strategic plan addressed a broad range of challenges in delivering quality HIV care to all Kentuckians who need it. "I think that we heard from people that had never been asked for their opinions, had never given their input in something like that before," shared Dr. Tisha Johnson, "and I think it really created some innovative ideas and gave us a really good perspective from multiple voices and different perspectives, such as institutions and persons with HIV and persons that work with HIV."

The implementation of the new policy allowing detention centers to collaborate with RWHAP to provide care to incarcerated people with HIV was an accomplishment for KDPH. "This was a group that wasn't getting the care that they needed," said Johnson. "It was heartbreaking because we didn't have any avenue to help them, and now we can help." The success of the policy was demonstrated by its rapid uptake and expansion across the Commonwealth. Gloria Dennis added that approximately 70 percent of local and county jails in Kentucky now are receiving RWHAP services. An additional benefit to the widespread uptake of RWHAP services at detention centers is the opportunity to continue care for people who inject drugs." [The new policy is] making sure that we're taking care of that population so that there's a continuation of care," explained Todd Hurst.

KDPH's strong relationship with its RWHAP subrecipients and linkage navigators was critical to the success of the program for incarcerated people with HIV, especially during the pandemic. "They are working well together to develop a relationship with the local jails and really build trust between them and also be a resource for them whenever they identify an inmate that is HIV positive," explained Hurst. This relationship, in turn, has led to improved care for incarcerated people with HIV. Johnson noted that the care that KDPH provides for incarcerated people with HIV now extends beyond the basic care detention facilities already were required to provide. "I would say it goes beyond adequate care. I would say that they're getting quality care and that we're developing these strong partnerships between the subrecipients and our local jails."

The use of telehealth to deliver services to incarcerated people with HIV demonstrates how KDPH and its partners were able to innovate to deliver improved care to this population. The benefits of telehealth went beyond virtually connecting incarcerated patients to HIV care. For example, the reduced transportation requirements that accompanied telehealth visits saved jail resources. Telehealth also helped protect incarcerated patients and jail staff from COVID-19, which was critically important because COVID-19 could spread rapidly within detention centers. Telehealth also helped ensure continued engagement of people with HIV during incarceration because jails frequently are unable to transport inmates to in-person health visits on a three- to four-month rotation. The ability of the incarcerated patient to meet with the physician via telehealth also helped ensure adherence to HIV medication regimens, which the Bluegrass Care Clinic demonstrated during a 90-day evaluation of its eight incarcerated clients.

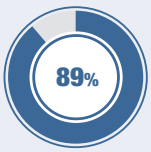
KDPH RWHAP staff all agreed on the importance of collaboration and partnerships to the successful implementation of HIV care programs. Collaboration between KDPH and its RWHAP-funded subrecipients and linkage navigators is helping move the Commonwealth closer to ending the HIV epidemic. Partnerships and a collaborative approach are key components of the new strategic plan, which will guide KDPH toward ending the HIV epidemic in Kentucky.

(L to R) Akosua Addo, Director, Case Management Program; Dr. John T. Carlo, Chief Executive Officer; Dr. Jason Gillman, Chief Clinical Informatics Officer.

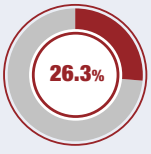
Telehealth Services During the COVID-19 Pandemic and Beyond: Prism Health North Texas (Part C)

Originally established as AIDS Arms Network of the Communities Foundation of Texas in 1986, Prism Health North Texas (PHNTX) is a HRSA RWHAP Part C recipient. PHNTX's mission is to connect people with HIV with personalized, integrated, and equitable HIV medical care and support services in north Texas, including Dallas County and eight surrounding counties. Currently, PHNTX's RWHAP serves approximately 3,000 clients, or 30 percent of the people currently in HIV care at four health centers. The program provides care to people with HIV of all races, ethnicities, and sexual orientations. In 2020, 49.5 percent of clients were White, and 49.4 percent were Black/African American; 26.3 percent of clients were Hispanic/Latino. Approximately 89 percent of all PHNTX clients are virally suppressed.

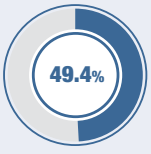
PHNTX's RWHAP has initiated several innovative programs to provide care and treatment to people with HIV to help end the HIV epidemic. One of these programs, Same Day/Same Week, is a Rapid Start program in which all people newly diagnosed with HIV are seen quickly by providers who evaluate them and



of PHNTX RWHAP clients **are virally suppressed**



of PHNTX RWHAP clients are **Hispanic/Latino**



of PHNTX RWHAP clients are **Black/African American**

Dr. Deborah Morris-Harris, Chief Medical Officer.

get them started on ART. "We essentially have a red carpet entry into care experience in which we get the patient in for an initial welcome visit, which includes lab tests and assessments for medical and psychosocial needs, as well as RWHAP AIDS Drug Assistance Program eligibility so we can start the patient on ART within seven days," shared Dr. Deborah Morris-Harris, Chief Medical Officer. "We have a median time to viral suppression in about 30 days, which is really pretty remarkable. We are currently studying how well those individuals are retained in care because of Rapid Start, but we really feel that this—along with our strong prevention and pre-exposure prophylaxis [PrEP] program—is a way to end the epidemic by reducing the community viral load in a very short amount of time."

PHNTX's RWHAP also addresses the social needs of patients with HIV through its case management program. According to Akosua Addo, Director of Case Management, "We help identify any type of needs that the patient may have. We also do a limited mental health and substance use screening, and the goal is to really support patients to access medical care and get referrals for other psychosocial needs they may have." Addo further explained, "We want to support the patients so they can attain some level of self-sufficiency, such as knowing how to access their doctor and other providers, how to navigate the health care system, and how to access transportation and ride a bus. Once we can get to that level and the patient is able to navigate the system, we graduate them, but they can always come back to the program if they should have any other needs that we can support them with, and we work closely with our medical team in the clinics."

In addition to HIV primary care, PHNTX offers prevention services; behavioral health services; and a wide variety of wraparound services, such as clinical pharmacy services, dietary services, and transgender care. Dr. John Carlo, Chief Executive Officer, explained the integrated behavioral health program at PHNTX. "We really do have a one-stop shop. … When patients come to see their doctors and present with depression, they are not referred out to a therapist or a psychiatrist. They get their issues addressed right then and there." Carlo emphasized the importance of patients' not having to go and retell their stories over and over again to several people, which can be traumatic.

Providing Comprehensive Services Through Telehealth and Telepsychiatry

Since the beginning of the COVID-19 pandemic, PHNTX has been offering telehealth and telepsychiatry appointments to patients. These key services are available for both medical and behavioral health visits. According to Dr. Jason Gillman, Chief Clinical Informatics Officer, "Telehealth implementation happened much more quickly than I think we had originally planned. We had talked about rolling it out last year, but we ended up implementing it over about a two-week period [due to the COVID-19 pandemic]." Dr. Thomas Kim, Chief Behavioral

(L to R) Akosua Addo, Director, Case Management Program, and Dr. Jason Gillman, Chief Clinical Informatics Officer.

Officer, worked with Gillman to implement telepsychiatry services and noted how all the PHNTX clinics were quickly on board, "not just to launch an internal health behavioral service, but to create what we're calling our integrated behavioral health service line utilizing telehealth." Kim added, "Behavioral health care in general has a longer history of using telehealth to deliver care. We don't have the regulatory prohibitions with the need for a physical exam and certain diagnostic tests; we can literally do everything at a distance, and as an organization, we have and will continue to effectively do that."

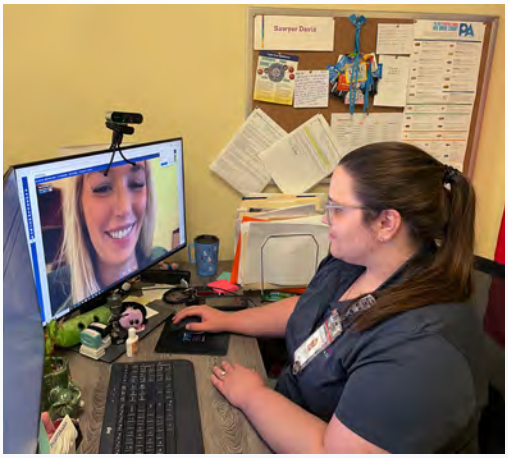
Telehealth and telepsychiatry appointments are made through the PHNTX portal and can be accessed by patients using a computer, smartphone, tablet, or other device with a webcam. Patients can log into the portal to see their lab results, appointments, and other information. According to Gillman, "A lot of our patients were already familiar with the portal, which made it a little bit easier for them to access." After making an appointment, patients receive a text message with a link to initiate telehealth video sessions. The service also has backup capabilities in case patients experience technical difficulties, and it can add a translator to the telehealth visit for non-English-speaking patients.

Telehealth training of behavioral health specialists and psychotherapists was initiated soon after the pandemic began. Gillman explained, "On the [behavioral] counseling side, the psychotherapists quickly jumped in, and we got them trained so that they could adjust their styles and their techniques." Because patients already were familiar with the one-on-one sessions, PHNTX also helped patients with HIV and behavioral health issues adjust to telehealth. Gillman explained that staff worked with these clients to help them navigate the telehealth process. "The team was incredible in creating all of the equipment and everything that we needed to make [telehealth] happen and really help our patients adjust to it."

Building and Maintaining Partnerships

PHNTX maintains relationships with more than 100 partner agencies through its AIDS Arms Network. According to Carlo, up-to-date information about partners and their services is maintained in a network database. The main PHNTX partners are local and state health departments that identify people who have tested positive for HIV and refer them to PHNTX's Same Day/Same Week Program for care and treatment. The state health department also receives RWHAP ADAP funds, through which many of PHNTX's RWHAP patients obtain HIV medications. Other partners provide additional assistance for people with HIV. As Carlo explained, "There are a lot of different organizations that provide everything from housing assistance to supplying additional valuable services, especially around behavioral health, substance use treatment, and inpatient services."

To stay connected, PHNTX conducts monthly virtual network affiliate meetings. These network meetings help PHNTX HIV care staff identify and share resources beyond the RWHAP. According to Addo, "We're working with our community partners [to connect with] their new programs, services, and referral processes to ensure that patients are receiving the best care whenever they are outside of PHNTX."



Virtual meeting between Clinical Nurses Sawyer Davis and Megan Rast.

For HIV-related education, technical assistance, and access to best practices throughout the south central region, PHNTX partners with the RWHAP South Central AETC Program. Morris-Harris shared, "We are in conversation with clinical directors monthly who share best practices from San Antonio to Houston to Arkansas and Louisiana. We really have a fertile conversation there." The AETC has assisted the PHNTX network with practice transformation efforts regarding PrEP and Rapid Start. This assistance is provided through an extensive network of clinical providers who give their time to create programming, which is now approved for continuing medical education. Morris-Harris added, "A lot of our speakers [for trainings] come from UT Southwestern Medical Center, and we're very happy about that, since they're doing a lot of education around adolescent PrEP, adolescent STI [sexually transmitted infection], and HIV prevention. We really are very appreciative of our academic partners, as well as our fellow RWHAP partners who are part of the AETC."

PHNTX currently collaborates with and provides technical assistance to Abounding Prosperity, Inc., which has an RWHAP SPNS grant to improve HIV care and treatment coordination for Black women with HIV in the Dallas area. According to Morris-Harris, PHNTX will be collaborating with Abounding Prosperity, Inc., to roll out TIC in the near future. "Our behavioral health department has been trained in trauma-informed care and will give technical assistance to our sister site. We try to pass on information and practice transformation opportunities to our partners that we gained through experience and training, especially as we initiate some of these programs."

Demonstrating Resilience During the COVID-19 Pandemic

PHNTX was able to rapidly and effectively respond to the COVID-19 pandemic and maintain the resilience of its HIV services in large part because of the telehealth program that was being planned before the pandemic began. Although in-office visits were maintained for initial medical evaluations or patient appointments that required blood tests or medication injection, telehealth and telepsychiatry services were implemented quickly when the pandemic hit. Telehealth appointments ensured that patients received continued delivery of quality HIV care, including medical and behavioral health care, as well as case management, linkage to care appointments, and support groups. Gillman noted that the behavioral telehealth services have been critical during the pandemic. "We started to see an increase in anxiety due to social isolation, fear of

Dr. Deborah Morris Harris, Chief Medical Officer, and Akosua Addo, Director, Case Management Program.

COVID-19 related to HIV, and definitely being in quarantine. As time progresses, we are helping our patients cope when people are passing from COVID-19. And we are really taking care of our therapists and making sure they have the support and resources they need to ensure that they are not affected by the vicarious trauma [of COVID-19]."

To support its programs during the pandemic, PHNTX received FY 2020 CARES Act funding, which was used primarily for telehealth software and hardware and to facilitate COVID-19-related provider training. In addition, the state granted PHNTX emergency application status for RWHAP services, including ADAP, through 2021. This status meant that PHNTX was able to streamline the RWHAP recertification documentation processes. As explained by Addo, "In the past, patients had to update about 17 pages of documentation every birth month and half-birth month, which was pretty much every six months. It was extremely difficult to chase patients for documentation in the midst of COVID-19, since they couldn't come in." Addo added, "The change meant patients and case managers didn't have to worry as much about getting documentation in time. Another change that helped to lessen the burden on patients while reducing their risk for exposure to COVID-19 was the use of 90-day medication refills, instead of 30-day refills."

In addition to telehealth services, PHNTX implemented centralized COVID-19 testing supported by FY 2020 CARES Act funding, which, Morris-Harris stated, "has been very instrumental in keeping our patients out of the emergency room and, perhaps, even reducing the number of people who have been hospitalized as a result of COVID-19, despite their multiple comorbidities." To mitigate pandemic anxiety and provide additional support to its employees, PHNTX established a new Department of Occupational Health. According to Morris-Harris, "Dr. Gillman was instrumental in developing an app to test our employees for COVID-19 and whether staff needed to isolate for a period of time. We have an occupational health nurse who manages [COVID-19] testing and clears employees to return to work, and I think that helped to reduce some of their anxiety. They did not have to try to find a testing place. There was no confusion about when they could return to work."

Also, PHNTX's clinical trials unit, which is sponsored by the AIDS Clinical Trials Group and several pharmaceutical companies, was involved in COVID-19 vaccine research studies. Morris-Harris explained, "Our clinical trials unit has completed enrollment for the AstraZeneca vaccine trial, which was really pretty much right on target with their goal of about 230 patients."

Key Successes and Lessons Learned

Despite the pandemic, PHNTX experienced a 10 percent growth in the number of patients served in 2020 through the use of telehealth. According to Dr. Thomas Kim, "We really did a great job at doing telehealth right. … We were able to be the right doc with the right information at the right time more consistently than many, many health systems who struggled in the past year."

Dr. Deborah Morris-Harris attributed many of PHNTX's successes to the ongoing review of best practices of other organizations for delivering HIV care, noting that staff have gleaned some unique and effective practices from HRSA's conferences and webinars. "PHNTX staff also regularly review relevant literature for interventions that might make the lives of their clients easier, considering such questions as, "What will reduce people's being lost to care? What will be effective in terms of viral suppression, retention in care, and progression along the continuum, from pre-HIV all the way to HIV care?" "We really try to put arms around the patient and ensure that no patients are left behind," said Morris-Harris.

Another success was the increased interdepartmental collaboration among case managers on various teams, such as the prevention and Minority AIDS Initiative teams, to ensure coordination and resilience of services. According to Akosua Addo, "We saw a definite increase in multiple departments stepping up in support of each other to help with client documentation so we could limit the face-to-face time [with patients]. It's been a great learning experience, and the people here have been very, very supportive and helpful."

One lesson learned is that although most patients have been receptive to telehealth, a few have been resistant to telehealth appointments and wanted to be seen in the office over the last year. In addition, Gillman noted, "There are definitely technology barriers. The main thing I have noticed is that some patients do not have broadband internet or even broadband over cellular internet. Some individuals do not have phones with cameras on them. We have to take all of that under consideration."

Another lesson was the need to find ways to reduce the paperwork and time burden placed on clients to ensure their continuing eligibility in the RWHAP. This task became substantially more difficult during the pandemic, when support services often could not be accessed in-person and reaching a real person to resolve problems or obtain protected information was difficult. Given that the streamlined process through the state-granted emergency application status for RWHAP services is temporary, "If there's something we can do, or even the federal government can support us with, going back to not putting so much burden on patients for paperwork and if we can establish eligibility once a year, … especially now at this time, I think that would be very, very helpful to us," said Addo.

In anticipation of declining COVID-19 infections and the wide administration of COVID-19 vaccines to the general population, PHNTX has established a recovery task force to plan the full reopening of facilities. According to Dr. John Carlo, "Very early on in April 2020, we established a recovery task force in response to client questions about when the offices would reopen and related concerns. … We set up a separate group to really think about recovery and what tomorrow looks like so that the folks could continue focusing on what today looks like." In the meantime, PHNTX continues to provide quality care services to people with HIV, while planning for the post-pandemic future.

Diverse & Resilient staff (L to R): Eemanuwayl Benkedem, Peer Navigator; Ronnie Grace, Lead Peer Navigator; Corey Clark, Peer Navigator.

Improving HIV Care Through Peer-to-Peer Connections: Medical College of Wisconsin (Part D)

The Medical College of Wisconsin (MCW) has been a longtime recipient of HRSA's RWHAP Parts B, C, and D funding. MCW's Pediatric Infectious Diseases Department supports primary care providers who care for pregnant women, infants, children, adolescents and young adults up to age 25, and adult women with HIV/AIDS through the Wisconsin HIV Primary Care Support Network. Clinical nurses help primary care physicians provide the most up-to-date pediatric HIV care by closely following children with HIV. According to Dr. Peter Havens, Wisconsin HIV Primary Care Support Network Medical Director, "In Wisconsin, the greatest driver of the HIV epidemic is new infections among youth, especially youth of color."

To develop a program that addresses the unique challenges young people with HIV face in transitioning to adult care and staying in care, MCW reached out to the Wisconsin Department of Health Services (DHS) HIV Program, the lead agency for coordinating Wisconsin's public health response to the HIV epidemic. Together MCW and Wisconsin DHS applied for one year of supplemental RWHAP Part D funding to plan a pilot peer support program to reach youth with HIV. As explained by Havens, "We were excited to partner with the state because they were already working on a peer support program." Amy Wick, HIV Care Unit Supervisor, Wisconsin DHS, concurred. "The idea of one [peer support program] was being tossed around." In fact, the Program first was conceived in a focus group spearheaded by Diverse & Resilient, a community-based partner organization that is focused on health and overall safety related to the LGBTQ+ community. According to Laura Kerecman, MCW Program Manager, "Part of why we wanted to initiate a peer program is that we learned that patients and clients

> *I don't know if you want to call it the 'Special Sauce,' but that is what we were looking for to provide to our clients.*

or potential clients feel a sense of connectedness when they work with someone—other than or in addition to a nurse or social worker—who might be of the same ethnic background as they are and who shares the experience of living with HIV. I don't know if you want to call it the 'Special Sauce,' but that is what we were looking for to provide to our clients. That is why we partnered with the state and with Diverse & Resilient—because they were organizations that had similar goals."

Planning the Peer Navigator Program

With RWHAP Part D funds awarded to MCW in summer 2018, the planning phase of the Peer Navigator Program began. According to Ryan Rohde, Program Development Coordinator, Wisconsin DHS HIV Program, the mission of the Peer Navigator Program is "to holistically improve the lives of individuals with HIV by reengaging the individuals into care through peer-to-peer connections." The program, which is located primarily in Milwaukee, offers a bridge from pediatric care to adult HIV care by using peer navigators to help youth stay in care and get the treatment and services they need to reach and maintain viral suppression. The program's five main goals are to (1) increase viral load suppression, (2) reduce barriers to achieving viral load suppression, (3) decrease the number of participants who are lost to care, (4) reduce HIV-related disparities and health inequities, and (5) increase community awareness of the peer navigator program.

Rohde shared that the team conducted research to determine how to create the Peer Navigator Program without "reinventing the wheel." During the program planning process, a community advisory board was established to obtain input from people with HIV; health care providers from Federally Qualified Health Centers; community organizations, including Diverse & Resilient; and DHS. Kerecman explained, "We very intentionally brought to the table a community advisory board. We didn't call it a client advisory board or a patient advisory board because we wanted it to be people with HIV. And I think it was really important for us to listen to each other and from the perspective of what we each brought." Rohde added, "Right from the get-go, we were completely transparent with the community advisory board with every step that we took. Community [advisory board] members were able to provide their feedback and share any recommendations that they had for us, and we wholeheartedly listened to that and changed anything that we needed to."

(L to R) Justin Roby, Director of HIV Care; Eemanuwayl Benkedem, Peer Navigator; Corey Clark, Peer Navigator; Julius Pittman, Peer Navigator; Ronnie Grace, Lead Peer Navigator.

In addition to obtaining community advisory board feedback, the year of planning allowed MCW, the Wisconsin HIV Program, and Diverse & Resilient to develop forms and protocols to ensure patient standards of care and conduct staff trainings on the program. The team also reviewed their existing client resources and determined which additional resources were needed for the program. The planning phase enabled Diverse & Resilient to became familiar with the program database to capture client enrollment eligibility information, including income, insurance, and residency. The database also is used to capture health and medication assessments and other data.

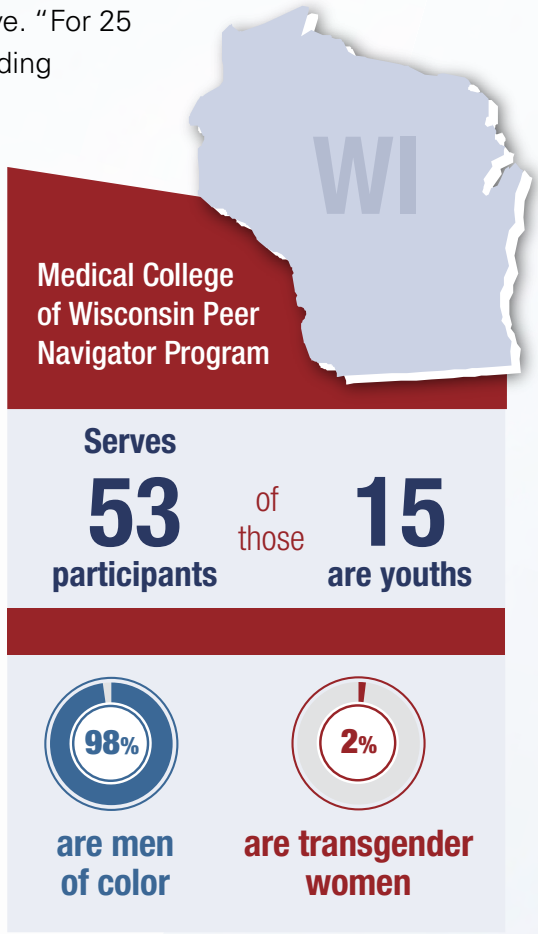
Justin Roby, Director of HIV Care.

Implementing the Program: Recruitment and Peer Matching

After the year of capacity building and planning was completed, the Peer Navigator Pilot Program was implemented using a combination of RWHAP Part C Capacity Development funding and State of Wisconsin 340B program income funds. The day-to-day operation of the program is managed by Diverse & Resilient, reflecting the organization's strong connections with the community. Peer Navigator staff are composed entirely of men of color with HIV. Justin Roby, Director of HIV Care at Diverse & Resilient, explained that the carefully selected team represents the community that they serve. "For 25 years, we've been here in the community, so a lot of staff—including those living with HIV—have mentored countless individuals and have that unique connection with the community. We are able to harness the trust they [the community] already have in our agency."

The Peer Navigator Program currently serves a population that consists primarily of men of color (98%), the majority of whom are Black. A smaller percentage of the participants are transgender women (2%). To date, 53 active participants are enrolled in the Peer Navigator Program, 15 of whom are youths.

Community outreach and engagement is crucial for client recruitment and retention. Social media is used to reach potential program participants, especially youth with HIV. Roby explained, "We post on Facebook and Instagram, and we do so regularly. I try to include as many things as I can that will present people with HIV in a positive light and break



Ronnie Grace, Lead Peer Navigator.

the stigma." Recruitment also is done through Diverse & Resilient's Intersectionality Among Men program, which serves men of color who are aged 18 to 29; the Grown Ups program, an empowerment group that has provided support to men with HIV for 10 years; and local and state partners. To obtain referrals, the team has visited local clinics and provided information about the program to infectious disease physicians, social workers, and case managers. When the team realized they wanted to reach individuals who are not virally suppressed, not engaged in care, or potentially at risk for falling out of care, they decided to partner with other programs, including the state's Data to Care program, which was used to identify potential clients. According to Rohde, Diverse & Resilient began to identify and prioritize people with HIV who have been out of care for more than 14 months and have high viral loads—more than 1,000 copies per milliliter—through the Data to Care documentation system.

To engage and retain program participants in HIV care, honest and effective communication between peer navigators and participants is essential while youth participants are learning more about how to navigate the adult health care system. To facilitate that communication, Diverse & Resilient matches participants with peer navigators after a detailed screening interview. The goal of peer matching, Roby explained, "is to ensure that program participants and peer navigators feel safe, comfortable, and engaged with one another."

In addition to one-on-one conversations, the Peer Navigator Program provides transportation assistance to ensure that participants do not experience barriers in getting to appointments; information on sexual and reproductive health, including achieving an undetectable viral load and having conversations with partners about PrEP; guidance on health insurance; enrollment assistance in the RWHAP AIDS Drug Assistance Program; assistance with medication adherence (e.g., pill bottles, key rings, regular reminders); and emotional support for participants. The program is associated with the Grown Ups program, which meets twice a month to discuss various topics related to HIV and health. Speakers are invited to Grown Ups meetings to answer questions about medications and care. Although the program is relatively new, one individual has already graduated from the program, and another is close to completing it.

Corey Clark, Peer Navigator.

Demonstrating Resilience During the COVID-19 Pandemic

COVID-19 appeared just as the planning phase of the Peer Navigator Program was completed and implementation was beginning. During this time, the needs of the program and community were great. According to Roby, "At first, when everything hit, there weren't available options. People were scared and stressed; people had just lost their jobs, and they were worried about how things would go. We became the answer to a lot of questions, including COVID-19 risk, from a lot of people." For some people with HIV, the emergence of a new virus caused concern and fear. Roby explained, "It was the immediate fear that I think every person with HIV has, that we're facing another virus. I knew that this second pandemic would cause additional stress and loneliness for people with HIV, especially for those who were aging with HIV."

> *We became the answer to a lot of questions, including COVID-19 risk, from a lot of people.*

Early in the pandemic, the program looked for innovative ways to address those concerns. Adjustments were made from in-person HIV care appointments and meetings to virtual platforms to ensure continuation of the program's services, alleviate client stress and isolation, and answer questions. Regular Grown Ups meetings—conducted via Zoom—helped maintain a connected and supportive community.

Another immediate priority was to respond to new financial needs resulting from the pandemic. According to Wick, FY 2020 CARES Act funding received from HRSA was used to provide food, rent assistance, and other resources to participants in the Peer Navigator Program. Roby expressed, "It was lovely to be able to get those resources. You know, rent assistance, anything that could help a person who was struggling."

Julius Pittman, Peer Navigator.

Key Successes and Lessons Learned

Despite the challenges of starting the Peer Navigator Pilot Program during the pandemic, the program has been a success in helping participants engage in care and achieve positive health outcomes. Overall, approximately 89 percent of youth in the Wisconsin HIV Primary Care Support Network, including participants in the Peer Navigator Program, have reached viral suppression. Among the 15- to 29-year-old age group, approximately 83 percent to 85 percent have reached viral suppression.

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are virally suppressed

Among the **15- to 29-year-old age group**

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Spending a year in the capacity-building planning phase and creating the program's infrastructure, staffing, and identity contributed greatly to its success. According to Laura Kerecman, "The program's success during this time reflects the team's unwavering commitment to its mission. It's a testament to having the right people in the positions and having the right people communicating with the right organizations. [We] have been able to recruit 50-some people during the pandemic when we're all working remotely. I just think that's a huge accomplishment that shouldn't be taken for granted."

Another strength that contributed to the program's success is the multiple partnerships across organizations that have forged connections within the community. Diverse & Resilient, which led the pilot phase, provides navigator services to help connect participants with HIV care and services. DHS, which led the capacity-building phase, provides technical support and oversight for the program, as well as the Data to Care system. MCW provides funding and the experience of building a program of nurse-led medical case management funded by RWHAP to support individuals who struggle to remain in care and reach viral load suppression. Other partners include Vivent Health, Children's Wisconsin, and Milwaukee Health Services (MHS)—which provides clinics for referrals—and Outreach Community Health Center. According to Amy Wick, "Outreach and [MHS] are Federally Qualified Health Centers, so they're uniquely set up to support the needs of a lot of our clients." Ryan Rohde added, "We have such strong community partners. They see the importance of care and that they [provide] a unique role within the peer continuum for individuals with HIV outside of the peer navigator or case manager or medical provider."

The team had some recommendations for RWHAP recipients that are interested in establishing their own peer navigator program. Justin Roby urged them to seek advice from established programs—including those in Washington, D.C., and Atlanta, Georgia—that can offer valuable insight on community-oriented systems. "Don't reinvent the wheel. Reach out to people. I've spent a lot of time in webinars, in conferences, learning from the experiences of others and what they have done. I think nuggets of knowledge can come from all of them as you build your own [program]."

(L to R) Debbie Adams, Employment Support Specialist; Dr. Joey Lightner, Evaluation Coordinator; Jamie Shank, Quality and Housing Manager; Kate Murphy, Housing Employment Specialist.

Improving Health Outcomes for People With HIV Through Employment and Housing Services: City of Kansas City, Missouri Health Department (Part F: Special Projects of National Significance Program)

The City of Kansas City, Missouri Health Department (KCHD) has been a long-standing HRSA RWHAP recipient with funding from Parts A and F. KCHD's Part A TGA funding provides a comprehensive system of HIV primary medical care, essential support services, and medications for people with HIV who have limited incomes and are uninsured and underserved. Serving an 11-county region surrounding Kansas City, KCHD's HIV Care Services seeks to empower people with HIV to overcome barriers to care and improve their health outcomes by offering a range of services, including linkage to care, medical care, case management, dental services, housing, and employment services.

In addition to its Part A funding, KCHD has been awarded three RWHAP Part F SPNS Program grants. Recently, KCHD completed its KC Life 360 initiative for the RWHAP SPNS, Improving HIV Health Outcomes Through the Coordination of Supportive Employment and Housing Services. This innovative SPNS initiative was designed to complement and expand the transitional housing program activities undertaken by KCHD and the U.S. Department of Housing and Urban Development (HUD). SPNS has allowed KCHD to implement and innovate the variety of housing and support services provided to clients living in the TGA over the last several years, a critical service due to Kansas City's lack of affordable housing.

Engaging People With HIV in the KC Life 360 Initiative

To engage people with HIV into care who were transitionally housed, homeless, or unstably housed, KCHD began implementing KC Life 360 in September 2017. The three-year initiative focused on providing supportive services to eligible clients to ensure they were capable of obtaining and maintaining employment, stable income, and economic mobility, with the goal of securing subsidized or unsubsidized permanent housing.

According to Frank Thompson, KCHD Deputy Director, "The initiative was part of a concentrated strategy within KCHD to address issues around housing and health equality. An earlier SPNS grant enabled us to integrate teams of HIV case managers and housing staff, as well as databases, to create a comprehensive approach to HIV care for clients instead of using a siloed approach. For the KC Life 360 initiative, our focus was to put processes and systems in place to effectively move our clients along a housing continuum of care so they would not cycle in and out of the continuum."

An essential component of the KC Life 360 initiative was providing employment support to clients. According to Travis Barnhart, Quality and Housing Program Manager, "Studies have shown that providing stable housing for people with HIV is one of the most important factors to help them establish and maintain their health outcomes. However, a key shift for us was the recognition that it's important for our clients to have some kind of income to support themselves to keep their housing and to not always rely on long-term, permanent supportive housing vouchers." Debbie Adams, Employment Support Specialist, concurred and added, "The main goal was to help the clients to find employment through case management services, which would lead to housing, which would then lead to better health outcomes."

Having dedicated co-located partners and staff to facilitate these services was another key component of the initiative. Adams explained, "KCHD partnered with Catholic Charities of Kansas City–St. Joseph, an employment services agency." Another KCHD partner was reStart, Inc., an agency in Kansas City serving all homeless populations—including people with HIV—by providing food and emergency shelter, transitional housing, and permanent supportive housing. KCHD also fostered relationships with local junior colleges for enrolling clients in school or GED classes, vocational rehabilitation facilities, and a local shelter for women and children experiencing domestic violence to obtain housing and counseling.

Enrolling and Onboarding Clients Into KC Life 360

According to Adams, clients were referred to KCHD through medical case managers, community partners, Catholic Charities, and reStart. Before being enrolled in the initiative, potential clients were screened for eligibility. In addition to being homeless, transitionally housed, or unstably housed, eligible clients with HIV were aged 18 years and older, not engaged in care, or not virally suppressed. Newly qualified clients met in person with KCHD's project evaluator, quality and housing manager, or housing support specialist to provide consent for the initiative's evaluation component and to participate in a baseline interview for

(L to R) Jessica Gant, 360 Employment Specialist, Catholic Charities, and Debbie Adams, Employment Support Specialist, KCHD.

the evaluation. Following the interviews, a warm "hand-off" was made to Adams for an employment assessment in which clients were asked to describe their employment history, educational history, skills, type of employment, and goals they wished to pursue. The assessment also covered potential barriers to securing employment and housing, such as a history of evictions; lack of work history; missing documentation, such as a social security card, driver's license, or birth certificate; unpaid utility bills; lack of transportation; history of felony convictions; and childcare needs. An Employment Action Plan with 30-, 60-, and 90-day time frames then was developed to ensure that clients and staff members had a mutual understanding of the required steps toward gaining employment and housing.

After the initial meeting with KCHD staff, referrals were made to Catholic Charities as needed to assist clients with employment services, such as resume building, job search assistance, workshops, and group classes. Clients met with Catholic Charities staff weekly for three weeks to complete workforce development trainings. Afterward, they met with Catholic Charities as needed to secure employment leads or to access referrals for obtaining cellphones, interview clothing, food, financial assistance (including utility assistance and obtaining identification and birth certificates), or transportation. Case managers also referred clients to reStart for a transitional housing program assessment if they were living in a shelter or needed assistance with more permanent housing. reStart also offered clients the support they needed to begin HIV treatment or to reengage in care by providing case management, substance use counseling, mental health therapy, and assistance in accessing benefits and health-related services.

Ongoing engagement with clients by KCHD and reStart staff initially occurred on a weekly basis to track progress. The team developed several innovative programs to address obstacles to HIV care, housing, and employment. To help clients overcome communication barriers, KCHD provided cellphones and monthly payment plans to clients to ensure that they had access to health care and service providers, employers, and landlords. According to Adams, "We realized within the first six months or so when we tried to contact people for interviews and to set up appointments that cellphones and phone service were limited in this population. And it's really hard to apply for a job and be able to get a call back if you don't have a working phone number or an email that you can access. One of our [partner] agencies was able to purchase cellphones and minutes, which was a huge help." Clients used cellphones to schedule employment interviews with prospective employers and contact housing providers, their landlords, their health care team, KCHD staff, Catholic Charities, and reStart.

When apartments were not available or ready for clients, KCHD started a short-term lodging program after learning about a similar program from Family Health Centers of San Diego and

Positive Impact Health Centers of Atlanta, which had been providing emergency hotel gap lodging through their SPNS grants. Adams stated, "We were able to start gap lodging—or short-term lodging, as we call it now—with hotel vouchers to keep people safe and [not living on] the street until their more permanent housing was available." To implement the program, KCHD contacted hotels in areas close to transportation, medical care, and employment opportunities to arrange short-term hotel lodging.

(L to R) Jamie Shank, Quality and Housing Manager; Debbie Adams, Employment Support Specialist; Frank Thompson, HIV Services Manager; and Sean Ryan, Social Services Supervisor, all from KCHD.

To help clients overcome transportation-related barriers to care and employment, KCHD offered free bicycles to clients. The bicycles allowed the clients to travel more easily to health care appointments, medical case management appointments, and their jobs. Adams explained, "We realized that some of our clients did not have transportation in terms of a car. We were providing bus passes, but some of the employers were off the bus path. So, we had an organization that provided bikes for some of our clients, and it was a great success. It made it a little bit easier for those clients to get to jobs that weren't necessarily on the bus route."

As barriers were addressed and goals reached, contact with clients generally became less frequent. During this time, clients developed the practical skills they needed to handle gaps in employment. With the support of the program, they were equipped to update their resumes, dress for interviews, and maintain independence. Adams emphasized that these skills are essential for independence. "It does provide you with some self-sufficiency to be able to feel as though you can manage some things on your own and not always rely on a system for things. I think as [our clients] transitioned through KC Life 360, they did gain independence just by the systems that we had in place for them." By September 2020, when the KC Life 360 initiative ended, 115 clients had completed the program.

Demonstrating Resilience During the COVID-19 Pandemic

Although the COVID-19 pandemic emerged just as the KC Life 360 initiative was coming to an end, KCHD made several adjustments. According to Barnhart, KCHD shifted to virtual service coordination meetings to continue to check in with providers and community partners and share information. He added, "As the pandemic hit, we stayed in contact with the Greater Kansas City Coalition to End Homelessness, a HUD Continuum of Care agency that kept track of who

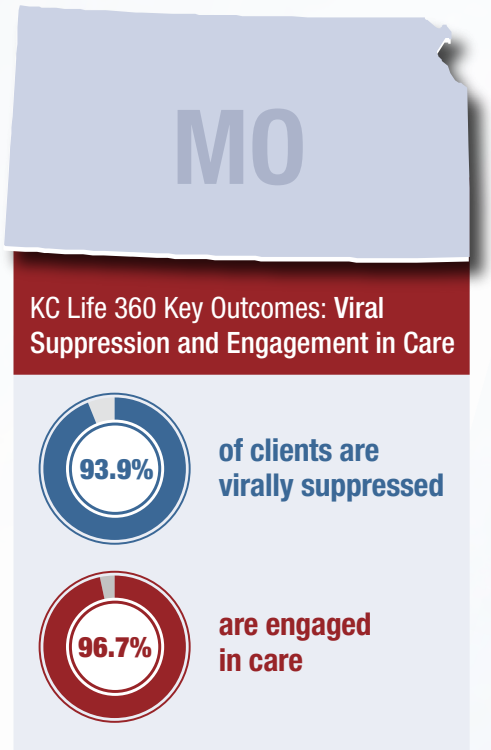
was still open and offering services. A 'street sheet' was put together and shared with our HIV service providers, so they knew where to go for different services or where to call. Also, we did have to shift more to phone calls and video conferencing with clients if they had the capacity."

Many KC Life 360 clients have faced employment and housing challenges during the pandemic. Some—particularly those working in the food industry—lost their employment. The team worked to redirect those affected into other employment options. They also helped ensure that all clients were provided information on how to obtain HIV care during this time, as well as COVID-19 testing.

KCHD received FY 2020 CARES Act funding that helped to extend the time frames and the level of assistance available for short-term rent and utility assistance. The FY 2020 CARES Act funding also was used to support medical case management and ambulatory outpatient care services and to purchase cellphones for clients, personal protective equipment, and cleaning supplies.

Key Successes and Lessons Learned

KC Life 360 proved to be a successful initiative that, according to Frank Thompson, fostered "a spirit of innovation both within KCHD and across our entire HIV system of care in Kansas City. The initiative set a different level of expectations for clients who have a full range of needs and, as a system, we had to be innovative to respond to those needs." KCHD was able to leverage its experience as a longtime RWHAP recipient—along with the infrastructure, systems, and programs that were already in place—to provide people with HIV with coordinated care and housing and to find creative solutions to housing and employment challenges, such as the hotel gap lodging, cellphone, and bicycle programs. The partnerships with Catholic Charities, reStart, and other providers, as well as working closely with medical case managers, greatly contributed to KC Life 360's success.



Another contributing factor to the initiative's success was the time allotted for preparation and training before KC Life 360 began. Debbie Adams stated, "We didn't just jump in and say, 'Okay, let us see clients and figure it out as we go.' We didn't see any clients in that first three to four months. We were preparing, we were getting documents in order, we were getting plans in place, and I think that was really important." Thompson added, "That preparation included systemwide training to make everyone aware of the program, how it was going to function, how the referrals would happen, etc., so that planning time was critical."

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Having dedicated staff to coordinate and facilitate services and HIV care for clients—as well as staff to conduct research activities, such as follow-up interviews, data collection, and data analysis—were other critical components that led to the success of the initiative. The infographics below show several key outcomes of the project.[8]

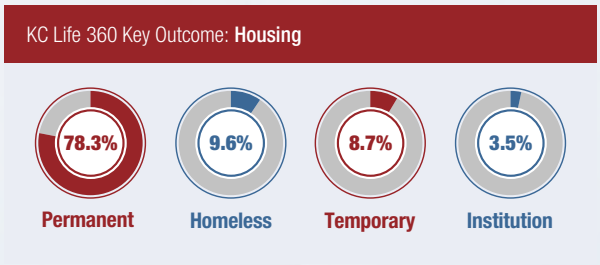
KC Life 360 Key Outcomes

Although KC Life 360 was a successful initiative, KCHD learned several lessons. One of the most significant was that it is easier for clients to achieve stable housing than stable employment that provides a living wage. Clients must develop practical skills that are essential for employment and self-sufficiency. Although clients worked on these skills during the program, developing them takes time.

Early on, KCHD and partners Catholic Charities and reStart realized the importance of creating "one-stop shops" for clients to receive housing and employment services. Instead of requiring clients to attend appointments at three different locations, the partners worked out colocation memoranda of agreement allowing staff to work onsite at partner agencies. For example, Catholic Charities' staff regularly worked shifts at the KCHD, and KCHD staff frequently met with clients who were residing at reStart's offsite transitional housing apartment building. This practice helped increase client retention and engagement in the intervention.

Health challenges experienced by some clients, such as side effects from medications, affected their employment status. Adams explained, "Vocational rehab does a really good job of doing an initial assessment and determining if the client may need part-time work, volunteer work, or if they can work full time with some adaptive schedule. We had to meet those clients where they were physically and mentally at the time."

To maintain many of KC Life 360's activities after SPNS funding ended, KCHD began sustainability planning in the second year of the initiative. As a result, KCHD has been able to allocate RWHAP Part A funds and HUD's Housing Opportunities for Persons With AIDS funds to maintain short-term lodging in its program portfolio, as well as service-level coordination, assessment, training, and capacity building among the housing, employment, and HIV care sectors. The Employment Support Specialist position, which greatly helped facilitate the success of the initiative, will continue to be maintained by KCHD. The continuation of these KC Life 360 activities will help ensure improved health outcomes, employment, economic mobility, and permanent housing for people with HIV in Kansas City.



University of Pittsburgh Graduate School of Public Health.

Using Technology to Provide Clinician Education and Improve HIV Care: The MidAtlantic AIDS Education and Training Center (Part F: AIDS Education and Training Centers)

The MidAtlantic AIDS Education and Training Center (MAAETC), a HRSA RWHAP Part F–funded recipient, is located at the University of Pittsburgh, with regional partner AETCs in Delaware, the District of Columbia, Maryland, Pennsylvania, Virginia, and West Virginia. Through live webinars, on-demand clinical consultations, virtual didactic and interactive trainings, preceptorships, and coaching, MAAETC provides clinical education and training to health care providers on HIV transmission, prevention, treatment, and care. This critical education is available to RWHAP providers—including physicians, physician assistants, nurses, dentists, pharmacists, and social service workers—and non-RWHAP clinicians who work in hospitals, clinics, and community-based settings across the mid-Atlantic region. In addition, MAAETC also is playing a vital role in educating the next generation of health care providers about HIV clinical care and the psychosocial, culturally responsive, health equity, and inclusion issues surrounding HIV by training faculty in health professional schools.

Engaging in High-Priority Activities to End the HIV Epidemic

MAAETC currently is engaged in several high-priority activities specifically geared toward ending the HIV epidemic. One of these activities involves capacity building to help clinicians and other providers effectively deliver the latest HIV medications to their patients. Dr. Linda Rose Frank, MAAETC Director at the University of Pittsburgh School of Public Health, explained that MAAETC focuses on "making sure that [health care providers] have the skills and the knowledge to offer HIV testing, initiate rapid start of antiretroviral therapy [ART],

and … identify people who are candidates for pre-exposure prophylaxis [PrEP]." MAAETC also runs an *Ending the HIV Epidemic in the U.S.* workgroup in collaboration with regional partners. According to Ingrid Godfrey, Distance Learning Specialist at MAAETC, "We really work closely with our regional partners to develop new trainings, new communities of practice, and really share ideas. It's been great to increase that collaboration, even during the pandemic, through virtual meetings." In addition, MAAETC conducts a webinar series focused on ending the HIV epidemic and has reorganized its online content according to each of the four pillars—Diagnose, Treat, Prevent, and Respond—in the federal *Ending the HIV Epidemic in the U.S.* initiative.

Dr. Linda Rose Frank, MAAETC Director at the University of Pittsburgh School of Public Health.

Another priority effort is the delivery of regularly scheduled webinars with input from the U.S. Public Health Service Region 3 Mid Atlantic Training Centers for Health and Human Services (MATCHHS) on intersecting epidemics, such as HIV, hepatitis, STIs, and substance use disorders. The webinar series involves partnerships with organizations outside of AETCs, such as the STD/HIV Prevention and Training Center at Johns Hopkins University, the Central East Addiction Technology Transfer Center, the Mental Health Technology Training Center, the Prevention Technology Transfer Center, and the Mid-Atlantic Regional Public Health Training Center.

Learner Education and Practice Portal

Over the last decade, MAAETC has developed and implemented LEAPP, a major innovative effort used by MAAETC, regional partners, and other AETCs to monitor, support, and improve the quality of their HIV education and support services. The LEAPP platform initially was developed as a tool for accessing MAAETC data on the number and types of providers trained and the impact of trainings for the purposes of evaluation, follow-up, and funding applications. "I think that the important thing about LEAPP is that it is built specifically for the AETC," said Susan Winters, Data Manager for MAAETC, "so we are able to capture the data exactly how we need to and report it exactly how we need to."

Since its inception, however, LEAPP has continued to evolve and expand. Winters explained, "We keep adding new features—things that we think will be beneficial to our trainees and to us to run our programs." For example, MAAETC staff quickly realized that, in addition to data collection, an online platform like LEAPP could be used to provide an online community of practice for providers receiving MAAETC training and education. As a result, MAAETC currently uses LEAPP to convene communities of practice and facilitate interaction among health care providers at practice transformation clinics, partner organizations, and other agencies and programs. Frank explained that these communities of practice extend beyond information sharing because "Information doesn't necessarily change practice. … We talk about particular

Susan Winters, MAAETC Data Manager.

issues that they're having that need to be addressed so that people get not just information, but technical assistance and consultation about real problems that they're having right now."

MAAETC also works closely with its regional partners to set benchmarks for meeting their goals, which is important for the success of their activities. According to Winters, "We do a deeper dive into what all that means and how we're going to do it, and so we all work together to come up with those benchmarks." MAAETC has an overall work plan in which partners benchmark activities and tasks they have in common. According to Frank, "[Regional partners] can go onto LEAPP and look at their own data to see where they are in meeting their goals, as well as [other] regional partners' [goals]. So, that goes back to the issue of quality management—not just quality management for the training but meeting our goals for our cooperative agreement."

Demonstrating Resilience During the COVID-19 Pandemic

As the COVID-19 pandemic unfolded, MAAETC recognized the need for providers to rapidly learn how to manage COVID-19 and HIV simultaneously. In response to this need and with FY 2020 CARES Act funding, MAAETC quickly developed and implemented a robust training initiative on COVID-19 and HIV and now conducts a webinar series on this topic. Frank estimated that MAAETC has conducted at least a dozen webinars on COVID-19 and HIV since May 2020.

The content of the webinar series largely has been guided by feedback obtained through a needs assessment specifically focused on issues related to COVID-19 and HIV care. "We've been doing an ongoing needs assessment of our trainees on what they want to know," explained Frank. The needs assessment also revealed that providers needed strategies for improving the resilience of their staff during the pandemic. In response to this finding, MAAETC began offering webinars on HIV and COVID-19 that addressed such questions as, "How do you support and [teach] self-care for those health care providers that are in the field doing this work?" explained Frank. Topics of this webinar series also have included basic pathogenesis of COVID-19, health care worker self-care and stress management, and COVID-19 vaccine basics.

> *"We've been doing an ongoing needs assessment of our trainees on what they want to know..."*

In addition, MAAETC has conducted virtual *ad hoc* technical assistance sessions with groups and individuals throughout the pandemic, often connecting those they assist with federal training centers outside AETC program (e.g., STI and public health training centers and addiction technology transfer centers). "I think one of the things the AETC does is it says, 'You are so important. You don't have to come to us; we're going to come to you," said Frank,

"and so, what we've done in the past year is to pivot, to come to them through distance-based technology, which I think works very well," adding that much of the MAAETC work "will never quite be the same after COVID-19, because this distance base has changed everything, and it's facilitated a lot of things that didn't happen before."

Ingrid Godfrey, MAAETC Distance Learning Specialist.

FY 2020 CARES Act funding has been an important factor in ensuring the resilience of the MAAETC efforts during the COVID-19 pandemic. In addition to supporting the COVID-19 and HIV webinars, FY 2020 CARES Act funds have been used to develop materials, offer virtual technical assistance and consultation on patients, deliver virtual didactic training, and strengthen and structure clinical services for people with COVID-19 and HIV.

Key Successes and Lessons Learned

Despite the barriers posed by the COVID-19 pandemic, MAAETC succeeded in conducting more than 1,200 events involving more than 19,500 participants in 2020. Dr. Linda Rose Frank noted, "We've been looking at our data on the FY 2020 CARES Act funding, and we've seen the number of health care providers that come to our webinar series—not just on COVID-19 but the other ones—increased dramatically." The number of participants in MAAETC events nearly doubled from 5,498 during the second half of 2019 (July 1–December 31) to 10,487 during the same period in 2020.

The LEAPP platform has played an important role in facilitating participation in MAAETC activities by supporting online interaction of workgroups and outreach to audiences during the pandemic. LEAPP also can be credited, in part, with MAAETC's resilience during the pandemic because it made so many more resources virtually available and shareable. Ingrid Godfrey noted that LEAPP allowed communities of practice to interact regularly to discuss challenges and successes in carrying out their work during the pandemic. "We've had a few new [communities of practice] pop up since spring. … We have at least 25 communities of practice going on right now; some of them meet quarterly and some meet monthly, and they've definitely increased over the past year." Susan Winters added that LEAPP provided access to forms, procedures, templates, and other resources necessary to perform AETC work, which was critical to the continued functioning of MAAETC during the pandemic.

LEAPP has facilitated another MAAETC success—continuous quality improvement of education and training services—because quality improvement is dependent upon a strong system

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of data collection, management, and analysis. "As a clinician, I always think about quality management. [LEAPP] becomes a way of doing quality management with our project, and it informs what we do, it informs where we're going, it informs us to take corrective action for things that may not be going as well as they should be and really to improve our operation," said Frank.

Some of the benefits of LEAPP include functionality that makes data entry faster and more accurate, a portal that links to the AETC central office and regional sites, tools for tracking user uptake, and modifiability that allows the system to be expanded and changed as needs evolve. These capabilities have resulted in the New England AETC's also adopting LEAPP.

In addition to LEAPP, a key success for MAAETC has been its partnerships. MAAETC has several regional partners, including the Health Federation of Philadelphia at Drexel University, Howard University, Johns Hopkins University, the University of Maryland, Virginia Commonwealth University, West Virginia University, ChristianaCare, and Inova Health System. "We've got so many talented people in our MidAtlantic AETC," Frank noted, emphasizing the importance of the partnerships. "[Regional partners] bring to the table their own set of skills and assets." Frank explained that one of the advantages of having the regional AETC partners is that they bring the unique resources of their institutions. "You can't put a price tag on that. We can call up an expert on hepatitis in the next hour and get the needed information." A key partner outside of Region 3 is the National Clinician Consultation Center at the University of California, San Francisco, which offers many warmlines, call-in interfaces for clinicians that provide information on numerous HIV-related topics; medication-assisted therapy for people with substance use disorders; and a perinatal transmission prevention program.

According to Frank and Godfrey, another valuable accomplishment of MAAETC was the development of pocket guides on a variety of topics for health care professionals. The most recent guides focus on HIV screening recommendations for transgender women and men and on routine HIV testing across states in the region, including testing for adolescents, women, and those with substance use disorders.

MAAETC also learned several important lessons from the process of developing and implementing LEAPP and from its efforts to adapt to the COVID-19 pandemic. The improved data management capabilities that LEAPP brought to MAAETC highlighted the importance of data for continual improvement of education and training services. "You know, now we talk a lot about precision public health, and that means using the data that we have to guide what we do," explained Frank, "So, getting direct input from providers, using our data, conducting evaluations, and engaging in a serious look at this information we collect—not just collecting it, but analyzing it."

A key lesson from the COVID-19 pandemic was, ironically, the importance of in-person outreach and interaction. Frank noted, "We're doing more telehealth, such as consultations and technical assistance via the Internet, but there's nothing like going and sitting down with a health care team in the field to know what they're dealing with on an everyday basis and trying to figure out how we can actually help them." Godfrey concluded that, "Perhaps the most important lesson is listening to and collaborating with partners and the audiences we serve as we are constantly listening, getting feedback, and improving our programming and reach."

(L to R) Kristen Brown, CBDPP Admininistrative Coordinator; Conor Sullivan, Referrals Coordinator; Dr. Jill York, CBDPP Administrator and RSDM Assistant Dean for Extramural Clinics; Darlene Saggiomo, Registered Dental Hygentist and Recall Recovery Program Coordinator; Dr. Michael Diorio, Assistant Professor of the Department of Community Health and Clinical Director of the Ryan White Program; Carol Medina, Lead Dental Assistant.

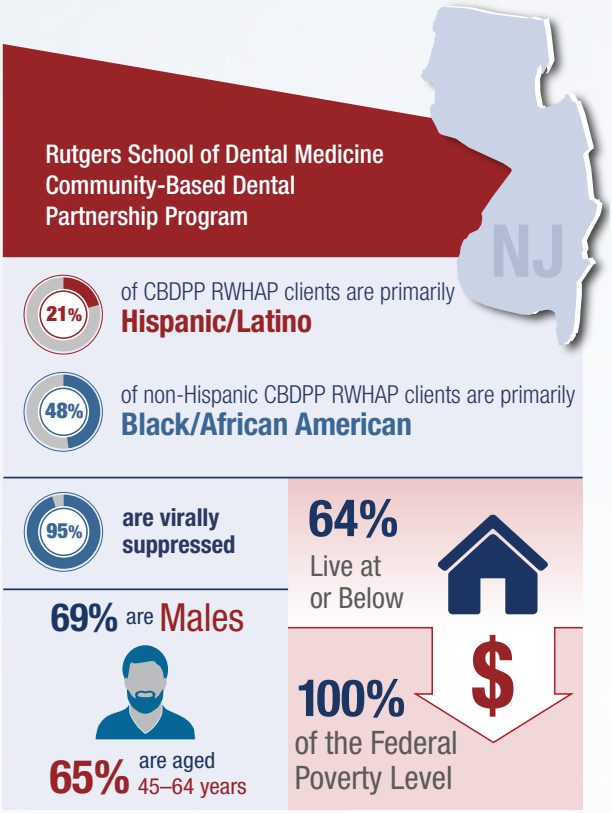
Engaging People With HIV in Dental Care: Rutgers School of Dental Medicine Community-Based Dental Partnership Program (Part F: Dental Programs)

With HRSA's RWHAP Part F Dental Programs funding, the Rutgers School of Dental Medicine (RSDM) provides a full range of comprehensive oral health care services to underserved, uninsured, underinsured, and underrepresented people with HIV in southern New Jersey through its Community-Based Dental Partnership Program (CBDPP). Given that people with HIV have a higher risk for dental caries, periodontal disease, oral lesions, and xerostomia (dry mouth), one of RSDM CBDPP's main goals is to increase access to oral health care in communities without dental programs, especially those near epicenters of HIV, such as Atlantic City and Camden, through a network of facilities. According to Dr. Jill York, CBDPP Administrator and RSDM Assistant Dean for Extramural Clinics, RSDM's CBDPP provides a wide range of key prevention, diagnostic, and treatment dental services for clients. These include oral health education and health promotion, nutrition counseling, tobacco prevention and cessation programs, oral medicine, oral pathology, restorative, periodontics, prosthodontics,

> *One of RSDM CBDPP's main goals is to increase access to oral health care in communities without dental programs.*

oral maxillofacial surgery, endodontics, and 24-hour emergency services.

Currently, RSDM's CBDPP serves approximately 600 clients with HIV. According to Kristen Brown, CBDPP Administrative Coordinator, approximately 21 percent of clients are Hispanic/Latino, and 79 percent of clients are non-Hispanic. Of the non-Hispanic clients, approximately 48 percent are Black/African American. Additional program details are shown in the graphic to the right.



Integrating Trauma-Informed Care Into Dental Practices

Because many people with HIV experience traumatic events that can negatively affect their health outcomes, RSDM became involved in the New Jersey Trauma-Informed Care Project in 2018. This five-year initiative of the New Jersey Department of Health Division of HIV, STD, and TB Services provides capacity-building support to integrate TIC into the culture, environment, and delivery of HIV care and support services. York explained, "Our aim is to increase access to care and optimize health outcomes for people with HIV. We wanted to reduce HIV-related health disparities and health inequalities because we knew that people of different racial groups suffer more significantly from trauma, and we wanted to achieve a more coordinated and regional response to the HIV epidemic."

To lay the groundwork for the initiative, RSDM participated in New Jersey Trauma-Informed Care Leadership Meetings and a Trauma-Informed Community Launch to outline the components and processes for operationalizing TIC, such as identifying existing trauma-informed practices within agencies, identifying priorities for advancing TIC, and staff training and technical assistance. RSDM also formed an implementation team and task force that were responsible for planning its TIC program at three community-based sites in southern New Jersey, providing training and technical assistance to staff and launching the initiative. The TIC approach utilized by RSDM is based on a medical care model and incorporates several core elements, including respect for patients' values, preferences, and expressed needs; coordination and integration of care; information and education; physical comfort; emotional support and alleviation of fear and anxiety; involvement of family and friends; continuity and transition; and access to care. York stated, "It should really be a bottom-up program, where the people at the site that are interacting with the patients are leading the charge, so staff members are the site leaders."

Darlene Saggiomo, Registered Dental Hygienist and Recall Recovery Program Coordinator, described how RSDM staff interact with their patients who experienced trauma. "We're

Rutgers School of Dental Medicine.

trained in trauma-informed care, but I like to call it care being informed of trauma or some aspect of the patient's life that is troubling them. Patients with HIV are already fighting one fight—but they also have the day-to-day things that go on, like all of us. Because of everything they are going through, when they come to us, it's all released." To give patients the time they need to discuss their concerns and for dental providers to review the patient's status—including such laboratory tests as CD4 levels and viral loads, as well as medications—RSDM allots more time for each appointment. Saggiomo stated, "When patients come in, we sit, and we talk. We ask them, 'How are you? How have you been?' At that time, patients will tell us what is going on in their lives, their traumas, and their concerns. We sometimes have patients that just lost a parent, a sibling, or a child, and they are crying in the chair. You have to calm the patient down and address those situations first before you can work on a patient. At that point, you gained your patient's trust, and they want to come back, and as a result, we are able to treat them and take care of their dental needs."

Retaining Clients in Dental Care: RSDM's Recall Recovery Program

Many people with HIV face challenges in accessing and retaining dental care services. These challenges may include disability, chronic illness, lack of dental insurance, inability to pay for dental care, shortage of dentists trained and willing to treat persons with HIV, fear of dental care, and logistical challenges, such as transportation.

To help retain clients in care, RSDM developed a Recall Recovery Program. According to Conor Sullivan, Referrals Coordinator, "We have a great, loyal population of people with

HIV, but sometimes things happen in their lives: traumatic experiences, they fall out of work, and they fall out of care. We have developed strategies to help retain our patients in care and make sure their labs are up-to-date, and they come in for their six-month check-ups and cleanings. When patients miss their six-month appointments, we will reach out to their agencies and their case managers to get them back into care. A lot of times getting back into care can also be traumatic, so we make sure that getting back into care is the right thing to do." Saggiomo elaborated, "We worked with IT to create and run monthly reports that inform us when patients need to be coming back in [for dental services]. When we find somebody that is out of care, we call them, we contact them by letter, we send them a text message, and we get them back into care. If we find out that the patients do not have a phone number or the phone number has been changed, we will reach out to their case managers and try and get them back into care."

> *When patients miss their six-month appointments, we will reach out … to get them back into care.*

RSDM also works closely with CBDPP partners, including case managers, to help clients with transportation, housing, and other needs. Kristen Brown, Administrative Coordinator, explained, "Some of our case managers have funding for taxi cab and Uber vouchers, for example, to help clients who can't afford the cost of transportation to get to appointments for these [dental] services. If we find out that a patient is homeless or they do not have a place to stay, we will contact the Housing Ambassador for South Jersey, hook them up with that individual, follow through, and hope that they receive the services that they need. If we feel that our clients qualify for Medicaid, we connect them with the appropriate individuals to get them signed up in the state of New Jersey so they can get insurance services."

Engaging Dental Providers Through Community-Based Learning Experiences

In addition to increasing access to oral health care in communities without dental programs, another critical goal of RSDM's CBDPP is to increase the number of dental providers capable of managing the oral health needs of clients with HIV through community-based service-learning experiences. To address this goal, CBDPP provides didactic and clinical training to RSDM's predoctoral and postdoctoral students so they will better understand the medical, social, and oral health care needs and challenges of people with HIV and how to care for patients with HIV in the clinical setting. York explained, "We have two programs for all of our fourth-year students that are enrolled at Rutgers School of Dental Medicine. One is a year-long program where students train at a community-based site, and the other program, which most students participate in, is for a minimum of 2 weeks of community-based training. Anywhere from 110 to 125 students rotate through our sites each year for a community-based learning experience," adding that RSDM has onsite specialist faculty to supervise the students.

To help guide dental education and training and clear up misconceptions about HIV dental care, fourth-year dental students are asked to complete a questionnaire to learn more about their

> *The RSDM core curriculum provides them with a foundation in the treatment of medically complex patients.*

HIV-related knowledge pre- and post-training. According to Dr. Michael Diorio, Assistant Professor of the Department of Community Health and Clinical Director of the Ryan White Program, "The analysis of our pre- and post-program student surveys shows that over 50 percent of incoming students initially feel very comfortable and knowledgeable about how to manage dental care for patients with HIV. This is, in part, due to the fact that the RSDM core curriculum provides them with a foundation in the treatment of medically complex patients, including patients with HIV." At the completion of the community-based service learning, all students gain valuable experiences treating patients with HIV. Diorio explained, "They learn how to assess patient lab values, such as their ANC, CD4 counts, viral loads, etc.; coordinate care with infectious disease and primary physician doctors; and appropriately manage and balance their oral health goals and needs. Additionally, the students value their communication lines with primary care providers to coordinate care of patients with HIV. … Students gain a greater understanding of the risk of transmission associated with percutaneous injuries, such as a needlestick, that may occur in a dental clinic during treatment of a patient with HIV."

Diorio emphasized that all of the students and staff practice the highest levels of standard precautions when treating each patient. These standard precautions are designed to protect health care personnel and patients from pathogens that can be spread by blood or any other body fluid. "It is important that we continue educating dental providers on the best practices in the management of patients with HIV and that we continue to provide resources to people with HIV to seek oral health care services. Every person deserves to have a positive oral health environment that is free of decay and infection, to feel good about their smile, and to be able to chew the foods that we all need and love."

Demonstrating Resilience During the COVID-19 Pandemic

At the beginning of the COVID-19 pandemic, the American Dental Association recommended that all dental offices remain closed except for extreme, urgent, or emergency dental care. To provide emergency care to patients, RSDM implemented a rotating on-call service with a limited team—a front desk staff person, a dental assistant, and a dentist to treat these patients. Within three months, however, RSDM was able to reopen offices by obtaining additional personal protective equipment for the providers and developing and implementing other strategies to safeguard the health of patients and staff. According to York, "One of the key things we did was to develop a COVID-19 response plan with staff roles and responsibilities, and then, prior to reopening our entire clinic, leadership got together and reviewed the plan to make sure that everybody understood it and were all on the same page." Some of the additional strategies used by RSDM included changing the office environment by installing physical barriers at the front desk, reducing the number of operatories or specialized spaces designed to deliver dental treatment to patients, staggering chairs in the waiting room

to reduce the clinic capacity, and adding signs in English and in Spanish to remind staff and patients about social distancing and mask wearing.

RSDM also established new procedures for patient appointments. Sullivan, explained, "We started prescreening patients over the phone for COVID-related symptoms—such as shortness of breath—and underlying conditions, staggering patient appointment times so dental rooms could be disinfected, confirming patient appointments by phone, and taking everyone's temperature [patients and staff] when they come into the building. Once inside, hand sanitizers are available throughout dental waiting rooms and offices." Sullivan added, "We're disinfecting constantly—the waiting room, the countertops, the rooms, and just maintaining proper hygiene."

> *We're disinfecting constantly—the waiting room, the countertops, the rooms, and just maintaining proper hygiene.*

To help keep patients in care during the pandemic, RSDM staff triage any people who are experiencing pain or other acute dental needs and reassure them that visiting the clinic is safe. During a patient's appointment, staff rely on their TIC training to help ease patients' fears about COVID-19 and maintain the necessary communication and connection through the increased layers of protection. "We look like astronauts, not dental providers anymore," said Saggiomo, "but we wear nametags, maintain eye contact, sit level with the patients, and ensure that each individual has their needs met. … We're kind of down to earth, people to people, heart to heart."

RSDM also is rolling out a teledentistry program for patients who do not feel comfortable visiting the clinic in person. According to York, "This is a way for us to bring the care to patients on their terms and in their homes. If they have a computer or a smartphone, we can still connect with them and have that face-to-face connection, but we can still provide them the care that they need." Brown added, "If there's no dental emergency, we will provide counseling over the phone, make sure they're staying healthy and have access to food, and we are also providing smoking cessation programs, since people have gone back to a lot of their old habits, such as smoking, because of the stress of the COVID-19. During teledentistry appointments, we find out exactly what their needs are, and we tailor a care package with supplies for dry mouth, rinses, electric toothbrushes, etc., to be sent to their homes. We find out exactly where they want us to send it, and then we will send them their care package to make sure they also have access to good oral care."

Key Successes and Lessons Learned

RSDM credits much of its success to communication among program staff at the different dental sites, especially during the COVID-19 pandemic. As dental educators, RSDM used the experience of the pandemic to develop effective and transparent communication strategies, because transparent communication calms patients' concerns and fears. RSDM's patient- and staff-centered approach to communications used a combination of telephone calls, emails, text messages, hard copy documents, online virtual meetings, and teledentistry to share information and help ensure that patients with HIV can receive the dental care they need to reach or maintain viral suppression. Ongoing communication with partner agencies and case managers also has been critical in obtaining patient referrals for dental services. In addition, monthly staff meetings allow staff to share program information and changes in protocol, and feedback from patients and RSDM's Advisory Council helps the program to continue to improve.

Another success is how RSDM approaches patient care as a result of implementing its TIC program. Organizational assessments and surveys, have demonstrated that RSDM staff have embraced many cultural and TIC practices. According to Dr. Jill York, "Surveys have shown that staff respect diversity and race, ethnicity, gender, sexual orientation, and the life experiences among our clients and staff. [RSDM] has formal policies in place to ensure clients and staff safety, and it has policies and procedures around staff roles and responsibilities."

One challenge has been coordinating patient referrals and documentation between RSDM and partner agencies and exploring the best ways to establish collaborations and referral networks among health care systems and primary care practices within local regions. Kristen Brown stated, "There seems to be a disconnect sometimes, since we don't always have patient labs from their case managers when they call us. It is a little bit more work on our end, but that is why we are here. Conor [Sullivan] uses CAREWare to track referrals, and then he uses reports to send to the primary care provider, so he is constantly communicating with the case managers."

A key lesson learned in the wake of the COVID-19 pandemic is the importance of resilience, flexibility, and the strong foundation they already had in place. Because the staff were experiencing the trauma of the pandemic in their own lives, they learned to be nonjudgmental with patients and to go above and beyond to take care of those who depend on RSDM's CBDPP as a critical part of their health care team.

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Page 13: Success Stories Divider, counterclockwise from top left: Prism Health North Texas; MidAtlantic AIDS Education and Training Center; City of Kansas City, Missouri Health Department; Diverse & Resilient; Rutgers School of Dental Medicine, Community-Based Dental Partnership Program

Pages 14, 15, 16, 18: New Haven Health Department

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Pages 28, 29, 30, 31, 32: Prism Health North Texas

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