

Harnessing the Power of Community Engagement *and* Innovation to End the HIV Epidemic

*2023 Ryan White HIV/AIDS
Program Highlights*



September 2023



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FOREWORD

Harnessing the Power of Community Engagement and Innovation to End the HIV Epidemic: 2023 Ryan White HIV/AIDS Program Highlights

For more than three decades, the Health Resources and Services Administration's (HRSA) Ryan White HIV/AIDS Program (RWHAP) has worked to reduce HIV-related health disparities and barriers to care that people with HIV face, including discrimination and stigma, by providing comprehensive primary care, medication, and support services to all clients. RWHAP recipients have been integrating a syndemic approach to HIV care and treatment by addressing the interlinked health conditions and public health threats, such as mpox, that have disproportionately affected people with HIV. Recipients also have been examining the ways that structural barriers allow these disparities to persist. By viewing HIV through a syndemic lens, RWHAP and its recipients continue to meet people where they are with the services they need—delivering whole-person care, addressing barriers to care, and closing gaps in health disparities.



To help ensure that people with HIV receive equitable care and treatment to improve their health outcomes, including reaching viral suppression, and to support the *Ending the HIV Epidemic in the U.S.* (EHE) initiative, the HRSA HIV/AIDS Bureau (HAB) and its recipients have been engaging people with HIV and the broader community in planning and implementing innovative strategies. In 2021, HAB hosted 16 virtual EHE [community engagement listening sessions](#) involving a wide variety of participants—including people with lived experience; health care providers; community leaders; and organizations involved in HIV prevention, care, and treatment—to obtain feedback on barriers to care and opportunities for effective and innovative HIV prevention and treatment. Sessions were also held with current and future partners outside the medical and public health communities. Participants provided valuable ideas and suggestions during the listening sessions, and many have been implemented or are underway. In addition, RWHAP recipients have been engaging with the HIV community within their jurisdictions to provide input on local EHE strategic plans, including identifying focus areas and priority populations, and to make progress toward meeting EHE goals.

The urgency to end the HIV epidemic in the United States while addressing health disparities and improving health outcomes is also a focus of the [National HIV/AIDS Strategy for the United States 2022–2025](#) (the Strategy). Both HRSA and the Strategy recognize that reducing health disparities involves concentrating efforts on those populations not yet successfully retained in HIV care, supporting racial justice, stopping HIV-related stigma and discrimination, providing leadership opportunities for people with HIV or those vulnerable to acquisition, and addressing social determinants of health (SDOH) and co-occurring conditions among people with HIV.

This biennial program report, *Harnessing the Power of Community Engagement and Innovation to End the HIV Epidemic in the U.S.*, highlights the many accomplishments and successes of RWHAP during the last two years in achieving its goals to reduce health disparities and end the HIV epidemic in the United States. In the sections that follow, a summary of HAB's accomplishments is presented, along with success stories of the innovative approaches used by recipients.

Highlights of the 2022 National Ryan White Conference on HIV Care & Treatment

The virtual 2022 National Ryan White Conference on HIV Care & Treatment was held August 23–26, 2022, with participation from nearly 7,000 attendees. The conference theme—“The Time Is Now: Harnessing the Power of Innovation, Health Equity, and Community to End the HIV Epidemic”—reflected the urgency to end the HIV epidemic in the United States while also highlighting approaches to accomplish this goal, including focusing on health equity to reduce HIV-related health disparities. Through plenary and conference sessions, exhibits, and poster sessions, the conference provided a forum for the attendees, who included RWHAP recipients and subrecipients, HIV health care providers, partners, national and local stakeholders,

people with HIV, and community members. Attendees learned about and shared innovative models of care and best-practice strategies to engage with the HIV community, address HIV-related health disparities and health equity, and improve health outcomes among people with HIV. Visit [TargetHIV](#) for an overview of the conference and to access presentation slides.

Ending the HIV Epidemic in the U.S.

The multiyear EHE initiative, which began in fiscal year (FY) 2020, is an ongoing effort to reduce the number of new HIV infections in the United States by at least 90 percent by 2030. The initiative focuses on jurisdictions that have a substantial HIV burden. In each year of the initiative, HRSA has awarded EHE funds to recipients to identify priority populations that are disproportionately impacted by HIV, including people who are either newly diagnosed with HIV or previously diagnosed but currently not in care, and link them to essential HIV care and treatment and support services. The initiative also funds recipients to provide workforce training and technical assistance. In FY 2023, approximately [\\$147 million was awarded to 49 HAB EHE recipients](#). EHE activities have included expanding the delivery of core RWHAP medical, mental health, and support services; planning linkage to care and re-engagement activities; identifying priority populations for EHE activities; leveraging technology and improving access; increasing community engagement; enhancing infrastructure and partnerships; conducting cluster response activities; and addressing barriers to implementation. In addition, approximately \$5 million was awarded to 11 RWHAP AIDS Education and Training Center (AETC) Program EHE recipients in FY 2023. This funding continues to enhance and expand the HIV workforce and provides technical assistance to providers across the country. Progress toward implementing EHE activities is described in [HRSA HAB's Ending the HIV Epidemic in the U.S. Initiative Data Reports](#).

RWHAP Data, Tools, and Best Practices to Support Recipients

To highlight and support knowledge sharing about RWHAP progress and client health outcomes, HRSA develops and disseminates data reports, data tools, and best practices to its RWHAP recipients and other stakeholders.

Ryan White HIV/AIDS Program Annual Client-Level Data Report, 2021

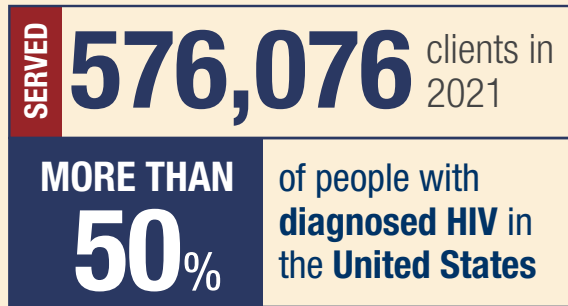
Each year, a comprehensive overview of RWHAP client-level data, including client demographic and socioeconomic factors such as age, race and ethnicity, transmission risk category, federal poverty level, health care coverage, and housing status. The [Ryan White HIV/AIDS Program Annual Client-Level Data Report, 2021](#) provides program data reported by more than 2,000 RWHAP grant recipients and subrecipients for clients served by RWHAP Parts A, B, C, and D during calendar years 2017–2021, regardless of the source of RWHAP funding. Annual client-level data allow us to understand and support the progress that RWHAP recipients are making to reduce HIV-related disparities, expand care and treatment, and improve health outcomes—such as viral suppression among people with HIV—while working to achieve the goals of the EHE initiative.

The “By the Numbers” infographic on the next page shows selected highlights from the 2021 report. Of particular note is that viral suppression rates among RWHAP clients receiving HIV medical care have continued to improve and reached 89.7 percent in 2021. This means people with HIV are taking their HIV medication as prescribed and reaching and maintaining viral suppression, allowing them to live longer and healthier lives. This accomplishment also reflects the ongoing commitment and dedication of RWHAP recipients to provide comprehensive and equitable HIV services to their clients.

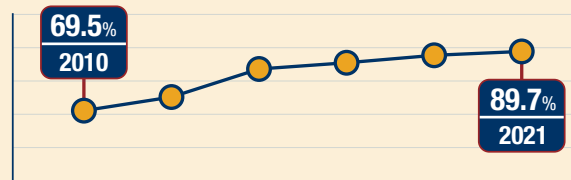
HRSA's Ryan White HIV/AIDS Program

BY THE NUMBERS: 2021

RYAN WHITE HIV/AIDS PROGRAM (RWHAP)



89.7% of RWHAP clients receiving HIV medical care reached viral suppression* in 2021

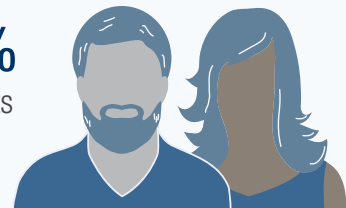


6.6% TEMPORARY HOUSING

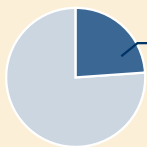


5.0% UNSTABLE HOUSING

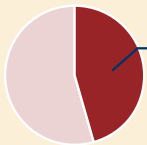
48.3% of RWHAP clients are **aged 50 and older**



59.2% of clients are living at or below **100% of the Federal Poverty Level**



24.1% of clients are **Hispanic/Latino**



45.8% of clients are **Black/African American**



73.3% of clients are from **racial and ethnic minorities****

* 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. People with HIV who take their HIV medication as prescribed and reach and maintain viral suppression cannot sexually transmit HIV to their partner.

** 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 2021 Ryan White HIV/AIDS Program Annual Client-Level Data Report.

Coronavirus Aid, Relief, and Economic Security Act and COVID-19 Data Report

Since April 2020, RWHAP recipients and providers have used [HRSA funding from the FY 2020 Coronavirus Aid, Relief, and Economic Security \(CARES\) Act](#) to prevent, prepare for, and respond to COVID-19, including implementing telehealth capabilities, COVID-19 testing and vaccination, therapeutics, and delivering additional essential support services. An analysis of FY 2020 CARES Act activities is available in the latest [COVID-19 Data Report](#), and the Technical Expert Panel Executive Summary—[Innovation and Resilience: How Ryan White HIV/AIDS Program Recipients Leverage Telehealth during the COVID-19 Pandemic](#)—outlines findings, lessons learned, and effective telehealth practices from several RWHAP recipients that provide care for people with HIV.



Ryan White HIV/AIDS Program Compass Dashboard

With the 2021 launch of the interactive [Ryan White HIV/AIDS Program Compass Dashboard](#), RWHAP recipients, partners, and other stakeholders can access data showing the reach, impact, and outcomes of RWHAP. Specifically, the dashboard provides national-, state-, and metropolitan area-level data and allows users to explore such RWHAP client characteristics and health outcomes as age, housing status, transmission category, and viral suppression. Each year, the dashboard is updated to reflect the most recent RWHAP client-level data.

Best Practices Compilation

The RWHAP [Best Practices Compilation](#), a knowledge-sharing tool, enables RWHAP recipients and subrecipients to learn about successful intervention strategies practiced in RWHAP settings and to find inspiration and new ideas to adopt for improving the care of people with HIV. Interventions can be searched by evidence category (e.g., emerging interventions), focus population, HIV care continuum stage (e.g., viral suppression), setting (e.g., state health department), priority funding by RWHAP Part, and EHE strategy.

Focused RWHAP Efforts to Address Health Disparities, Health Inequities, and HIV Stigma

During the last two years, RWHAP launched or enhanced the following resources, approaches, initiatives, and projects to reduce HIV-related health disparities and stigma and address health equity.

“Life Beyond HIV” Videos

To engage the HIV community and help reduce HIV-related stigma, several video stories were created to highlight the unique perspectives of people with lived experience and how they have been impacted by RWHAP. The [“Life Beyond HIV” videos](#) demonstrate that HIV does not define people’s lives and life does not stop after an HIV diagnosis. The individual stories convey that for some people, an HIV diagnosis was a catalyst for their taking an active role in their HIV care, becoming leaders in their communities, and inspiring others, including those newly diagnosed with HIV.

Part F: Special Projects of National Significance Initiatives

Through its demonstration, implementation, and information technology projects, the [Special Projects of National Significance \(SPNS\) program](#) uses implementation science to evaluate the design, implementation, utilization, cost, and health-related outcomes of treatment strategies while promoting the dissemination and replication of successful interventions. Three new projects are described below.

Emerging Strategies to Improve Health Outcomes for People Aging With HIV

Using HRSA's implementation science framework, this SPNS initiative is focusing on emerging interventions that address the health care needs and outcomes of people aged 50 years and older with HIV. These interventions will aim to screen and manage comorbidities, geriatric conditions, behavioral health, and psychosocial needs of people aging with HIV. The SPNS initiative also is focusing on assessing the adoption and integration of these implementation strategies; understanding and documenting broader contextual factors affecting implementation; evaluating the impact of the emerging strategies; and disseminating the emerging strategies.



Telehealth Strategies to Maximize HIV Care

This SPNS initiative is focusing on identifying and maximizing the use of effective telehealth strategies to improve linkage to care, retention in care, and health outcomes (including viral suppression) among RWHAP clients. The initiative builds on existing programs and will also include creating an inventory of project strategies and tools, providing technical and capacity-building assistance, assessing implementation strategies, disseminating products developed through the initiative, and evaluating the initiative using an implementation science framework.

Supporting Replication of Housing Interventions in the Ryan White HIV/AIDS Program

The [Supporting Replication \(SURE\) of Housing Interventions in the Ryan White HIV/AIDS Program](#) is an SPNS initiative focused on adapting and implementing housing-related interventions and strategies to support three key populations of people with HIV who experience unstable housing: (1) lesbian, gay, bisexual, transgender, and queer or questioning people; (2) youth and young adults (aged 13–24 years); and (3) people who have been impacted by the carceral system. As part of the initiative, an implementation and technical assistance (TA) provider is funding implementation sites, providing implementation-related TA to the sites, and developing a communication plan and tools for widespread adoption of these housing-related intervention strategies for the three key populations. An evaluation provider will develop and implement a multisite evaluation of these intervention strategies and provide evaluation-related TA using an implementation science framework.

Status-Neutral Approaches

HRSA HAB, the HRSA Bureau of Primary Health Care, and the Centers for Disease Control and Prevention (CDC) have recognized the importance of adopting status-neutral approaches to HIV care and prevention to reduce HIV-related disparities and stigma and advance health equity. When feasible and within the confines of RWHAP statute, RWHAP recipients are encouraged to work with public health partners to implement approaches that weave together tools like pre-exposure prophylaxis and post-exposure prophylaxis, as well as to incorporate SDOH to deliver comprehensive whole-person care, regardless of HIV status. In a January 2023 [program letter](#) to recipients, HRSA outlined status-neutral approaches—such as implementing HIV prevention and treatment activities in places where people seek other services and making it easy for people to access care in convenient alternative health care settings that do not require an appointment (e.g., pharmacies, mobile health units). The program letter also addresses funding approaches for delivery of services.

Other RWHAP Efforts to Address Health Disparities and Improve Health Outcomes

Enhancing HIV Care of Women, Infants, Children, and Youth—Building Capacity Through Communities of Practice

This new RWHAP initiative is using a collaborative community of practice (CoP) framework to bring RWHAP Part D recipients together to learn from one another and from recognized experts through three 12-month learning systems. Using a CoP platform, a select group of recipients, partners, and providers will share challenges, lessons learned, and information on best practices related to three focus areas: preconception counseling, trauma-informed care, and the transition from youth services to HIV adult care. CoP participants will also exchange information on scaling up and disseminating focus area interventions and strategies to enhance the care of people with HIV and their affected family members, as well as to improve their health outcomes.

Using Evidence-Informed Interventions to Improve Health Outcomes Among People Living with HIV

In 2022, the SPNS initiative “Using Evidence-Informed Interventions to Improve Health Outcomes among People Living with HIV”—known as E2i—supported the implementation and evaluation of 11 evidence-informed interventions to reduce HIV-related health disparities and improve outcomes for people with HIV, including retention in care, treatment adherence, and viral suppression. The interventions focused on improving health outcomes among transgender women with HIV and Black men who have sex with men with HIV, as well as integrating behavioral health with primary medical care for people with HIV and identifying and addressing trauma for people with HIV. To support RWHAP and other HIV service delivery organizations in adapting and implementing the interventions, the E2i initiative produced and disseminated interactive toolkits, including implementation guides, training modules, and videos.

Responding to Mpox

Since the beginning of the mpox (formerly known as monkeypox) outbreak, which was declared a public health emergency in August 2022, HRSA has worked with federal partners across the U.S. Department of Health and Human Services, including the CDC, to provide information and resources to prevent the spread of the disease, help health care providers who are treating patients with mpox, support mpox vaccine distribution, and ensure that those most impacted are the focus of HRSA's response efforts. A variety of resources are available on the RWHAP [mpox information webpage](#), including press releases, fact sheets, webinars, videos, and answers to frequently asked questions, as well as resources from the CDC and other federal partners.

The next section of this report highlights the success stories of seven RWHAP recipients who have implemented effective strategies and syndemic approaches to HIV care by addressing health disparities and SDOH and engaging the HIV community in the planning and implementation of programs. The seven recipients have focused on partnering with service providers to deliver innovative programs to priority audiences, fostering workplace diversity and equity, conducting outreach to youth, offering housing services, providing mpox vaccine distribution, developing CoPs for provider engagement and training, facilitating peer-led engagement of transgender women, and integrating oral health services and dental training. These and many other recipients of HRSA's RWHAP provide inspiration for harnessing the power of community engagement and innovation to end the HIV epidemic in the United States.



(Clockwise from top left) CrescentCare's Diane Murray, Prevention Coordinator III, and clients, Cora Lightfoot and Leana Davis; Dr. Alexandra Frankel, Harlem United Dental Director, talking to patient James Williams; training led by Dr. Lydia Barakat, Principal Investigator, Connecticut Regional Partner Site, New England AIDS Education and Training Center; the transgender flag used in San Juan Pride 2022; Jonathan Gelb and Jonathon Katz, Columbia University College of Dental Medicine third-year students; and an aerial view of rural Alaska.

SUCCESS STORIES

Fostering Community Engagement and Overcoming Barriers to HIV Care: Detroit Health Department (Part A and HAB EHE)



(L to R) Denise Fair Razo, Chief Public Health Officer; Angelique Tomsic, HIV/STI Program Director; Akilah Benton, Ending the HIV Epidemic in the U.S. Manager; Keith Hughes, Senior Public Health Educator; Christina Floyd, Deputy Director of Public Health; and Miglena Mihaylova, Physician Detailer.

As a HRSA Ryan White HIV/AIDS Program (RWHAP) Part A and HAB *Ending the HIV Epidemic in the U.S.* (EHE) initiative funding recipient, the Detroit Health Department (DHD) HIV Program works with its service provider partners (i.e., subrecipients) to serve people with HIV in the Detroit Eligible Metropolitan Area (EMA). Of the nearly 18,000 Michigan residents with HIV, about 63 percent live within the Detroit EMA. The DHD offers a variety of medical and support services—including medical case management, linkage to care, early intervention services, mental health counseling, medical transportation, and housing assistance—to ensure that people with HIV receive the care they need to reach viral suppression. In addition, the DHD works closely with 13 subrecipient providers and makes referrals to supportive services—like food or housing assistance and workforce development—to address gaps in care as they are identified, with a focus on improving overall health outcomes for people with HIV.

A key partner of the DHD is the RWHAP Part A Planning Council, whose members provide guidance, approval, and support for needs assessments and long-range plans, including those related to EHE initiatives. The Planning Council is also instrumental in disseminating and sharing information about the DHD’s RWHAP projects and initiatives. In addition to the Planning Council and service providers, partners include other programs within the DHD and the Michigan Department of Health and Human Services (MDHHS). The MDHHS provides data on HIV clusters for targeted prevention and linkage to care efforts, such as mobile outreach.

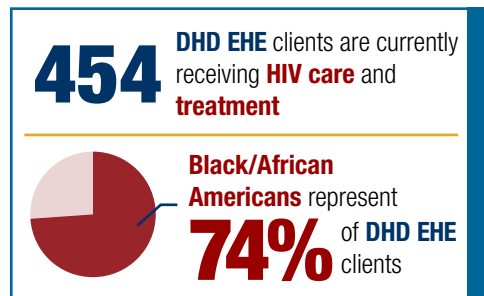
Engaging the Community in EHE Planning Efforts

The COVID-19 pandemic began soon after the DHD received its EHE funding award, and the DHD recognized that some of its EHE plans needed to be modified. With support from capacity-building funds to prepare for implementing EHE activities, the DHD initiated community

engagement efforts with health care and service providers, community organizations, and people with HIV—through virtual group discussions, online surveys paired with video, focus groups, telephone interviews, and community board posts—to obtain feedback on priority focus areas. These efforts identified education and workforce development—including opportunities to complete high school and college and professional training, such as community health worker training—as top priority areas. Other priorities that emerged during community engagement activities included the importance of addressing stigma as a barrier to care, supporting people with HIV who were out of care or not adhering to medication, and improving housing for people with HIV.

Community engagement efforts culminated in a plan to issue requests for proposals (RFPs) for EHE innovative projects; most of the awards were granted to existing Part A subrecipients who could implement their projects quickly. Angelique Tomsic, HIV/Sexually Transmitted Infections (STI) Program Director, explained, “Part of the reason we targeted [Part A service providers] with our EHE funds was because we knew we’d be able to get the money into the community the fastest. And, then part of it was that these were ways for our RWHAP-funded providers to be able to do work they always wanted to do.”

With EHE funding, the DHD and its partners have been able to focus on the priority areas identified through the community



engagement efforts and on priority populations that are affected disproportionately by HIV and currently are not engaged in care. One outcome of implementing several EHE innovative projects is that 454 clients are currently

receiving HIV care and treatment. Among them are Blacks/African Americans (who represent 74 percent of DHD EHE clients). EHE Manager Akilah Benton stated, “The great thing about the work we’re doing with EHE is that we’re able to engage different populations that we haven’t been able to in the past, through designated programming for those populations.”

Reducing Health Disparities and Health Inequities

Many of the EHE innovative projects are focused on reducing disparities among identified priority populations. This work involves a syndemic approach to address HIV-related health disparities and such social determinants of health (SDOH) as stigma, lack of housing or employment, and behavioral health challenges that clients experience. Benton explained, “You can’t focus on one area without the other. When someone does not have adequate or stable housing, the expectation to get them into care and sustain viral suppression—that is not a priority when you’re struggling with meeting these basic needs.” To address these barriers to care and improve health outcomes for people with HIV, the DHD, in partnership with its subrecipients, has implemented several EHE innovative projects, including Stigma Fighters, Stigma Index, Telehealth Navigation, Women Organizing Resources and Knowledge, and Mpowerment.

At the DHD, stigma is addressed through a variety of lenses that are related to the areas of internalized stigma; HIV criminalization; stigma from family, friends, and intimate partners; lack of health care provider education; and marginalization of populations. Stigma Fighters, a “train

the trainer” project, was created to empower people with HIV—who were referred by case managers or were existing clients—to be advocates within their communities to address HIV-related stigma as a barrier to receiving HIV care. According to Benton, the Stigma Fighters are required to complete at least five training sessions and workshops to train community members, clinicians, and other health care professionals to recognize HIV-related stigma in health care. In addition to addressing stigma, another outcome of the project is that many participants have since gained employment at the DHD. Benton stated, “It’s really amazing for us to see how some of our work is coming full circle in providing these opportunities for people in the community and addressing stigma and barriers, while also addressing workforce development.”

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Another project, the Stigma Index, has focused on data on stigma and the barriers associated with HIV care. These data have helped inform the planning of care and the development of stigma-reduction messaging around HIV and getting people into care. As a result, the DHD is supporting novel approaches to disseminating stigma-reduction messages and information about RWHAP services and engaging in care via a media campaign that includes advertisements on billboards, television, social media, dating sites, and music streaming platforms. Several of these outreach efforts have focused on priority populations, such as Black cisgender women, who often are not included in outreach, as well as young Black/African American MSM. The outcomes of these dissemination efforts are being tracked via media reports. The DHD is also focusing on other SDOH, including those associated with behavioral and mental health, as well as access to care. In addition to offering psychosocial support groups, rapid mental health services are provided to clients in a traditional onsite setting, and the Telehealth Navigation project provides



(Clockwise from left) Detroit Health Department staff: Akilah Benton, EHE Manager; Blair Carter, Senior Public Health Educator; Miglena Mihaylova, Physician Detailer; and Keith Hughes, Senior Public Health Educator, Imagining Ending the HIV Epidemic.

cellphones or tablets to young MSM, older Black MSM, and women. These mobile devices are used by clients for telehealth appointments with their health care providers to improve retention in care. Tomsic explained, “We wanted to make sure that [clients] didn’t lose communication or linkage to care.” The telehealth services allow patients to engage directly with providers in a setting where they feel comfortable.

The Women Organizing Resources and Knowledge project provides housing and wraparound support services to women with HIV who have children. Services are intended to help clients achieve a better quality of life and include transportation, childcare, trauma-informed mental health care and treatment, psychosocial support, financial literacy training, and workforce development. Ultimately, Benton emphasized, these areas of support are critical to helping people with HIV access and remain engaged in care.

Supported by RWHAP Part A funds, Mpowerment Detroit employs a multilevel community-building approach

to providing education and support while working to destigmatize HIV. According to Benton, “The Mpowerment project allows people with HIV to access training and support to further their education and careers. The project is to be housed within a community space that is run by people with HIV.” Mpowerment Detroit’s core members with HIV are empowered to be decision-makers within the community. For example, they select discussion topics for group meetings, including completing a General Educational Development degree, applying to training programs or college, or developing interview skills. They also provide opportunities for members to practice new skills, and they encourage one another and their friends to engage in the HIV care continuum. In addition, participants can also seek paid staff positions within the initiative. Tomsic reflected, “Mpowerment opens the door for so many other opportunities, which is very important to us. Everything comes back to workforce development.”

Learning From the Past and Looking Toward the Future

The DHD is proud of its successes in providing care to people with HIV through RWHAP Part A funding and in reaching priority populations through the EHE innovative projects. In 2022, 85 percent of Part A clients reached viral suppression, compared with 79 percent in 2021. In addition, among EHE clients, 95 percent are currently in care, 84 percent are virally suppressed, and 47 percent have maintained viral suppression over the past year.

85% of Part A DHD clients reached viral suppression

84% of DHD EHE clients reached viral suppression

The team will continue to work with its partners to identify program gaps and community concerns and develop approaches to meet the ongoing needs of the populations they serve. Tomsic explained, “I think it’s important that we tailor things to make sure that our consumers are getting what they want. We are making sure that as things change, we’re changing with them.” For example, over the past year, the DHD recognized that a media campaign was needed to disseminate information about the RWHAP and how to access HIV care. Therefore, the DHD funded a few different providers to rapidly launch care-focused media campaigns with anti-stigma messages and encouraging priority populations to engage in care and access pre- and post-exposure prophylaxis. Benton noted that implementation of the media campaigns was challenging but that “it is extremely beneficial working with a provider who has the infrastructure in place already.”

Currently, the DHD is developing a new system to mitigate future administrative burdens that service providers face during the RFP-writing process. The hope is that a new system will enable providers to apply to funding opportunities quickly and implement responsive services rapidly. At the same time, the DHD is challenging service providers to explore new ways to approach care using RWHAP funds while providing them with communication and support to help them succeed.

Building a Diverse Workforce to Support Health Equity: Washington State Department of Health (Part B)



(L to R) Lydia Guy Ortiz, Health Equity and HIV Community Services Manager, and Lauren Jenks, Environmental Public Health Assistant Secretary.

The Washington State Department of Health (DOH), an RWHAP Part B recipient, provides comprehensive programs and services, including HIV care, to its residents. These services are provided in collaboration with local agencies; health departments; and federal, state, and private partners. In 2022, the Washington State DOH served 6,144 clients in the RWHAP AIDS Drug Assistance Program, of whom 48 percent were White, 22 percent were Black/African American, 21 percent were Hispanic/Latino, 3 percent were American Indian/Alaska Native, and 6 percent were another race/ethnicity. Through its cornerstone values of equity, innovation, and engagement, the Washington State DOH aims to reduce health disparities among priority population communities.

Several years ago, the Washington State DOH assessed HIV health outcomes data by looking at viral suppression rates to gain a better understanding of existing disparities. The assessment showed disparities among different groups. Although the overall viral suppression rate for the state was 68 percent, the rate among White middle-class men was much higher than among people from other races and ethnicities. Rates ranged from 64 percent among Hispanics/Latinos to 61 percent among Blacks/African Americans, 58 percent among American Indians/Alaska Natives, and even lower viral suppression rates among Pacific Islanders.

To address these health disparities, Lydia Guy Ortiz, Health Equity and HIV Community Services Manager, decided that there needed to be an intentional focus on race due to deep disparities that are persistent across Washington State. She emphasized that her

specific goal is to achieve optimal health for all, meaning the same outcomes for all populations.

Addressing Gaps by Diversifying the Workforce

Washington State DOH leadership recognized that engaging with key populations to improve HIV health outcomes would require diversifying its workforce. As a result, Washington State DOH leadership advanced internal efforts, such as the HIV Disparity Reduction Demonstration Project, to achieve equitable change. This project focused on recruiting peer navigators, linkage-to-care navigators, and other staff who better reflect the populations the Washington State DOH serves. Hiring peer navigators with lived experience was also a priority. Peer navigators connect with people who are newly diagnosed with HIV or who had not previously been in care to help them get care and treatment. Guy Ortiz also emphasized the significance of hiring staff who speak the same language as the clients. She pointed out that interpretation and translation are important because speaking to someone in a language they do not understand is the same as not speaking to them.

To ensure that peer navigators provide equitable peer support, the Washington State DOH provides training in intentional peer support to teach staff (1) the specifics of peer support, (2) best practices, and (3) how to navigate the boundaries of professional and personal relationships. In addition to peer navigators, the Washington State DOH has hired other staff to work with a variety of organizations and partners across the state to engage the HIV community through events and to identify groups that may require focused efforts.

The Washington State DOH and its leadership also recognized that diversifying its staff, including hiring people who had worked in community-based organizations, would bring new employees with different skills and improved ways to deliver HIV care. Ray Harris, Stigma Reduction



Lydia Guy Ortiz, Health Equity and HIV Community Services Manager.

Consultant, emphasized the importance of the Washington State DOH leadership's equity mindset to its success, explaining, "A lack of creative ideas and an unwillingness to try new strategies has hindered the field in the past, but when you diversify your staff, that's when you get different problem-solving skills."

Reducing Health Disparities and Health Inequities



Yehoshua Ventura, Bilingual Equity Peer Navigator Supervisor.

By diversifying its workforce and establishing 10 peer navigator programs across the state, with several peer navigators who are working in a community-based environment, the Washington State DOH is better able to reach and support people with HIV and address barriers to care. Not only do peer navigators understand the impact of living with HIV,

but they typically represent similar races and ethnicities, gender identities, or sexual orientations as their clients, as well as speak the same language. Peer navigation is provided through individual, group, or community services.

Yehoshua Ventura, the Bilingual Equity Peer Navigator Supervisor, explained, "In Washington, peer navigators have often been the first ones to reach people with HIV who previously had not been in care and can talk to them about their HIV diagnosis in their language. HIV is still seen as a death sentence in our communities, so to have someone who can talk to you about your feelings but also challenge the stigma and fear [of having HIV]—it shifts the whole trajectory in terms of health care access, engagement, and support."

In addition to linking clients with HIV to care and treatment, peer navigators address SDOH—such as lack of housing and mental health and substance use issues—that affect the client's ability to engage in HIV care. Peer navigators are also instrumental in linking clients to supportive services. They aim to be role models and show clients how to engage in health care treatment and reach viral suppression while demonstrating that it is possible to maintain a job, have stability, and live a full life with HIV.

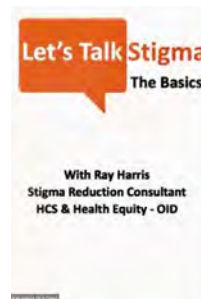
Through efforts of the Washington State DOH—including peer navigators and partners—to engage clients with HIV in RWHAP services, 85 percent of its clients reached viral suppression in 2022,

85% of DOH clients reached viral suppression compared with **75%** in 2022

which is higher than the 75 percent viral suppression rate for people with HIV in Washington State overall. Among priority populations receiving RWHAP Part B services, viral suppression was 85 percent among White populations, 87 percent among Hispanics/Latinos, 86 percent among Blacks/African Americans, and 80 percent among American Indians/Alaska Natives.

Ventura emphasized that although viral suppression is the ultimate health outcome goal, it is important to acknowledge that not every person with HIV in Washington will reach viral suppression because of barriers to care and SDOH. Peer navigators focus on both viral suppression and other quality-of-life measures.

The Washington State DOH has also been addressing HIV stigma through its "Let's Talk Stigma" training for community members and partners. The training looks at multiple facets of how stigma can be reduced within the health care system. Stigma-reduction training often is very limited, but stigma is such a multifaceted issue that



Ray Harris, Stigma Reduction Consultant, leading a "Let's Talk Stigma" training.

outside-the-box thinking is required to address its many components. Harris noted, "A lot of people use buzzwords like stigma and health equity, but they don't have meaning. I created an immersive experience for people to absorb information [on stigma] and be engaged by sharing their opinions on stigma as they're learning."

Learning From the Past and Looking Toward the Future

As a result of its commitment to hiring diverse staff, the Washington State DOH now has more peer navigators who represent the client population served, including individuals with HIV, staff who identify as LGBTQ+, bilingual individuals, veterans, and people with disabilities. Many staff members also come from community-based organizations, which is an intentional way to add on-the-ground experience and expertise in the communities being served.

Washington State DOH staff noted the support they have received from the department and its leadership in both their client work and supporting reducing health disparities. Ventura said, “This is the first time I’ve seen organizationally that peer navigators have appropriate caseloads, and they’re getting the support that they need.” Harris added, “When leadership understands at the core what equity is and where the problems lie, as the Washington DOH does, this support creates a demonstrable connection to the work and the community.”

Although the Washington State DOH now has dedicated peer navigator programs for several of the priority populations it serves, a program for transgender people has not yet been developed. HIV Community Engagement Coordinator Vanessa Grandberry, who joined the Washington State DOH recently, has connected with a transgender advisory committee and begun to build new relationships between the state and the transgender community. Grandberry noted challenges resulting from the lack of data on transgender populations in the state, which is an area that the Washington State DOH is focusing on improving. Programs for other people with HIV—such as Asian Americans/Pacific Islanders, youth, women, and people in rural communities—are also under discussion based on outcome data.

The Washington State DOH has also begun to focus efforts on connecting people aging with HIV to necessary services. Ventura explained, “Aging with HIV is something that is here right now.” Washington State DOH staff are already encountering situations and challenges that require building additional connections to aging services, including hospice and end-of-life care. Staff members have begun reaching out to aging-related institutions and community-based organizations to identify strategies to improve care for aging populations.



*Vanessa Grandberry, HIV
Community Engagement
Coordinator.*

To further address health disparities, SDOH, and health outcomes, the Washington State DOH plans to release RFPs to expand its recipients and community-based partners and help them implement specific strategies, programs, and activities, including hiring staff to match the communities they are serving. The Washington State DOH also hopes to introduce new service categories around respite care and childcare and to expand its trauma-informed care work even further. In addition, Guy Ortiz shared that she is going to try to help the program managers and educators at their agencies use data to direct their programs. Ventura emphasized, “This team is constantly bringing up the ideas of equity and social justice and using those opportunities to move that conversation and the work forward.”

Enhancing HIV Care and Support for Alaska Native Communities: Alaska Native Tribal Health Consortium (Part C)



Health care providers loading supplies for a rural Alaska field clinic.

Established in 1997, the Alaska Native Tribal Health Consortium (ANTHC) is a nonprofit organization that offers comprehensive medical services to approximately 180,000 Alaska Native and American Indian people, including individuals with HIV, through its partnership with the Alaska Tribal Health System and the community. The organization is based in Anchorage, where it co-manages the Alaska Native Medical Center. In addition to medical and support services, it provides wellness programs, disease research and prevention, rural provider training, and infrastructure support.

Because Alaska is a vast and sparsely populated state, and many communities outside Anchorage are difficult to access, ANTHC's HIV Early Intervention Services (EIS) Department works across multiple private and public health care systems and with a variety of providers to deliver outpatient primary health care and support services to people with HIV. According to Laurali Riley, Senior Program Manager for HIV EIS, "We have been a direct recipient of RWHAP Part C funds for the last 22 years, and we're one of two tribally operated RWHAP Part C clinics in the State of Alaska focusing on Alaska Native and American Indian people who are disproportionately affected by HIV." EIS data show that approximately 33 percent of new HIV diagnoses in Alaska are among the Alaska Native and American Indian population, and 32 percent of overall HIV diagnoses are among Alaska Native and American Indian females. In addition, 14 percent of HIV diagnoses are among Blacks/African Americans and 10 percent are among Hispanics.

Through its RWHAP Part C clinics, ANTHC supports 206 clients throughout the state by providing clinical and case management services to Alaska Native and American Indian people with HIV in Anchorage and case management for all people with HIV in the rest of the state. Clinical services for both tribal and nontribal patients are provided through rural field clinics in Bethel and Fairbanks every four months and in other locations as needed.

Reducing Health Disparities and Health Inequities

As part of its mission, ANTHC seeks to optimize the health and well-being of its clients with HIV by addressing barriers to care, including Alaska's unique landscape and climate and related transportation challenges; the lack of health care providers with specialized knowledge in caring for people with HIV in remote communities; limited financial resources; and HIV-related stigma. ANTHC takes a multiprong approach to addressing these challenges and reducing the health disparities and inequities that disproportionately affect Alaska Native and American Indian people.

Because Alaskan communities are primarily remote and rural, traveling great distances for care is a major barrier for people with HIV. To overcome this obstacle, ANTHC has developed telemedicine consultation services for patients and travel programs for health care providers. Riley explained, "Alaska has been a leader in telemedicine for the last 20 years—way before the COVID-19 pandemic, when telehealth services became more widespread in other regions of the country. Our organization has taken a proactive approach to rural health care by providing cutting-edge telemedicine options. To advance the best

“Alaska has been a leader in telemedicine for the last 20 years—way before the COVID-19 pandemic, when telehealth services became more widespread in other regions of the country. Our organization has taken a proactive approach to rural health care by providing cutting-edge telemedicine options.”

”

care possible, the clinical care team provides direct video telemedicine appointments with clients who are at home. Previous telemedicine services required a client to connect to an HIV provider in Anchorage from a local community health center.”



Health care providers at a rural Alaska facility.

ANTHC has also established a rural field clinic travel schedule to fly health care providers to remote communities across Alaska, ensuring that care is available to patients with HIV. “We go out to other tribal health care organizations and provide specialty care in those rural areas within their primary care settings,” Riley explained. “It’s a lot cheaper to fly out a couple of providers for a few days to see 20 patients than it would be to fly 20 [patients] in. In addition, patients don’t have to miss multiple days of work or time with their families.” Activities associated with the rural field clinic were paused during the COVID-19 pandemic but have since resumed and intensified. “We started increasing our rural travel again in the summer of 2022. I would say, on average, every two months we are going out to a location and providing direct clinical care or linkage-to-care services with our case managers and providers,” explained Riley.

“It’s a lot cheaper to fly out a couple of providers for a few days to see 20 patients than it would be to fly 20 [patients] in. In addition, patients don’t have to miss multiple days of work or time with their families.”

Because of the inflated cost of living in Alaska, patients with limited financial resources often must choose between medical care and other necessities—rent, utility bills, and food, for example. To ensure that patients with HIV keep their medical appointments, the ANTHC HIV EIS program provides transportation within the city of Anchorage, eliminating another barrier to accessing care. Patient reminders related to appointments or medications are sent via a secure Health Insurance Portability and Accountability Act-compliant text messaging system because wireless internet in many communities is not reliable, and not all clients have access to email. The ANTHC HIV EIS program has also implemented support programs, such as having snacks available for visiting patients. These programs have been very popular with patients and have helped engage them in care.

To address the lack of health care providers in rural communities who are knowledgeable in providing care for people with HIV, the ANTHC HIV EIS program—which is also an RWHAP Part F AIDS Education Training Center—has been training a new generation of practitioners who can return to their home communities and provide HIV care and treatment services to patients. The ANTHC HIV EIS program also partners with tribal health organizations to support small clinics in rural areas, providing training in HIV care and receiving guidance from local organizations on how best to implement programs and overcome various challenges that are encountered when providing care to patients.

ANTHC also works to help overcome HIV-related stigma. Riley elaborated, “It has been noted at our RWHAP Part C Consumer Advisory Board that many clients in rural settings do not reach out for primary care and behavioral health services due to a lack of trust in patient confidentiality. The clients often are related to the health care provider through family or marriage because these villages have such a small population, and they do not feel comfortable disclosing their HIV status.” The ANTHC HIV EIS program has been addressing these HIV-related stigmas through training and education sessions. HIV training programs—which are open to anyone but are primarily intended for health care providers and those who work with at-risk populations—are informed by the effects of stigma on people with HIV. “Our goal through education is to offer HIV clinical training, clinical consultation, and capacity-building assistance on prevention, diagnosis,



Public health clinic in rural Alaska.

and treatment of HIV and commonly associated co-morbidities—such as viral hepatitis, STIs, and substance use disorders—to health care professionals and organizations across the State of Alaska,” Riley explained. “We talk about ‘Undetectable = Untransmittable,’ about pre-exposure prophylaxis access. We talk about post-exposure prophylaxis access, and then we also talk about how stigmatizing behaviors can hinder people from accessing care and how we can be more proactive to support that person.” As part of the provider training, the ANTHC HIV EIS program has implemented guiding principles for trauma-informed care that were developed by the Substance Abuse and Mental Health Services Administration, including how to take a sexual history.

To counteract the widespread stigma associated with HIV, the ANTHC HIV EIS program is also cosponsoring a project to interview people with HIV about the effects of stigma on their health and well-being. The goal is to develop recommendations to improve HIV care at ANTHC. Data collection for the project was completed in December 2022, and the results are being analyzed. The organization also works directly with clients and its Consumer Advisory Board to document and better understand experiences of stigma.

Promoting Health, Wellness, and Safety Among Youth

To support the health and wellness of Alaska Native and American Indian youth and to help prevent HIV and other STIs, ANTHC’s HIV/STD Prevention Program has developed iknowmine.org. The website provides educational materials

and resources on a variety of topics that are informed by Alaska Native values and have been translated into multiple Native languages. Topics include sexual health, including STIs and STI testing, birth control, and pregnancy; healthy relationships, abuse, and violence; and substance use. [Safe in the Village](#)—a series of short films written, produced, and acted by Alaska Native and American Indian youth—discusses substance use, and domestic violence, and other issues in the context of relationships and can be ordered through the website as a DVD or streamed on YouTube.

In addition to offering [I Want the Kit](#) STI self-testing kits (through a partnership with Johns Hopkins University), the website promotes healthy lifestyle choices by allowing young Alaskans to order personal condom packs, harm-reduction kits, NARCAN® kits, and safe medication-disposal supplies. HIV self-testing kits were added during the COVID-19 pandemic to ensure that Alaska Native youth still had access to HIV testing. Each quarter, ANTHC sees increased numbers of website visits and individual condom orders. ANTHC HIV EIS nurse managers perform outreach to anyone who orders an at-home HIV test to offer voluntary risk assessment counseling. Riley described the detailed linkage-to-care process—which involves confirmatory STI and HIV testing and working with a primary care provider, linkage-to-care services, disease intervention specialists, or a case manager to ensure a same-day visit with an early intervention specialist.



Safe in the Village DVD.

Learning From the Past and Looking Toward the Future


The accomplishments of ANTHC’s HIV EIS program have been impressive. The program has resulted in better access to quality care for Alaska Native and American Indian people and high rates of viral suppression among clients with HIV. “We have about an 88 to 91 percent viral suppression rate; we’re very proud of that,” emphasized Riley. However, the ANTHC HIV EIS program plans to continue addressing major barriers to care for Alaska Native and American Indian people with HIV in Alaska.

88–91%
of ANTHC clients
reached viral suppression

To help overcome the continued challenges of health disparities and SDOH—such as high levels of poverty, lack of access to care, and behavioral health issues—and to improve health outcomes among the Alaska Native and American Indian population, ANTHC plans to hire a new staff member to curate and maintain a comprehensive up-to-date list of health care provider resources to better connect people with services and organizations at the village and community levels. “We are looking at adding to our team very soon with a project coordinator to assist the Nurse Case Managers in identifying information on services and assistance to people living out in rural communities,” shared Riley. Compiling these resources will enable ANTHC’s HIV/STD Prevention Program and EIS programs to work more closely together on linkage to care and will help clients remain engaged in care.

ANTHC’s HIV EIS program also plans to continue to invest in its current workforce. “As a trauma-informed care clinic, we support our staff by meeting them where they are. We have candid conversations during supervision sessions regarding burnout and internal and external frustrations. We take those conversations and identify quality improvement measures and processes,” noted Riley. The ANTHC HIV EIS program supports the continued education of the clinical and support teams. Training and educational opportunities surrounding HIV care and treatment are offered to team members, with the expectation of improving their services. As part of its workforce investment, the ANTHC HIV EIS team is engaged in process development and review to improve communication within the organization and enable more efficient operations—for example, improving the ease of using electronic health records and enhancing collaboration between the HIV prevention and clinical teams to provide optimal care for clients.

A Comprehensive Approach to HIV Care in New Orleans: CrescentCare (Part D)



(L to R) Chauntelle Randle, Quality Manager, and Clifford Wilson, a CrescentCare client.

Originally founded in 1983 as the NO/AIDS Task Force to respond to the devastating effects of the AIDS epidemic in the New Orleans area, CrescentCare is a Federally Qualified Health Center (FQHC) and RWHAP Part D recipient and is also funded by Parts A, C, and F. CrescentCare offers a range of services to the community, including people with HIV, in two locations in New Orleans and one in nearby Houma, Louisiana. Each year, CrescentCare serves more than 13,500 clients of all ages. Approximately 3,000 CrescentCare clients are people with HIV, of whom more than 2,800 are also RWHAP clients. Most of CrescentCare's RWHAP clients are Black/African American (63 percent), and approximately 10 percent are Hispanic/Latino. Additionally, 6 percent of CrescentCare's clients are people who are transgender, nonbinary, or genderqueer. CrescentCare's Part D program serves 847 clients with HIV, most of whom are Black/African American.

CrescentCare offers primary and specialty medical care, behavioral health services, and medical case management to women, infants, and children living with HIV through its Part D funding. The organization also offers housing assistance, syringe services, legal services, a food pantry, and other assistance to support clients with HIV, funded through other Parts of the RWHAP. Alice Riener, Chief Executive Officer, emphasized the importance of the comprehensive services provided by CrescentCare: "Since the organization's founding, our approach has always been very broad and included an understanding that it requires more than just a doctor for people to be healthy."

Reducing Health Disparities and Health Inequities

As part of its values and mission to provide comprehensive and inclusive health care, CrescentCare addresses health disparities and barriers to care, such as systemic racism, lack of housing, stigma, and other SDOH. These factors can interact with and exacerbate each other; affect a

client's ability to access HIV care and treatment; and influence HIV-related health outcomes, such as viral suppression.

To identify and address potential barriers to care, new CrescentCare clients are assigned a case manager who completes a comprehensive biopsychosocial assessment and works with them on goals for their care and health. After the assessment, clients are referred to the appropriate CrescentCare programs or to programs run by community partners. For example, a client who is unstably housed is referred to housing services. For help with issues related to their HIV status—such as discrimination, securing public benefits, or creating a will—clients are referred to CrescentCare's legal services. Peer support also is offered to people with HIV to connect with others who have HIV to share their experiences and offer emotional support.



(L to R) Diane Murray, Prevention Coordinator III, and clients, Cora Lightfoot and Leana Davis.

Newly diagnosed people with HIV are referred to the CrescentCare Start Initiative (CCSI), a rapid-start program to initiate antiretroviral therapy (ART) within 72 hours of diagnosis and provide ART for 30 days. Rapid ReSTART, a program for clients who have not received HIV care for nine months, is also available. Katherine Connor, Director of HIV



(L to R) La'Nya Odoms, Physician, and Sasha Menstate, client.

Services, explained how CCSI has helped address systemic racism and other biases often embedded in HIV care:

“The Rapid Start program really helps with bias and equity because it is the same protocol [for everyone], and it is not dependent on somebody’s housing status or funding.” To ensure retention in care and care adherence, CrescentCare

linkage coordinators track the patients’ follow-up visits, viral loads, and viral suppression

85% of CrescentCare clients **reached viral suppression**
 compared with **67%** statewide in 2022

status and engage or reengage with them as necessary. In 2022, CrescentCare patients with HIV had a viral suppression rate of 85 percent, compared with a statewide suppression rate of 67 percent.

CrescentCare also addresses structural barriers to HIV care to ensure that it provides services that meet people where they are. Pamela Holm, Director of Primary Care, explained, “We do a lot of venue-based testing in the community at untraditional hours. We’re out at events. We have a mobile medical unit that goes out to reduce any sort of stigma from people coming in. We have bilingual staff to help with our Spanish-speaking population.”

Improving Health Outcomes With Access to Housing

In New Orleans, [housing and homelessness](#) are substantial challenges for many individuals, including people with HIV, and these problems are exacerbated by natural disasters like hurricanes and tornados. The housing crisis in New Orleans

is also made worse by [poor housing conditions](#)—including mold, pests, and plumbing and electrical issues—that are present in almost 80 percent of New Orleans rental units.

Housing status is one of the strongest predictors of health outcomes for people with HIV. “The research certainly bears this out when you’re talking about social determinants of health and structural interventions that impact people’s health,” Riener explained. Individuals who are unstably housed are less likely to receive and adhere to ART; have lower CD4 counts and higher viral loads; and are more likely to have delayed entry into HIV care, be hospitalized, or require emergency care. “Here in New Orleans,” added Riener, “it’s very hard for our doctors or nurses to be working on people’s health when [patients] don’t have a stable place to live.”

To help clients secure stable housing, CrescentCare offers Short-Term Rent, Mortgage, and Utility Assistance; Permanent Housing Placement; and Tenant-Based Rental Assistance (a program similar to housing vouchers) through the U.S. Department of Housing and Urban Development’s Housing Opportunities for Persons With AIDS grants. CrescentCare also supplies landlords with funds to help clients pay the first month’s rent, housing deposits, or outstanding utility bills. CrescentCare’s Director of Client Services, Tara Managan, pointed out that CrescentCare’s housing efforts are seamlessly tied to other RWHAP services: “Anybody who is eligible for Part C or Part D funding gets assessed and evaluated and referred to any of our housing opportunities.”

In 2022, CrescentCare housing programs helped 447 clients maintain stable housing through the end of the year. Managan also shared that in their experience, people can focus on many other aspects of their life once housing is lifted as a barrier.

Responding to the Mpox Outbreak

Because CrescentCare already had an infrastructure and processes in place to handle COVID-19 testing and distribution of vaccines, the organization was able to expand services to respond to the outbreak of mpox (formerly called monkeypox) in 2022 by requesting and distributing vaccines allocated by HRSA. Connor noted the unique challenges associated with mpox. For example,

mpox—which is spread by prolonged physical contact with someone who is infected or an exchange of bodily fluids—had predominantly been detected in gay men and communities of color. Recognizing the vulnerable populations, the subsequent stigma associated with mpox, and the limited availability of the mpox vaccine, CrescentCare worked diligently to identify high-risk patients and focus resources where they would make the biggest difference.

As more mpox vaccines became available, CrescentCare held regular vaccine events at each of its locations. Vaccine availability and events were promoted through CrescentCare’s website, social media, and word of mouth, as well as by directly reaching out to clients. “We did want to open it up to the community and not just our patients,” explained Connor. “Once we got more supply, we were able to do more walk-in events, which really helped to eliminate barriers.” Mpox vaccine clinics were held on weekends and early in the evening to ensure that services were accessible to the community. In total, CrescentCare vaccinated 2,426 clients.

In response to the stigmatizing and confusing information circulating about the virus, CrescentCare developed

a comprehensive guide to mpox and its risk factors, which was distributed to the community on social media alongside information about the availability of the mpox vaccine.

In addition to holding its regular vaccine clinic events, CrescentCare prepared for Southern Decadence—an LGBTQ+ festival and parade that takes place annually in New Orleans over Labor Day weekend. The event is a celebration of diversity, inclusiveness, and LGBTQ+ culture that attracts thousands of people from around the world. CrescentCare, aware of the stigma surrounding mpox, held private vaccine clinics and reached out to patients via their primary care providers. As Connor noted, “For some people, getting it at their doctor’s visit was a more discreet way of doing it than some of the events at bars.” Following the Southern Decadence festival, CrescentCare also offered a vaccine clinic for people who were concerned about their potential exposure to mpox during the event. According to data from the Louisiana Department of Health, no sustained increase in mpox cases was observed following the festival; Louisiana has averaged less than one mpox case per day since October 2022.

Learning From the Past and Looking Toward the Future

CrescentCare is proud of the organization’s resiliency and accomplishments during the many challenges of the previous years, including COVID-19, Hurricane Ida, and mpox. Riener noted, “There are certainly several other organizations around the country that are HIV/AIDS service organizations that became Federally Qualified Health Centers. There are not very many of them operating in the Deep South in such resource-poor environments and in places that are being so directly negatively impacted by climate change.”

While the COVID-19 pandemic created obstacles to care, it also provided CrescentCare with opportunities to expand services. The medical and behavioral telehealth services that were quickly established at the beginning of the pandemic were so successful that they have continued even after in-person care was reinitiated. Telehealth services enable many clients to access care without having to miss much time from work or leave their homes. According to Managan, “Without telehealth services, patients had to choose: Do I go to work and make money to support myself and have food and housing and everything else, or miss work for an appointment?”

In summer 2020, CrescentCare’s leadership embarked on a series of conversations about how the organization could embed racial equity as a value into every aspect of the way it delivers services. With staff members serving as a steering committee, CrescentCare has been working with Beloved Community, a Black-led nonprofit, to develop a work plan to enhance racial equity within the organization. Feedback is being obtained from both staff and clients, and CrescentCare has been implementing components of the work plan, such as conducting trauma-informed training for supervisors.

Promoting Engagement Through Communities of Practice: New England AIDS Education and Training Center (Part F: AIDS Education and Training Center Program)



NEATEC Community Health Worker video image.

As a HRSA RWHAP Part F and EHE recipient, the New England AIDS Education and Training Center (NEATEC) provides education, consultation, technical assistance, and



Vanessa Carson-Sasso, Co-Investigator and Senior Project Director, NEATEC Regional Office.

resource materials to health care professionals throughout Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. Vanessa Carson-Sasso, Co-Investigator and Senior Project Director, NEATEC Regional Office, explained that the AIDS Education and Training Centers Program is the training arm of RWHAP. The program trains all members of the

interprofessional health care team, from case managers and peers to prescribers. NEATEC's diverse region is composed of both urban and rural communities, with priority populations that include Black/African American and Hispanic/Latino communities; the LGBTQ+ community; and people with substance use disorders.

NEATEC works with its Regional Partners to understand the needs of providers in their communities, and training efforts are tailored accordingly. To inform its training efforts, NEATEC also engages key informants and stakeholders—including FQHCs, state and local health departments, community organizations, academic institutions, and people with lived experience.

Building Communities of Practice and Facilitating Discussions

NEATEC convenes several CoPs to facilitate collaborations, bridge communication gaps, break down silos, and enable networking and sharing of best practices and resources among health care providers in EHE-funded community

health center sites in Suffolk County, Massachusetts. The CoPs ultimately are intended to help health care providers—including community health workers (CHWs), pre-exposure prophylaxis (PrEP) navigators, and case managers—deliver more effective care to their priority populations with HIV or those vulnerable to HIV acquisition, with a goal of ending the HIV epidemic in the United States. NEATEC support also includes facilitating training and technical assistance on a variety of topics. Carson-Sasso stated, “With the CoPs, our participants have a space to share challenges, successes, and strategies so that they can feel supported—through camaraderie and being together. I think that’s really very powerful.”

The Massachusetts Regional Partner site, located in Suffolk County, supports a PrEP navigator CoP; a CHW CoP; and an EHE HIV Community of Practice and Learning, which meets quarterly to discuss challenges and successes within its programs. Hathy Simpson, Program Manager in the NEATEC Regional Office, underscored the value of engaging diverse perspectives in this space: “We’re focusing on the CHWs, the peer navigators, the case managers. It’s not just the people in the white coats; it’s not just prescribers. It’s focusing on the whole health care team.” Amanda Hart, Program Director for the Massachusetts Regional Partner site, noted that both the CHW and PrEP navigator CoPs serve to encourage communication among peers and providers to promote a better understanding of members’ different roles within the team.



Hathy Simpson, Program Manager, NEATEC Regional Office.

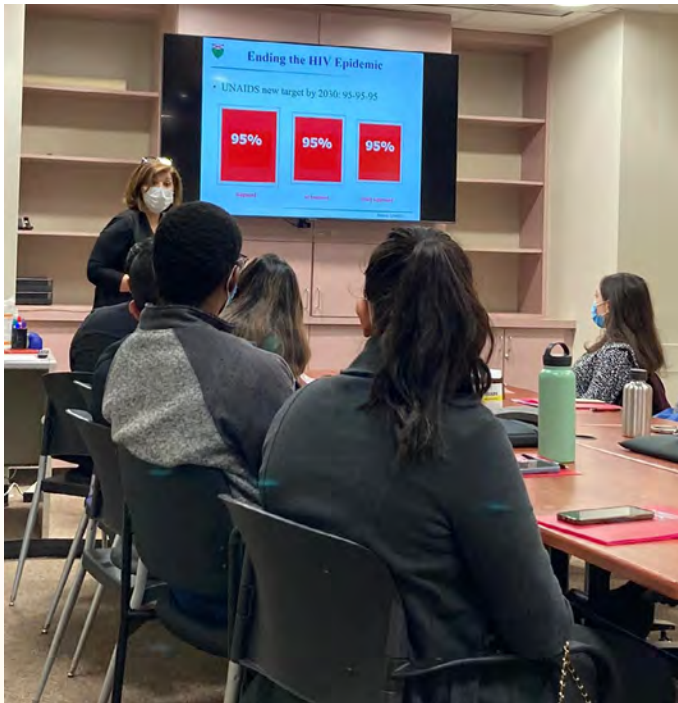


Amanda Hart, Program Director for the Massachusetts Regional Partner site.

Although the Connecticut Regional Partner site does not receive EHE funding, it provides a CoP—called the CHW Extension for Community Healthcare Outcomes (Project ECHO)—and is establishing a new CoP for HIV providers this year. The Connecticut Regional Partner site oversees efforts to train internal medicine resident

physicians to be HIV providers through annual HIV ambulatory workshops, with a focus on improving communication skills and delivery of care to people with HIV.

Training topics have included testing for HIV, prescribing PrEP, and treating individuals with newly diagnosed HIV. Lydia Barakat, Principal Investigator at the Connecticut Regional Partner site, explained that her team is partnering with the Connecticut Department of Public Health (DPH) and has hosted statewide summits (with listening sessions, community panels, and expert lectures), which included



Training led by Dr. Lydia Barakat, Principal Investigator, Connecticut Regional Partner site.

providers’ sharing best practices in such areas as patient care, policy changes, and available resources. Listening sessions with CHWs and other health care providers have also been held to discuss challenges they encounter. Barakat underscored the benefits of these interactions: “Our activities are informing the state about opportunities they might want to explore and resources that they will use. They are learning about best practices and then disseminating this work. I think this is what, at the end of the day, will impact patient care.” In addition to training physicians, NEAETC provides training to nurse practitioners about HIV prevention, diagnosis, and treatment.

Reducing Health Disparities and Health Inequities

Together with its partners and health care providers, NEAETC has been integrating syndemic approaches into the delivery of patient care to help address interlinked health conditions, as well as the SDOH and structural barriers that allow HIV-related disparities to persist, including discrimination and stigma. According to Carson-Sasso, the syndemic approach has always been central to NEAETC’s work: “You can’t talk about HIV without talking about the populations that are most disproportionately impacted and the other factors that they’re facing—both structurally and in terms of related comorbidities. You can’t silo them.”

Racial inequity and health disparities are core priorities that are addressed in CHW CoP trainings. Hart explained that this plays a part in whom her team engages to conduct group trainings, the tools that the CHWs share, and the strategies they use for outreach. To ensure that the health needs of diverse populations are being discussed, the CHW CoP intentionally has included representatives from Spanish-speaking, Portuguese-speaking, Haitian Creole-speaking, and LGBTQ+ communities. The CHW CoP also includes representation from peers with lived experience and from different racial backgrounds. Hart emphasized, “These are really the boots-on-the-ground people. Community health workers are out in the community; they know the needs of their populations really well and really deeply. And so, I think that our group members have a lot of perspectives to bring about the needs of different communities, particularly communities dealing with stigma. The work that the CHWs are doing to keep the patients



Dr. Lydia Barakat.

connected in care is really critical.”

The Massachusetts Regional Partner site has also been focusing on the intersection of HIV, hepatitis C, and substance use. This topic was explored in a two-year webinar series that addressed community outreach, harm-reduction

programs, and how to engage the population that has HIV and substance use disorder. With a grant from the Massachusetts DPH, the Massachusetts Regional Partner site is working with health care providers to integrate hepatitis C screening and treatment into primary care and is providing training on HIV and hepatitis C coinfection. The training is designed to recognize patient needs as they relate to coinfection, provide care for the whole patient, and ultimately serve patients as effectively as possible.

The Connecticut Regional Partner site has also been focusing on the triple threat of HIV, hepatitis C, and substance use disorders through provider training. In addition, health inequity is being addressed in multiple

contexts within the site’s strategic plan and through training and summits held in collaboration with the Connecticut DPH. For example, the Connecticut Regional Partner site and the DPH’s Infectious Disease section conducted physician training on health equity, including ways to improve communication with their patients with HIV. When discussing health equity, Barakat stated, “People relate better when they have somebody who looks like them, so we try to make sure our speakers come from diverse backgrounds, depending on the topic and their area of expertise. We are very mindful of being culturally sensitive when delivering information.” Another consideration is to engage familiar, trusted experts as speakers. Carson-Sasso explained, “If you’re going into a community health center to do training, the message is going to be received

“ People relate better when they have somebody who looks like them, so we try to make sure our speakers come from diverse backgrounds, depending on the topic and their area of expertise. ”

Learning From the Past and Looking Toward the Future

NEAETC considers its CoPs to be one of its greatest successes in breaking down silos, strengthening partnerships, and sharing information among health care providers. Hart also underscored the importance of engaging community members at all times to ensure that their voices are heard, their perspectives are incorporated, and their efforts are not being duplicated. Engaging CoP members and allowing them to shape their group's goals and priorities was also critical. Hart stated, "We are making sure that the people who are in the group are driving the group. We've tried to step back as much as possible and let the groups lead themselves. We're there for support and facilitation, but we're not pushing in a direction." In this effort, the team has remained flexible and pivoted to address community needs as they are identified. Hart explained that challenges during the COVID-19 pandemic have included declines in HIV testing rates and in workforce support. She noted that in a time when providers are feeling overtaxed and overburdened, NEAETC is trying to be thoughtful about asking providers to integrate more testing into primary care but making it clear it isn't as much of a huge lift as it might seem to be.

Barakat noted that the COVID-19 pandemic brought to light many existing health inequities—in the areas of mental health and SDOH, for example—and her team is working to address these ongoing challenges by leveraging NEAETC's existing infrastructure and working closely with providers. Barakat added that her team has continued to respond to community needs as they arise across different areas.

Moving forward, the Massachusetts Regional Partner site plans to keep working with each CoP to identify its ongoing needs and will continue to expand where possible, particularly as new EHE sites are funded and as relationships with these sites grow and strengthen. The Massachusetts Regional Partner site has also begun working closely with the Harvard University Center for AIDS Research on training for the EHE CoP. The Connecticut Regional Partner site plans to build a CoP for HIV providers to enhance the collaboration with the Connecticut DPH's annual summit, with a focus on EHE and syndemics; expand Project ECHO for CHWs; and initiate seminars to address topics related to HIV and aging and health disparities.

Overall, Carson-Sasso highlighted the impacts of these efforts and expressed her excitement at seeing the evolving activities of NEAETC, its Regional Partners, and the community health centers to serve people with HIV. She reflected, "We learn, and we share. I think that's a success of our region. We don't gatekeep; we're all in this together."

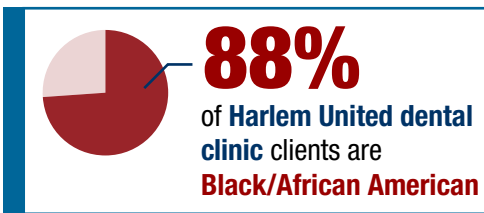
Providing Dental Care to People With HIV: Columbia University College of Dental Medicine (Part F: Dental Programs)



(L to R) Dr. Alexandra Frankel, Harlem United Dental Director, talking to patient James Williams.

The Columbia University College of Dental Medicine (CDM) has been a longtime recipient of HRSA’s RWHAP Part F Community-Based Dental Partnership Program funding. Through its partnership with the Harlem United Community AIDS Center, Inc. (Harlem United), a RWHAP recipient and FQHC, a state-of-the-art dental facility opened in 2003 to continue providing oral health care services to people with HIV and other priority populations in Harlem and nearby locations in New York City, while also supporting essential learning opportunities for dental students. In 2022, 126 patients with

HIV were treated in the Harlem United dental clinic. Of these individuals, 88 percent were Black/African



American and 18 percent were Hispanic/Latino (several identified as both Black/African American and Hispanic/Latino).

In addition to dental services, Harlem United provides a wide range of health care services to people with HIV in a traditional setting, including primary and specialty care, such as behavioral health services, cardiology, and women’s health services. The organization also offers support services such as housing; an adult day health care program, which provides nursing care, case management, and hot meals; vocational education, such as computer and job skills; and more.

Engaging People With HIV in Dental Care and Linking Them to Medical Care

Clients who require dental care receive comprehensive services at Harlem United’s dental clinic and through its mobile unit, which serves Manhattan and surrounding boroughs. Dr. Alexandra Frankel, Harlem United’s Dental Director, explains, “We provide all dental services—



Harlem United mobile dental unit.

emergency dental care, exams, cleanings, fillings, extractions, root canals, bridges, crowns, cosmetic dentistry, and removable dentures. We make it as easy as possible for patients to receive care. If getting to dental appointments at the clinic is a barrier for clients, we have the mobile unit, and we bring the dental chair to them. It’s pretty amazing what you can fit on a mobile unit.”

During appointments with new patients, Harlem United’s dental staff take thorough medical histories, dental histories, and social histories. Since they have been trained in trauma-informed care, dental staff ask open-ended questions and, in most circumstances, feel comfortable asking difficult questions, such as, “Do you have stable housing?” which is incorporated into the patient’s history and intake. Since Harlem United provides primary, specialty, and mental health care, in addition to oral health services, staff will immediately schedule an appointment for patients with HIV who have not been engaged in medical care. Frankel explained, “We have coordinators or case managers and patient navigators at The Nest, Harlem United’s brick-and-mortar location, who help patients with HIV or other comorbidities with their appointments and other medical care coordination. The case managers are really vital in connecting patients to all the services that they need, including housing. We also have a department that will help patients with insurance.”



(L to R) Columbia University College of Dental Medicine third-year students Jonathan Chen, Niki Elahi, and Joseph Vigoda.

Providing Service-Learning Experiences to Dental Students

As part of their clinical training, third-year dental students receive comprehensive education through a service-learning curriculum developed by CDM in partnership with Harlem United. According to Carol Kunzel, Director of the CDM RWHAP Part F grant, “Service learning entails the full educational experience, along with the experiential experience and the opportunity for reflection.” Students receive didactic education, including an intensive orientation training with lectures and a case study assignment, to prepare them for the clinical experience. Students also receive a one-week clinical rotation—under the supervision of CDM-appointed faculty—during which they are exposed to diverse client populations, including people with HIV who need oral health services.

Emily Byington, CDM RWHAP Part F Program Manager, remarked, “The students are so excited to be out in the world of FQHCs and meet patients from different backgrounds. They really do get this holistic perspective of patient-centered care during their rotations at Harlem United, learning about social determinants of health, meeting patients where they are, talking to them about any barriers to care, what their past experiences have been like, and what brought them into the clinic.”

One goal of the dental program is to develop a more informed and empathetic workforce to work with patients with HIV. Byington explained, “We have some pre-test and post-test survey data to support that—when we look at confidence and comfort—the students do say they’re more comfortable working with this patient population. We hope that in the long run, better-prepared providers lead to better health outcomes.” Ivette Estrada, CDM RWHAP Part F Project Coordinator, added, “We ask the students to reflect and write about their experiences at both the clinical and the outreach sites. We know from the reflections that they appreciate observing care delivery systems that differ from what they experience at CDM. [Students] often talk about social determinants of health, and how they now understand how those factors play a role in why a person with a certain background may not be receiving dental care because of the barriers that exist for them. The students also appreciate being able to link patients to medical and dental care.”

“ We have some pre-test and post-test survey data to support that—when we look at confidence and comfort—the students do say they’re more comfortable working with this patient population. We hope that in the long run, better-prepared providers lead to better health outcomes. ”



(L to R) Jonathan Chen, Columbia University dental student, and Dr. Alexandra Frankel, Harlem United Dental Director, with a patient during an appointment.

Reducing Health Disparities and Health Inequities

Since its inception, Harlem United's mission has focused on eliminating racism, stigma, and discrimination in care. The mission is reinforced by staff and is communicated to the dental students. Frankel explained, "Every patient is deserving of the same care. What I tell the students when they come onsite is that we practice equity care here." Kunzel added, "During our students' week of experience at Harlem United and other community sites, they are exposed to programs like housing and day care that consider social determinants of health. This environment

enables us to directly address any issues of stigma that our patients and students may experience."

In addition to providing equitable primary and oral health care services, Harlem United addresses other barriers to care and SDOH among its clients. The organization has long recognized that lack of housing plays a vital role in a client's ability to focus on HIV care and treatment. Tamisha McPherson, Harlem United's Executive Director for Healthcare Business, explained, "A lot of our clients are in shelters or single-room occupancies. Every year, about 75 percent of our patients are experiencing homelessness, and sometimes it's more like 80 percent." Harlem United offers a variety of housing options to meet the needs of chronically homeless populations. In 2022, Harlem United housed 723 people in emergency housing, transitional housing, and long-term supportive housing. Once housing needs are met, case managers and other support staff provide residents with a range of critical services.

Harlem United's equity approach also includes ensuring that patients see themselves reflected in their care providers. Since many patients are from West Africa and speak French, Harlem United employs French-speaking peer navigators and other staff from the same region. According to Frankel, "This can make patients more comfortable opening up. And, it helps the dental staff to communicate with patients better, to help patients understand why we're doing what we're doing."

Learning From the Past and Looking Toward the Future

In response to recommendations from CDM's leadership, the CDM dental program recently has evolved from training only dental residents to training all third-year dental students. The revamped program, now in its second year, has grown from training 25–30 dental students to almost 100 students. CDM also responded to student feedback by offering enhanced clinical experiences and greater opportunities for the students to engage with patients with HIV. Frankel explained, "I think we're changing how dental students approach care. Based on the feedback and what I've seen, by the end of the rotation, they are very engaged and feel comfortable approaching and treating patients with HIV."

The hope is that by developing a more engaged and informed workforce, future dentists will be able to provide care for their patients, help improve health outcomes, and help reduce HIV-related stigma and health disparities.

Building a Caring and Supportive Community for Transgender Women: Centro Ararat (Part F: Special Projects of National Significance)



(L to R) T.W.E.E.T. graduates Maria Leonor Aviles Rivera and Anacaona Reyes Fernandez.

As an RWHAP Part F: Special Projects of National Significance (SPNS) recipient, Centro Ararat's Translucent Clinic in San Juan, Puerto Rico, was one of three sites to implement Transgender Women Engagement and Entry to Care (T.W.E.E.T.) as part of the four-year Using Evidence-Informed Interventions to Improve Health Outcomes Among People Living with HIV (E2i) initiative. T.W.E.E.T. is an important intervention because many transgender women are disproportionately affected by HIV and frequently face multiple barriers to receiving HIV care and treatment and other essential services due to pervasive discrimination and stigma. Since Centro Ararat provides primary care services, including HIV health services, and has a long-standing commitment to equity without discrimination, T.W.E.E.T. was a natural project for the organization. Larry Zayas Rivera, Translucent Project Manager, explained, "The main focus of the project was to engage and retain transgender women who were HIV positive in care, but also to reach out through peer leaders to other transgender women who might have had a diagnosis of HIV and didn't know about it." Identifying and developing peer leaders was an essential component of T.W.E.E.T. because the peer leaders helped recruit new participants, lead education and discussion groups, provide supportive services, and inspire other participants to adopt healthy behaviors.

The main focus of the project was to engage and retain transgender women who were HIV positive in care, but also to reach out through peer leaders to other transgender women who might have had a diagnosis of HIV and didn't know about it.

Adapting T.W.E.E.T. and Creating a Community for Transgender Women

The vast cultural differences between the Centro Ararat T.W.E.E.T. site in Puerto Rico and other T.W.E.E.T. sites in the United States initially posed challenges to implementing T.W.E.E.T. Zayas Rivera explained that being in Puerto Rico "is very different than being in the mainland U.S.A. We have a different culture, so cultural humility was very significant in the development of the [program] implementation. Also, HIV-related [and transgender] stigma is significant in Puerto Rico and can be dangerous. So, we couldn't just follow the T.W.E.E.T. guidelines as they were—we adapted them to the culture of Puerto Rico."

As a first step to implementing T.W.E.E.T., Centro Ararat had to develop a sense of community for transgender women and create a safe, inclusive space that would allow them to talk about their HIV diagnosis without the fear of stigma or harm. Zayas Rivera noted, "San Juan had gay and lesbian bars and clubs, but transgender women did not have safe community spaces to themselves." To create a conducive environment for the T.W.E.E.T. intervention, a small group of transgender women known to Centro Ararat was recruited to participate in focus groups to discuss the barriers that kept the women from seeking HIV-related care and treatment. The women shared that HIV stigma was one of the barriers to getting care—many transgender women who knew their status could not disclose it without risking violence or exclusion. Zayas Rivera said, "They didn't want to seek out those services because if somebody saw them coming out of [an HIV] clinic, they would be labeled as HIV positive, and that's very dangerous here." Additionally, at the time, many institutions classified transgender women as MSM, which contributed to the stigma the women felt in the community.

Another barrier to care was the lack of local health care professionals who were trained in transgender health. Providers did not know how to address the needs of

transgender women beyond HIV. This caused some transgender women to stop going to the doctor.

As a provider of primary health care for the HIV-positive community, Centro Ararat recognized the need for specialty care as an opportunity to provide support to this priority population. To help address HIV-related stigma, Centro Ararat decided to separate the programs for transgender women from the ones offered to MSM by leasing a different building, which they named Translucent. Using this name rather than T.W.E.E.T. also allowed Centro Ararat to preserve participants' privacy, ensuring that no one knew they might have HIV, which helped keep them safe and build their trust.

Designing and Implementing a Curriculum for the Local Community

With feedback from the focus group discussions, Centro Ararat designed a T.W.E.E.T. curriculum for the participants, who could then teach those lessons to their communities as peer leaders. The first set of sessions began with 10 participants, with the goal of developing these 10 women into peer leaders. Although the curriculum was designed to engage transgender women in care, the first peers also needed to learn how to lead meetings. Many peers and participants did not have experience in a structured learning environment. To address this need, the curriculum was adjusted, and training sessions on how to speak to and facilitate groups were created for the peer leaders.

Thirty people attended the next series of sessions. The Translucent workshop sessions were held for transgender women with HIV—who were considered T.W.E.E.T. participants—and for transgender women who did not know their status or were HIV negative and were not technically T.W.E.E.T. participants. The first topics covered self-esteem, gender transition, and how to address their own needs. Subsequent sessions focused on wellness—mental health, sexual health, HIV care, and other topics. Although peer leaders guided the discussions, shared their experiences, and offered advice, all participants were encouraged to talk about their experiences. The program was successful because word spread among transgender women that Centro Ararat and Translucent would respect them, their gender identities and pronouns, and their life experiences.



Peer Leader Shakira Gonzalez Hernandez.

Reducing Health Disparities and Health Inequities

As part of its mission, Centro Ararat recognizes the importance of access to quality health care, cultural sensitivity, and empathy in a space that does not discriminate against people, regardless of their health status and gender identity. In addition to locating the Translucent clinic in a separate building to reduce stigma, Centro Ararat provided status-neutral services, which use a whole-person framework to provide individualized solutions. Translucent participants who were not previously diagnosed with HIV were invited to make an appointment at Centro Ararat to get tested for HIV and other STIs. Those individuals who tested positive for HIV were included in T.W.E.E.T., but those who tested negative received the same health services and benefits as T.W.E.E.T. participants, as well as health education to prevent getting HIV.

Primary care services, including HIV treatment and education, were and continue to be provided to transgender women who are diagnosed with HIV to help them achieve desirable health outcomes, including viral suppression. Centro Ararat has provided various services, such as behavioral health services, in ways that respect the privacy and identity of transgender women. Zayas Rivera noted, "Not only did we give them a sense of community, but we started to actually treat them with the respect they deserve."

In addition to referring transgender women to specialty care and support services, Centro Ararat case managers work with transgender women to obtain health insurance and change legal documents, such as medical records, to reflect the correct name and gender marker, which has helped reduce discrimination in employment, housing, and other areas. This is support that they did not have before they came to Translucent.

Other SDOH, such as employment, were also addressed by the program. Translucent recognized that many of the transgender women faced job challenges because they did not have a formal education. To help them gain other employment opportunities, Translucent started holding a graduation ceremony for participants who completed the peer leadership program. Graduates receive a diploma and coaching on how to include their successes on their resumes. Centro Ararat also hired several Translucent participants as retention specialists, who serve as role models and use their personal experiences to help other transgender women access and remain in care. These employees are also given opportunities to further their education. “One of our transgender retention specialists was homeless at one point, had problems with substance use, had been incarcerated, and was HIV positive,” Zayas Rivera shared. “And yet she is graduating this year from college as a social worker. She is the most knowledgeable person, peer, and social worker that you can ever imagine, and because of her life experiences, she is able to meet many participants where they are and connect with them.”

Centro Ararat also hired transgender staff in other roles, which helped participants become even more comfortable with clinical services. “One of our former retention specialists is our clinical case manager now,” said Zayas Rivera. “I can tell you that she never would have had that opportunity had she not been a participant in T.W.E.E.T., because there, we identified her social skills and how caring she was about the health care issues of other peers, and that made her the perfect clinical case manager.”

Empowering Transgender Women and Advocating for Change

The Translucent program continues to grow through recruitment by peer leaders, word of mouth, and such events as beauty pageants. Many transgender performers wanted to give back to their communities by talking about the importance of barrier protection, HIV testing, and the Translucent program during their shows.

Centro Ararat had a presence at these shows, offering free kits with condoms and home HIV tests, as well as a barcode link to Centro Ararat’s website to request an appointment for testing or care.

Zayas Rivera further explained, “In just one night, we had 600 requests for condoms and 60 requests for HIV home tests.” Sachelle Pagan Nunez, Retention Specialist, former T.W.E.E.T./Translucent Peer Leader, and a Miss California Universe Latina 2022 title holder, added, “I got involved in these beauty pageants to empower the trans community and to create a community so that transgender women who are scared to go to a pageant will be cared for.”

To raise awareness of transgender health issues, such as the need for better medical care and specialized health care provider training, Translucent engaged with and educated the public during San Juan Pride 2022. Pagan Nunez explained, “My unique idea was to make



(L to R) Centro Ararat staff Sachelle Pagan Nunez and Larry Zayas Rivera at an outreach event.



Transgender flag used in San Juan Pride 2022.

a big transgender flag for the Caribbean, to involve the community, and to teach others how to engage us.” The flag required 60 people to carry it, and the effort garnered significant media coverage. Zayas Rivera said, “Our mission was accomplished, because a lot of medical schools now want to get involved with us, they want to know how to change their curriculums to include transgender health, and they want to better understand how to provide quality, respectful services to a person of transgender experience.”

Learning From the Past and Looking Toward the Future

As T.W.E.E.T. and Translucent were being implemented, staff and peer leaders learned more about the participants’ experiences and realized that flexibility was needed to make necessary curriculum changes, such as adding gender identity and other components to ensure that the curriculum addressed the participants’ needs. When it was not possible to hold in-person workshop sessions during the height of the COVID-19 pandemic, the program started conducting them virtually and adjusted the curriculum accordingly. Zayas Rivera explained, “It’s very different when you’re helping somebody face to face, and now you have a virtual platform. We had to train peer leaders on how to address themselves and others on Zoom.” The program also had to be flexible enough to continue during the natural disasters that have affected Puerto Rico in recent years. Workshops now are offered over Zoom, allowing the center to extend its reach throughout Puerto Rico and even to nearby islands.

When T.W.E.E.T. began at Centro Ararat, it comprised just 10 women, and some of these early participants had HIV without knowing it. These women are now virally suppressed and have mainstream jobs, and Translucent has continued to expand, demonstrating the success of the program and the strength of the community that was created. Today, 98 percent of Translucent participants who have been diagnosed with HIV are virally suppressed due to the care and treatment they receive at Centro Ararat.

98% of Translucent participants with HIV are **virally suppressed**

As a result of the success of the T.W.E.E.T. program, the sustainability of the intervention, and the community Centro Ararat has built to support its efforts, Translucent continues to move forward. Now in its fifth year, it has more than 600 participants. Translucent has been expanding the services it provides to transgender men and nonbinary and gender-nonconforming participants. These groups are the fastest-growing populations at Translucent, and the curriculum has been modified to reflect the differences in experiences and language. The clinic now is a meeting place with a strong sense of community, and Translucent participants feel secure and accepted and know they are no longer alone.

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Page 8: Success Stories Divider, clockwise from top left: CrescentCare, Claire Bangser; Harlem United Community AIDS Center, Inc.; New England AIDS Education and Training Center; Centro Ararat; Columbia University College of Dental Medicine; and Alaska Native Tribal Health Consortium

Pages 9, 10: Detroit Health Department

Pages 12, 13, 14: Washington State Department of Health

Pages 15, 16, 17: Alaska Native Tribal Health Consortium

Pages 19, 20: CrescentCare, Claire Bangser

Pages 22, 23, 24: New England AIDS Education and Training Center

Pages 26, 27, 28: Columbia University College of Dental Medicine and Harlem United Community AIDS Center, Inc.

Pages 29, 30, 31, 32: Centro Ararat



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