Speaker 1 (00:00):

Our agenda for the session today includes a brief overview of status neutral approaches, including benefits as well as challenges for implementation. And then we'll have our panelists from Oregon and San Antonio provide a brief update and overview of their approach in their jurisdiction. And then we'll have a facilitated discussion. I'll also note we have received many questions in advance, and certainly there are many questions on how we fund activities. Everyone wants to know how to make it work, and so we have tried to incorporate some of those questions today. And then what we really want to do is provide an opportunity for all of you to ask questions, engage with the panelists, and perhaps most importantly, engage with each other to also share what you are doing. This is the opportunity to hear from each other, and then we'll close out and share the evaluation link. So if you have a question for the panelists during the discussion or want to share what you're doing in your jurisdiction, please go ahead, add it to the chat, raise your hand. You'll be able to come off mute when we get to the discussion, and then you can ask your question or share your experiences. And especially when we get to the discussion point, we really encourage you to come on camera if you're able.

(01:21):

So let's dive in. We do recognize that coordinating prevention and care services is not new. Many of you have been implementing what we're now calling a status neutral approach for a long time for others. You're thinking now about how do we coordinate efforts differently perhaps, or how do we work across funding streams and across programs? How do we braid funding? How do we incorporate a EMIC approach more broadly in your jurisdiction? Status neutral uses a whole person approach and a one door approach to meet the needs of individuals. Regardless of HIV status, IT advances health equity by integrating prevention and care into routine care so that people can access prevention, treatment and other critical services in the same place. And I'll note often when we see information about status neutral, we typically see that an HIV test serves as the entry point to services, but individuals may also enter the prevention or care pathway at other points.

(02:30):

That might be through syringe services programs. It might be through STI testing care at health centers, emergency departments, social service organizations. There are other ways to enter those pathways as well. So a status neutral approach, if we go to the next slide, provides an opportunity to engage people in care early and continually address their healthcare and social service needs. And that's to maintain and achieve optimal health and wellbeing. It also addresses institutionalized stigma by integrating prevention and care rather than supporting separate systems. So those separate systems can perpetuate biases, deepen the divide between people with HIV and those who can benefit from prevention services. So just reiterating what we've seen on the previous slides, a status neutral approach intends to support the pathway to optimal health outcomes by providing culturally affirming stigma free holistic services, and those are delivered by supportive and accepting providers. So a status neutral approach also prioritizes a positive experience for the individual seeking services.

(03:48):

So on the challenges side, while CDC and HRSA encourage status neutral approaches for prevention and care, we know there are many barriers and challenges to implementing them. Most notably funding as we've heard. So these include restrictions in the Ryan White h hiv aids program, legislation, funding limitations such as the administrative cap and the clear mandate that funding provides services for people with the diagnosis of HIV through the Ryan White hiv aids program. But we know there's other challenges, limited providers, limited resources for support services, billing, reporting, contractual challenges, and that status neutral innovations are not always reflected in the data that we report to

funders. So from our perspective on the next slide, we were curious about how many jurisdictions were moving forward with status neutral approaches. And so when the IAP TAC team reviewed all of the submitted 2022 to 2026 integrated HIV prevention and care plans, we identified those that incorporated any status neutral language.

(04:56):

So they may have been things like no wrong door or linkage between prevention and care services at all entry points. And we found that almost two thirds of the integrated plans that were submitted to CDC and HRSA did include some degree of status neutral approaches in their plans, or at least that language incorporated in their plans. So it seems that many of you are incorporating or working towards status neutral service delivery, and that's also why you're here today. So with that, let me turn it over to my colleague, Julie Hook, who will introduce our panel and we'll hear from experiences in the field.

Speaker 2 (05:34):

Great. Thanks so much, Julie. I'm really happy to introduce our panel. First is Linda, Dr who is a senior operations and policy analyst at the Oregon Health Authorities, H-I-V-S-T-I and TB section. She received her MPH from the University of Michigan, has worked in many areas of public health over a long career, but she always comes back to sexual health. And her first public health job was as an H-I-V-S-T-I disease intervention specialist in Chicago. We also have Barbara Jardine, who is the ending, the HIV Epidemic Program coordinator in the Policy and Civic Engagement Office in San Antonio. Barbara's very first public health experience was an internship with San Antonio Metro Health under an HIV prevention program. And over the years, she has functioned as a coalition coordinator, data analyst, and epidemiologist across several state and local health departments. She earned her master of public health in epidemiology from Texas a and m University, and currently she's practicing employing a collective impact approach to improving outcomes across the HIV care continuum in San Antonio. Christina Win Bigler also representing San Antonio is an EHE Disease intervention specialist with a Bachelor of Science in neuroscience from Allegheny College where she completed a thesis in early pornography exposure, furthering her role as a sexual health advocate. She moved to San Antonio and became a disease intervention specialist to confront the challenges impacting people seeking sexual health Outside of work. You'll find her spending time outdoors with friends and family and checking out hole in the wall restaurants. So now I'd love to turn it over to Linda.

Speaker 3 (07:07):

Hi everybody. Linda DRock. I use she her pronouns. I'm from Oregon as mentioned, and Oregon Health Authority is the state public health department in Oregon. So we're the Part B grantee. We also have a prevention program, and we're not an EHE jurisdiction. Okay, so I'm going to apologize in advance for a lot of wordiness on my slides, which you'll see. We really talked, Julie did a great job kind of setting the stage for why status neutral in Oregon specifically. Really we're doing it because it works even though we're seeing rising rates of new HIV and STI diagnoses after the C Ovid 19 pandemic. We're still a low incident state. So if we're to find people who need services, these are folks who the current

Speaker 2 (07:58):

System hasn't

Speaker 3 (07:59):

Really worked for them. So we really need to make those services as stigma free as possible. We need to be providing services in places where maybe we didn't provide them in the past. And so status neutral really works. A couple of things too, I should have really put on the slides instead of all this is when we went to our community planning body and talked to them about the status neutral approach, they really said this resonated for them. And some of the quotes that from our community planning members were status neutral really reflects that quote, we're all in this together. And they also said that it moves us from a medical model to a community focused model, and I really like that. Okay, next slide. So some examples of status neutral status neutral approaches that we have implemented in Oregon. And this is an imperfect implementation for a lot of the reasons we'll discuss around challenges, but we have had an planning group for more than 10 years.

(08:58):

So that's the end. H-I-V-S-T-I, Oregon Statewide Planning Group. So that includes our part A, our Part B Ryan White Jurisdictions includes Prevention, A, TC, all of, and then lots of other partners who are not necessarily HIV specific, especially, we're trying very hard to recruit people from priority populations who may have not been in the sexual health space before. We as a state health department, of course, we do have co-located prevention and care services, but that really works well at the community level. So we're trying to fund and encourage that. A couple of examples of that are one of our local public health authorities, our local public health departments, they're probably called in other jurisdictions, has an STI clinic that they call just checking. And it's just a way that people can come in, even if they're not really thinking about H-I-V-S-T-I, very low bar, low stigma, low threat, and people can come in and then get funneled into other services.

(10:01):

We also have our prevention and our Ryan White Care Services contractor in eastern Oregon, which is extremely rural, is located at a disability services organization, so not an HIV specific organization. So some of those things are ways to help implement status neutral. A couple of other things, I think the other thing I'll just highlight on this slide is really communication and messaging, which really doesn't take any funding at all, right? So it's really trying to talk about this in a new way, not talking about disease, talking about sexual health, wherever possible. Really avoiding those old messages about sero sorting and those things that divide people and put people into different silos really. And then also just really, really being careful to not talk in any way that would imply that there's a wrong outcome of an HIV test because there are options for people regardless of how the test comes out. Okay, next slide.

(11:04):

And then one example of this that I wanted to highlight. So this is, as Julie highlighted or mentioned, this really isn't a new approach for Oregon. We had our community planning group highlighted in our 2017 to 21 integrated plan that sort of the highest priority at that point was funding early intervention services and outreach statewide. Our metro area had had EIS for a number of years at that point, but we really didn't have EIS services in other parts of the state. So we really focused at that point on outreach to priority populations, H-I-V-S-T-I, education and testing, and then of course, rapid linkage to care for those who test positive referrals to prep harm reduction syringe services, all of those services for folks who tested negative. So again, really just exactly what we're talking about, status neutral. At the time, we were doing this in 2017, we were doing a little nail biting because we do fund this through Ryan White Care Act dollars and we'll talk, I know a lot more about that. At the time, we were nervous about it because we felt very confident we were not out of compliance with HRSA requirements. If you look at the definition of outreach, it very much is all about identifying people who may not know their status or may know their status and be out of care. And those are the folks, exactly the folks we wanted to be

bringing into services. But it made us a lot more comfortable seeing that joint letter from CDC and HRSA recently that really supported this approach that we've been taking.

(12:50):

Okay. I think the only thing I want to say for these, I'm happy to answer questions when we get to that point, but at this point, I will pass it to my colleagues, Barbara and Christina from San Antonio.

Speaker 4 (13:06):

Awesome. Well, hello there. I'm Christina. I'm with the San Antonio Health Department. I am a disease intervention specialist with EHE. So I can speak to kind of on the ground approach for status neutral and basically how we do the one-on-ones with everybody. So basically just to start, for San Antonio, we decided to go with status neutral because we had a big need for integrative care for creating this one-stop shop. In other aspects of San Antonio healthcare things aren't as integrated. So understanding the need for status neutral allowed us to create a more cohesive healthcare system for people living with HIV and for people who are interested in getting into care of some kind related to prep related to just anything related things needed to happen for those people. So we were more interested in creating integrative care, and that kind of led to tailoring to people who needed other things as well. So basically here in San Antonio, we are able to, I'm sorry, can you guys hear me?

(14:23):

Yes. Oh, okay. I see Linda. Thank you. Sorry about that. All right. So here in San Antonio, we can basically speak to a lot of different populations, but largely underinsured and Latino, Latinx people. So there's a lot of room to kind of bring people into understanding of HIV in general. So we get people in the health department here just for general testing, and we often people aside just to say, Hey, what do you understand about HIV? What do you understand about prep pep? Things like that. And then we can just guide them to where they need to go. So we kind of create this one-on-one environment where we can say, Hey, we can offer you an instant test. There's no wrong answer to what the test is going to convey. Either way, we're going to get you into some sort of long-term care if you are up for it.

Speaker 5 (15:19):

Yeah.

Speaker 4 (15:19):

So Barbara,

Speaker 5 (15:21):

Yeah, thank you, Christina. And my name is Barbara Ardine. I'm the ending bay HIV program coordinator with San Antonio. Just to build off of the need for creating a one-stop shop. That's not only for to Christina's point, having this integrated care model, but also having even just within our programs at the health department and managing up to our leadership, helping people understand the expansion to social determinants of health in advancing our partnerships with our HIV planning group. Two sectors beyond health, and I'll speak to that a little bit more later. But yeah, so just again, creating this one-stop shop for having a more integrated care perspective, and then again, having people start to think that status neutral goes beyond the traditional elements associated with the HIV care continuum. And then another part of our rationale for the status neutral approach when we're trying to plan and implement what that approach looks like.

(16:23):

We received a lot of really good feedback from our peers and consumers who are living with HIV that are part of our planning group, that when building out the status neutral approach, it's important to ensure meaningful involvement of people living with HIV and disproportionately impacted communities. So again, for San Antonio, that looks like our Latina men who have sex with men, black women, and people experiencing substance use disorder or who are homeless. So again, when building out that status neutral approach, keeping in mind those communities, also ensuring that funds that are dedicated to people living with HIV are not diminished in order to broaden a status neutral approach. And then lastly, ensuring that status neutral activities can be reasonably linked to improved prevention specific outcomes. And we can speak to that a little bit more later, but I'm ready for the next slide.

Speaker 4 (17:21):

Okay. Yeah. And just to kind of expand, what it really looks like is when somebody comes in and is in a room with ADIS or basically anybody who's doing that public health, it is just really looking at the client and saying, what do you understand? Regardless of if you've been living with HIV for years and years, or if you just heard about it yesterday, I get a lot of people who never heard of HIV before. So that's kind of the important part of integrating status neutral into a community like San Antonio specifically. So our approach, our Rapid Start protocol is linkage to care within 72 hours of receiving a positive result for HIV. But we also have a pretty rapid linkage to prep program here. So we have a prep clinic here in the health department. We do only have a cap of around 200 patients, but we only recently experienced an actual reaching of that cap. So we can link people to prep in eight or nine other facilities without insurance. And just to receive that peace of mind, we can do that within seven days of receiving a negative result as well.

Speaker 5 (18:35):

Again, with that Rapid Start protocol, that was a protocol that was co-created by the HIV planning group in San Antonio, which is comprised of different AIDS service organizations, community-based organizations, folks who we've identified as key players with our endemic approach with substance use disorder and homelessness. So it was really important to have that community buy-in surrounding this Rapid Start protocol. And then that expansion to prep definitely required this kind of whole of society approach and having the right playmakers in the room while we were building this out. Another part that's slightly unique, I think, to San Antonio's approach to Rapid start protocol is where my position is situated within the health department. So I know a lot of jurisdictions, the EHE coordinators typically housed within the HIV or STI clinic. With my role being in the policy and civic engagement team, I think it really allows me to broaden the scope of our EHE work, specifically with that emphasis on social determinants of health within the city's health department.

(19:42):

And within that team, we have three planning group coordinators. So there's me who plans the HIV planning group for San Antonio, and then we also have two coalition coordinators who are spearheading our food insecurity issue in San Antonio and our housing stability in San Antonio. And so by having the three of us all in the same spaces and learning about how can we help maybe streamline some referral processes or how can we help expand the status neutral approach associated with people living with HIV or people who are at higher risk for HIV, getting them connected to more of these social determinant programs that are again outside of the typical HIV care continuum. And then a more specific approach that San Antonio has is the emphasis on harm reduction by partnering with untraditional testing partners. So we support a endemic approach, again, specifically pertaining to substance use disorder

and harm reduction, and a more, I don't want to say tricky way that we fund this status neutral approach is again, we provide EHE funding to do HIV testing with these untraditional partners.

(21:02):

So the two organizations primarily are Cordone Ministries, which is a day center for people experiencing homelessness, and they also have a syringe exchange program for people with substance use disorder. And then we also have this Center for Healthcare services that conducts street outreach testing. So again, CORDONE is more of this day center, one-stop shop and Center for Healthcare Services conduct street outreach to our unhoused population. And so we feel that this has been very helpful because these individuals are seeking more based on their need. The services that they consider that are more pressing, whether it be with housing or substance use disorder, or their mental health care, that's really their first link into some sort of program or initiative. And then there just so happens to be HIV testing involved. So again, speaking to that bullet point of the HIV test is often serves as the entry point for services. This is kind of the inverse approach where folks are seeking out these more pernit services based on their need. And then there's also that HIV care component, and I believe that's all we have for San Antonio.

Speaker 2 (22:21):

Great. Thank you so much. And Shay, if you can pause the slides for a minute coming to the discussion part. So I know all of you talked a little bit about how you involved your planning body, your planning council, but if you could more fully share a little bit how you engaged community members and the planning body or planning council informing or developing your status approaches that you put into place. No, go ahead, Barbara. It looks like you're about to come off mute.

Speaker 5 (22:55):

No, I wasn't, but I can. So yeah, I think specifically where that's relevant is with the ethical considerations that San Antonio kept in mind with the status neutral approach. And to be quite honest, those ethical considerations were really co-created by a particular local, I can't remember off the top of my head, but it was a local advocacy group. And so just ensuring that as we move forward, again, we're keeping in mind that we center the community voices, not just people living with HIV, but also those who are disproportionately impacted. Again, ensuring that funds are not diminished for people living with HIV in order to fund the broader status neutral approaches. Again, I don't think that that would've really come up organically had we not had a diverse group of people at the table when we were creating this approach. And so I would just say keeping your, ensuring that you have the right folks in the room, as silly as it sounds, even with our planning group, we would just say bring a plus one particular planning meetings so that we had, again, a good diverse group of stakeholders that were helping build this out.

Speaker 2 (24:11):

Great. Thanks for sharing that. How about you, Linda? Anything to add around how you engage community members, the planning body back when you were developing your status neutral approaches and what you wanted to put into place?

Speaker 3 (24:23):

Yeah, first of all, plus one. I love

Speaker 2 (24:26):

That.

Speaker 3 (24:26):

That's great. So that was worth the price of admission right there. Yeah, I mean, I think, I'm not sure what else I have to add other than it is so important to have people at the table, a diverse group at the table, and that can be challenging for lots of reasons. So while we're still working hard to diversify our planning group, and we've put some policies in place so that members are folks from priority populations, other people can join as partners, but then the members are the ones who receive stipends and have voting rights in order to kind of shift the balance of power, there are still folks who are never going to come to a planning meeting. So it's really important for us to, in addition to what happens at community planning meetings, also lean on needs assessments from the community evaluations. And we also put into place in 2016 a mini grant program so that we could be really, I want to say recruiting new partners. I mean, that's not exactly right. I mean, it was really to support projects in the community with non-traditional partners. But then of course, naturally as you have this relationship where you're getting to know each other more and it's less transactional, it's not like, Hey, come to our meeting. We want to check a box. You're learning more, you're getting more of that input, and people are coming up with great ideas.

Speaker 2 (26:05):

Great. I'm going to keep you off mute and ask you the next question, which is, you talked a little bit about some of the things you needed to put into place. So were there other changes you had Oregon had to make to move forward? What were those structural, what were those things that you had to policy? Any changes to put into place?

Speaker 3 (26:25):

This is a great question. I'm trying to think exactly. I mean, certainly when you are, I don't want to jump the gun on this question, but when thinking about using Ryan White Funds, we have to be extremely careful about how they're very specific uses for those. And that really is how we have funded many, well, I'd say the bulk of our status neutral interventions. There are some other funds, we can talk about that when we get there. But those kinds of things I think have required some changes in training policies such as if there's someone, a contractor who's been traditionally doing more prevention services, some of the Ryan White reporting requirements are really new, and we have to take time to help build that capacity. So that's one example.

Speaker 2 (27:19):

Great. How about you, Barbara, or Christie, anything that you want to add around what San Antonio has had to do around any changes to policy or anything you needed to do to kind of move forward with implementing a status noodle approaches?

Speaker 5 (27:36):

I don't think I have anything to add, but thank you.

Speaker 2 (27:39):

Great. And then I'll keep, what about challenges or barriers? Were there structural, I know there's probably some funding challenges, stakeholder buy-in. What were the challenges or barriers that you faced and how you have been addressing them?

Speaker 5 (27:56):

I think from the collective impact approach with our planning body, it's just trying to get people to understand where they fall within the status neutral approach. That it's not just isolated to aid service organizations or medical providers, but again, getting folks to see where, what is their role within this work? And so it's been challenging, but I think also people are within these care professions, very willing to come on board and participate. And it's kind of like a, you don't know what you don't know kind of thing. And so specifically with our two untraditional testing partners, once we got them up to speed with your priority population as one of our priority populations and how can we work together to ensure that they're having this service that was previously not offered within their organization. And so yeah, I would say it was a challenge just to get them to understand their role in it. But again, the people who are engaged in this work are very open to expanding services and collaborating and having this whole of society approach. And so I think it was worth it to engage in those conversations, but initially a little bit challenging.

Speaker 2 (29:19):

Right. Great. And Linda, anything you want to add about challenges or barriers or face? And we can certainly talk about structural stakeholder, but if you want to bleed into funding, we can talk about that too, if that's a bit of what kind of challenges or barriers around that as well.

Speaker 3 (29:35):

Yeah, I think that is the main challenge. Certainly for us and probably for a lot of people on this call and kind of a concrete example, we have provided funding to a agency, Familia and Axion, which provides services to the Latina community, a wide range of services, perfect partner, very excited about starting a sexual health program. And they did that, and that's been wonderful and they're doing great work, but just simple things like they would like to be able to have funding to provide people have needs, people who are not HIV positive have needs for specific services and some things around social determinants of health. And we can't fund that through Ryan White clearly. So that's something where we have to say, no, you have to leverage other funds in your agency. And in some cases they certainly can do that. That is the advantage of working with a kind of multi-service agency. But there are specific areas where it would be great if we could, it would support our programming too, if we could do that and we can't.

Speaker 2 (30:47):

And you talked a little bit a moment ago about challenges around or how you have to keep reporting separate. Can you talk a little bit how you're monitoring funds for different grant reporting purposes or any sort of best practices around the monitoring of funds or reporting up through these different reporting mechanisms?

Speaker 3 (31:07):

Sure. Well, so we do have some outreach contracts, so some contracts with community-based organizations around the state to provide outreach. And this past year we have been getting those contractors onto careware so that they can report. And that's been a bit of a lift. That was not something they had done previously. I think I alluded to this before, some of these contractors had

mostly had prevention funds in the past, and so this was not, Careware was not something, so that's the system for Ryan White care services and case management reporting traditionally. So that was not something they were familiar with. That was a whole new kind of body of work for people. And at a certain point, that's the feedback we get from folks. They say status neutral is great. We support the concept. We think it works better for clients, but it makes more work for the provider at this point because of these, even though we're trying to have a non-siloed approach. The fact is we have siloed funding.

Speaker 2 (32:14):

Great. I mean, not great, but thanks for that answer. I guess I would love to hear too about, we just talked about challenges, but what benefits or successes have you all seen and also a follow up if you've formally evaluated the different approaches, impacts, would love to hear any benefits you've been seeing? Yeah, so

Speaker 4 (32:38):

Basically just on the ground talking to people and conducting this approach, we have seen a lot of greater adherence to prep and a lot of an increase in prep uptake. A formal evaluation has not been conducted in San Antonio. It's kind of basically in the health department, when we do have the prep clinic with us already, we are able to just say, this person wants this right now. So if I'm talking to someone and they just learned about prep, I can say, you can go start that process here and now if you would like to. So we have that, and we also have just the occasional but still worthwhile adherence or just the uptake of understanding HIV testing and prep services for people who just haven't heard about it before. So there is a great benefit to doing things that way.

Speaker 3 (33:35):

Yeah, I say, oh, I'm sorry, Barbara, go ahead.

Speaker 5 (33:38):

Oh, real quick, I just wanted to say with benefits or successes with one of the organizations that was the untraditional testing partner, they had, I say success, but it's also slightly upsetting. They had the highest positivity rate associated with all of our EHE funded testing sites. So again, speaking to the fact that we're getting to our priority population, again, their positivity rate I think was higher than the state average even for that particular site. So it just speaks to the fact that we are where we need to be to help potentially identify some folks who need to be linked into care.

Speaker 3 (34:22):

And then I wanted to just comment on the linkage to care piece that we were seeing much better rates of linkage to care once we put our early intervention services and outreach program into effect. So people coming in through that door we're getting linked to care very quickly.

Speaker 5 (34:43):

Excellent. And before we move to the q and a,

Speaker 3 (34:46):

Just would love to hear from you

Speaker 5 (34:48):
All, just

Speaker 3 (34:49):
A big general high level question. Any lessons learned or advice you

Speaker 5 (34:52):
Have for jurisdictions or agencies that are thinking about implementing these approaches or

Speaker 3 (34:57):
Those that

Speaker 5 (34:57):
Have been bumping up against challenges?

Speaker 4 (35:05):
I feel like the best approach to this is truly

Speaker 5 (35:09):
Networking

Speaker 4 (35:10):
And understanding what everyone's strengths are in your community so that you are not asking something that isn't doable for a particular organization. So just having those available context is the most useful part of this approach.

Speaker 5 (35:31):
Great. Anything to add,

Speaker 3 (35:34):
Linda? Only that I agree. I mean, I think it's all about partnerships. Yeah. That's the only way to make it happen.

Speaker 4 (35:44):
Excellent. Well, thank you both all for sharing those experiences. And now really wanted to pass it off to my colleague Eddie to facilitate AQ and a, but also wanted, as Julie mentioned at the top of the call, definitely if you have an experience you want to share or you have a question that you don't feel like putting in the chat, you're welcome to raise your hand or come off mute and we'll call on you. So now I'm going to hand it over to my colleague, Eddie.

Speaker 6 (36:10):
Awesome. Thank you Julie. And thank you to our wonderful presenters. Don't forget, if you do have a response in the audience, please raise your hand and I will call on you. So the first question I want to ask

is, how have you engaged non-traditional providers, whether that's in a doctor's office or a medical provider, and if you have engaged a primary care provider, how did you convince them that status neutral is relevant to their work?

Speaker 3 (36:46):

I'll take the first hit on that. So we work a lot with our AIDS education and training center. They are marvelous, and they're doing a lot of work, particularly with FQHCs, federally qualified health centers. So those are clinics that are serving populations, and it really just by definition, it's kind of status neutral. They're serving primary care, family practice, serving broad, broad population. So that's been helpful. They do public health detailing. They have one-on-one consults, and they've worked really hard to especially focus on, again, sort of non-traditional providers. Providers who maybe haven't been doing HIV care in the past, but are serving a high number of folks who may need that care.

Speaker 4 (37:44):

I think additionally, you can convince a provider that something is important by if you're already talking to them. So if you talk to patients on a regular basis, then you know have to kind of corral certain providers into the mix to allow for that patient's care to thrive. So in that process, say, Hey, by the way, we are doing this new thing. I think that this situation could have been avoided if we were to be involved. Can we meet at some point? So just using that situation as an educational moment to move forward might be just an easy way to say, we're already on the phone, how about we set something up?

Speaker 6 (38:28):

Thank you. So it looks like no one from audience. I'll move on to the next question.

Speaker 4 (38:35):

And remember, if you do have a response to the previous question, just raise your hand and I'll come back to you. So have any of you all used any community advisory boards to help expand status neutral services? And if so, are there any pros or cons and any insights now? Is this just to us three or Oh, there we go. Patrick, everyone. Okay. Alright, here we go. Patrick.

Speaker 7 (39:21):

Yeah, thank you so much. So I guess good afternoon everyone for me. I can dive into this question a little bit more. I'm really curious around how communities that are disproportionately impacted, how they're engaged, how y'all are working to navigate to ensure that there's equitable distribution of care and support and participation. And so I am not sure what modality you're using to do that. Is it a community advisory board? Are you doing more qualitative methods to obtain feedback? So I'm just curious to know how are you continuously working with those populations that are disproportionately affected by HIV?

Speaker 4 (40:01):

I was, oh, go

Speaker 3 (40:02):

Ahead.

Speaker 4 (40:04):

Just quickly, we basically ask everybody that we talk to, where can we test, where can we talk to people? So if anyone is coming in with a specific concern, we know that there must be more concerns in that particular community. So we gather addresses, we gather gas stations, we gather restaurants, just little spots to where we can put our mobile units. And so basically just word of mouth is our best way of understanding where our actual need is.

Speaker 3 (40:37):

And I'd say we're doing a lot of work as much as we can to transfer funds to the community because I'm from a state health department, we're removed from this. And it's just the services need to be located in the community and also the needs assessments. So one example I mentioned the Familias and Exon, our partner, we're funding them to do a community needs assessment. They've been doing a bunch of learning collaboratives and engaging agencies, Latino service agencies from around the state. So they're getting a lot of new partners involved that we would never be able to get involved from the state health division. So that's helping to identify those needs. Also funding other agencies from other priority populations to help build capacity where maybe there isn't currently or there hasn't traditionally been a presence around sexual health. So some of that's a long game. Some of it is happening right now. And I think those mini grants, even though they were small, also really helped. Now that we're in the seventh year of doing that, I think that that has helped bring more people to the table as well. I don't even want to use that. Why do I say bring people to the table? It's not even bring people to the table. Again, it's sending money out to the community where the decisionmaking and power needs to be.

Speaker 5 (42:05):

Yeah, I agree with that, Linda. With our EHE contracts that we, with the funding that we distribute, reallocate to the community every year, we ensure that there's representation from organizations that prioritize, again, the same populations that we see disproportionate negative health outcomes. So one of them is a beat aids, for example, is one of our testing contractors this year, and they prioritize black women. And then again, with the two previous contractors that I mentioned previously for HIV testing, they focus again on the substance use disorder and homeless population that we have. And so yeah, just that. But I think also really prioritizing the planning group that should be your sounding board for a lot of these initiatives with that really intentional approach to that planning group, ensuring that that makeup is accurate and reflective of the community that we're attempting to serve. I know in San Antonio, we don't particularly have an issue with meeting our Latinx quota, for example, but we do try to ensure that we have people living with HIV, about 25% of our group of the planning group is a consumer. And then again, ensuring that the sectors that we do have present in that planning group are in alignment with our health equity strategy, which is the ensuring that we're reaching those disproportionately affected populations. I guess not necessarily being selective with who you allow in your planning group, but just making sure that it aligns with your health equity strategy. And if you're naming those particular priority populations within your health equity strategy, then it should all kind of line up a little bit better, if that makes sense.

Speaker 6 (43:54):

Yes, totally makes sense. Thank y'all for that. Now, what about the rural areas? What does status neutral implementation look like in rural areas? And this is for everyone on the call today. So if you were working in the rural area, what does that look like?

Speaker 3 (44:16):

Well, right now it doesn't exist, but what we're thinking of doing is having the prep portion, anybody who ends up not being HIV

Speaker 6 (44:26):

Positive,

Speaker 3 (44:27):

Just working with a provider

Speaker 6 (44:30):

Who

Speaker 8 (44:30):

Is HIV knowledgeable knows about prep and is able to do, I guess the risk education part of it. So we have a couple of providers who want to learn and want to be involved. So if we have somebody who doesn't know their status, they would go to that specific provider because they would be considered at risk. That's as much as we figured out so far. But now we're looking for funding, we're getting there,

Speaker 6 (45:12):

Getting there. And where are you, Allison?

Speaker 8 (45:15):

I'm sorry. I don't have a camera today, but I'm at Mendocino. It's about three hours north of the Bay Area in California.

Speaker 6 (45:28):

Thank you. Okay. I have another question from the chat actually. Would you be able to address the collective impact approach and maybe planning work that achieves consensus outside the traditional hierarchical Robert's Rules of order model?

Speaker 5 (46:00):

I'm not familiar with the Roberts Rules of Order model, but working in government, I am very familiar with traditional hierarchy, so I can at least assume that those two things go hand in hand. The collective impact approach that we use, again, it's really focused on ensuring that the individuals that we have participating in the planning group are reflective of the community and being extremely intentional with our, I don't think we can hear you, Barbara.

Speaker 6 (46:43):

Maybe a freeze.

Speaker 5 (46:48):

I wish I could finish speaking for that side of it, but she's the one who knows about this. So anyone else in the audience have a take on this one?

Speaker 6 (47:07):

Okay. Well, Barbara comes back. I have another question. Let's talk about trainings and resources. So what trainings and resources are you providing to address the need for status neutral approaches and engagement? And what are some of those training ideas for staff and community partners or Barbara's?

Speaker 5 (47:58):

Okay. Oh, was that directly for me? I'm sorry.

Speaker 6 (48:03):

No, no, no. It didn't have to be, but if you would

Speaker 5 (48:06):

Like to rephrase. Oh, sorry. I didn't hear the first half of that question, but it's okay. I've talked enough. I

Speaker 4 (48:15):

Can say, I mean, speaking just for San Antonio itself, training wise, it's been a lot of just kind of handing me down, observational, just observing people talk to patients and then doing it yourself. So taking skills from motivational interviewing, which you can get on CDC train and skills just from modules on HIV, providing that direct education and just finding what works for you communication style wise, saying, how can I actually reach this conversation with this person sitting in front of me based off of what their particular concerns are in the conversation that we've had. So it's kind of more of a seamless conversation towards HIV prep, things like that.

Speaker 6 (49:11):

And one final question on most of the projects I work on, everyone wants to know how do you engage youth and how are youth engaged in these approaches? So how has you all engaged youth in Status Mutual? And again, it's for anyone on the call. Okay. It looks like nobody else, Linda, Christine, I was going to say,

Speaker 5 (49:46):

I'm sorry.

Speaker 4 (49:48):

Definitely.

Speaker 5 (49:50):

Oh, were you going to say something, Christina?

Speaker 4 (49:52):

No, you got it. Go ahead.

Speaker 5 (49:53):

Okay, cool. I think, again, with the funding or reallocation to community-based organizations in San Antonio, one half of our EHE funding goes to that testing with Untraditional partners. And then the

other half is Youth Prevention Education. So we fund two main organizations in San Antonio, the San Antonio AIDS Foundation, which is a really cool one-stop shop kind of place. But we specifically fund the CURE education, and they have MOUs and agreements with the major independent school districts in San Antonio where they go out and provide supplemental HIV education. I'm trying not to bash on Texas, but y'all know, y'all already know the political landscape and what we're allowed to say, what we're not allowed to say over here. So they're really important supplemental education component that our young people get to experience. One of the challenges unfortunately, is they're not in every school district, and especially as of late superintendents and other folks who typically engage in that partnership have been hesitant to allow the AIDS foundation to participate in their expanded health curriculum.

(51:12):

So yeah, I think that's one way we've been able to help engage youth in the status neutral approach. And then we also fund an organization to do peer support groups for young people. So that can be, they have three main groups. It's a young, young group. I think it's like, I don't know, Christina, you might know the age brackets for Fiesta Youth, but I think it's like 13 to 17 for one of the groups. And then there's 18 to 22. And then they also have a parent support group for parents of LGBTQ plus children. And so just helping them to create that space for community, I think is again, a really helpful approach. They do HIV one oh one-on-one education. They do prep education within those support groups, but it's also just a place for young people to kind of just spend time together and especially on the parental end, help engage in some de-stigmatizing language, make sure that they're engaging in person first language. Those kinds of things are some of the topics that they cover within those support groups. But even just getting them to understand that that prevention side is also part of status neutral and that making it tailored to the individuals, I think is a really cool way that we've prioritized, again in San Antonio, like the HIV testing component and then the youth prevention side. So yeah, that's what we do over here.

Speaker 6 (52:44):

Awesome. Thank you. And on that note, I'll pass it back to Julie.

Speaker 1 (52:49):

Thank you. Thank you Christina, Barbara, Linda, for sharing the experiences in San Antonio and in Oregon. Certainly there are always nuggets that we get from all of these conversations and discussions and look forward to learning more from everyone as we move forward. So just as a reminder, there is an evaluation that will pop up after the session ends, and it helps us plan and improve our TA and training offering. So please take the time to respond to those few questions. And then finally, as a reminder, we are here to help with your integrated planning needs. Talked a lot about planning groups today as well. So that being part of integrated planning, if you're new to integrated planning or if you would like a refresher, we'd also encourage you to start. We have an introductory online module, so it's an introduction to HIV prevention and care planning, self-paced online course.

(53:44):

Do it on your own time and you can access the course as well as all of our other materials on target hiv.org. And we also encourage you to subscribe to our listserv because when we have new things, we share those as well as a monthly newsletter. So feel free to reach out if you have specific questions regarding status neutral that we were not able to get to today or need additional assistance. We're happy to check in and talk one-on-one as well. So thank you for joining. Just a final reminder, please

complete the evaluation that will pop up. We appreciate your participation and hope you have a great rest of your day. Thank you all so much.