# Division of Metropolitan HIV/AIDS Programs (DMHAP) Business Day

## 2022 National Ryan White Conference on HIV Care and Treatment

*August 23, 2022*

**Chrissy Abrahms Woodland, Director**
**Monique G. Hitch, Deputy Director**
**HIV/AIDS Bureau (HAB)**

Vision: Healthy Communities, Healthy People

# Health Resources and Services Administration (HRSA)
## Overview

Supports more than 90 programs that provide health care to people who are geographically isolated, economically or medically challenged

HRSA does this through grants and cooperative agreements to more than 3,000 awardees, including community and faith-based organizations, colleges and universities, hospitals, state, local, and tribal governments, and private entities

Every year, HRSA programs serve tens of millions of people, including people with HIV/AIDS, pregnant people, mothers and their families, and those otherwise unable to access quality health care

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# HRSA's HIV/AIDS Bureau Vision and Mission

## Vision

Optimal HIV care and treatment for all to end the HIV epidemic in the U.S.

## Mission

Provide leadership and resources to advance HIV care and treatment to improve health outcomes and reduce health disparities for people with HIV and affected communities.

# HRSA's Ryan White HIV/AIDS Program (RWHAP) Overview

- **Provides a comprehensive system of HIV primary medical care, medications, and essential support services for low-income people with HIV.**
- **Funds grants to states, cities, counties, and local community-based organizations to improve health outcome and reduce HIV transmission.**
  - Recipients determine service delivery and funding priorities based on local needs and planning process.
- **Provided services to nearly 562,000 people in 2020—more than half of all people with diagnosed HIV in the United States.**
- **89.4% of RWHAP clients receiving HIV medical care were virally suppressed in 2020, exceeding national average of 64.6%[i].**

i. Centers for Disease Control and Prevention. Core indicators for monitoring the Ending the HIV Epidemic initiative (early release): National HIV Surveillance System data reported through December 2020; and pre-exposure prophylaxis (PrEP) data reported through September 2020. HIV Surveillance Data Tables [Table 5a] 2021;2(No. 2). http://www.cdc.gov/hiv/library/reports/surveillance-data-tables/vol-2-no-2/index.html. Published March 2021.
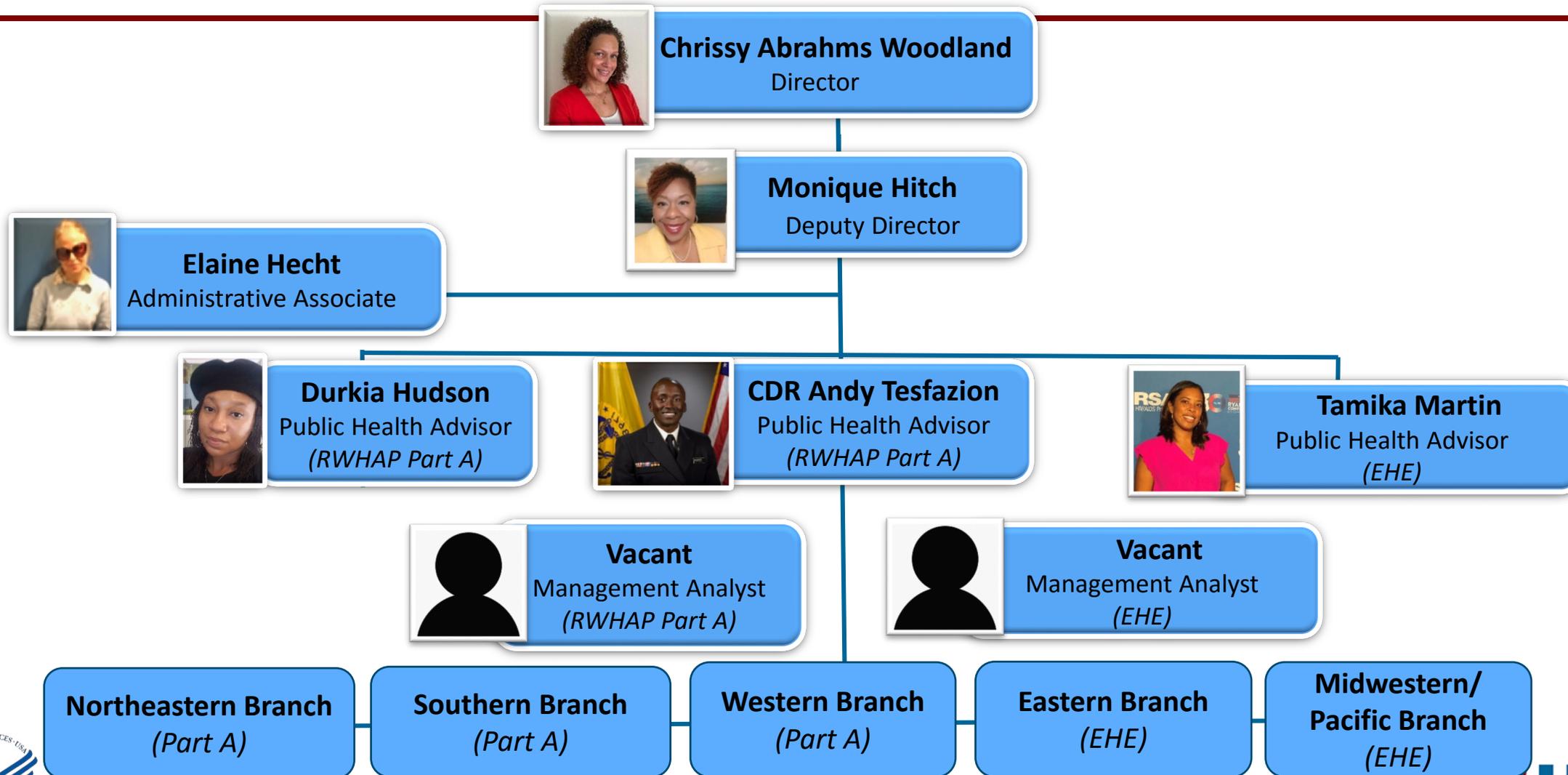
# Agenda

- DMHAP- Who we are
- Division updates
  - Non-Competing Continuation Reports
  - Part A Supplemental Methodology
  - Part A National Monitoring Standards
  - Part A Manual
  - Site Visits
  - Resources for Recipients
- Using Data for Programming
  - Jurisdictional data
  - Maricopa County Department of Public Health
  - Cuyahoga County Board of Health
- Approaches to End the Epidemic
  - New York City
  - San Francisco Department of Public Health
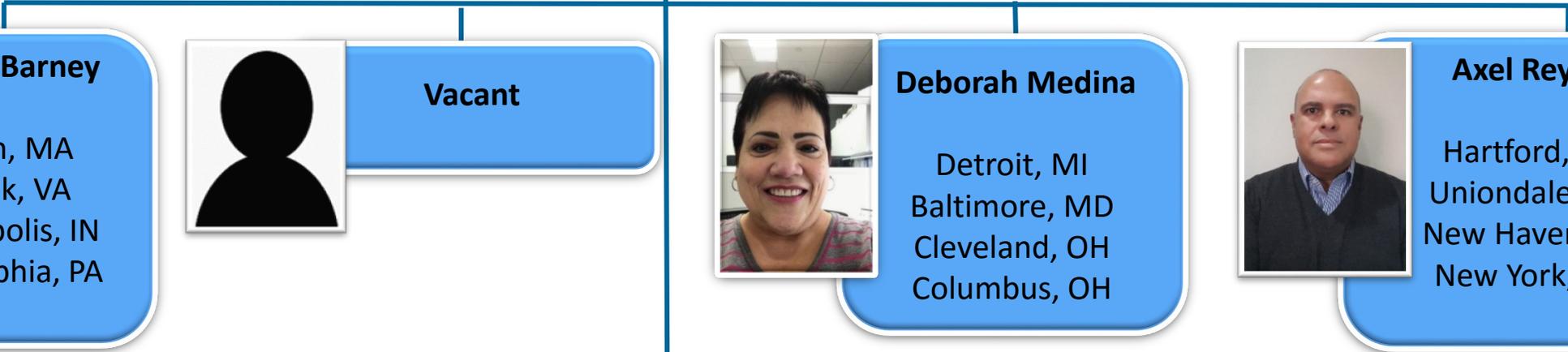  - City of Philadelphia
- Activity

# Who We Are

# Who We Are - Office of the Director



**Chrissy Abrahms Woodland**
Director

**Monique Hitch**
Deputy Director

**Elaine Hecht**
Administrative Associate

**Durkia Hudson**
Public Health Advisor
*(RWHAP Part A)*

**CDR Andy Tesfazion**
Public Health Advisor
*(RWHAP Part A)*

**Tamika Martin**
Public Health Advisor
*(EHE)*

**Vacant**
Management Analyst
*(RWHAP Part A)*

**Vacant**
Management Analyst
*(EHE)*

**Northeastern Branch**
*(Part A)*

**Southern Branch**
*(Part A)*

**Western Branch**
*(Part A)*

**Eastern Branch**
*(EHE)*

**Midwestern/ Pacific Branch**
*(EHE)*

# Who We Are - Northeastern Branch (Part A)

**Mae Rupert**
Branch Chief

**Kristina Barney**

Boston, MA
Norfolk, VA
Indianapolis, IN
Philadelphia, PA

**Vacant**

**Deborah Medina**

Detroit, MI
Baltimore, MD
Cleveland, OH
Columbus, OH

**Axel Reyes**

Hartford, CT
Uniondale, NY
New Haven, CT
New York, NY

**Jose Au Lay**

Washington, DC

**Pricilla Baez Merced**
San Juan, PR
Paterson, NJ
Secaucus, NJ
Newark, NJ
New Brunswick, NJ

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# Who We Are - Southern Branch (Part A)

**Mark Peppler**
Branch Chief

**Jenifer Gray**

Miami, FL
Baton Rouge, LA
Orlando, FL

**LCDR Jonathon Fenner**

Fort Worth, TX
Nashville, TN
New Orleans, LA
West Palm Beach, FL
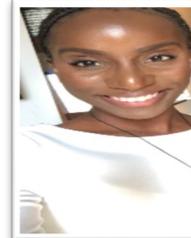
**Melody Barry**

Austin, TX
Memphis, TN
Tampa, FL

**LCDR Lawrence Momodu**

Atlanta, GA
Houston, TX
Jacksonville, FL
San Antonio, TX

**Kristin Athey**

Charlotte, NC
Dallas, TX
Fort Lauderdale, FL

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# Who We Are - Western Branch (Part A)

**Karen Gooden**
Branch Chief

**Lennwood Green**

Chicago, IL
Denver, CO
Saint Louis, MO
Kansas City, MO
San Diego, CA

**Babak Yaghmaei**

Las Vegas, NV
Los Angeles, CA
Phoenix, AZ
Santa Ana, CA
Seattle, WA
San Bernardino, CA

**Vacant**
Minneapolis, MN
Oakland, CA
Portland, OR
Sacramento, CA
San Francisco, CA
San Jose, CA

**Vacant**

**Vacant**

# Who We Are - Midwestern/Pacific Branch (EHE)



**Amy Griffin**
Branch Chief

**Matt James**

Dallas, TX
Clark County, NV
Bexar County, TX
Austin, TX
Harris County, TX

**Durkia Hudson**

Indianapolis, IN
Baton Rouge, LA
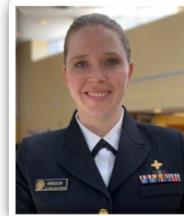
**LCDR Jessica Kreger**

San Francisco, CA
San Bernardino, CA
San Diego, CA
Maricopa County, AZ
King County, WA

**Tonia Schaffer**

Los Angeles, CA
Orange County, CA
Sacramento, CA
Alameda County, CA
Tarrant County, TX
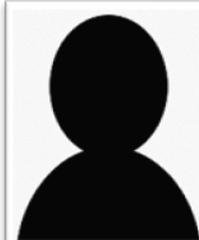
**Vacant**

# Who We Are - Eastern Branch (EHE)

**Michael Carrigan**
Branch Chief

**CDR Holly Berilla**

Boston, MA
Philadelphia, PA
Detroit, MI
Baltimore, MD
New Orleans, LA

**Barbara Kosogof**

Washington, DC
Charlotte, NC
Memphis, TN
Atlanta, GA
Chicago, IL

**Eric Shell**

Columbus, OH
Cleveland, OH
Fort Lauderdale, FL
Jacksonville, FL

**Jesus Hernandez-Burgos**

Miami, FL
Tampa, FL
Orlando, FL
West Palm Beach, FL

**Sylvia Moreno**

Secaucus, NJ
San Juan, PR
Newark, NJ
New York, NY

# DMHAP Core Values

# Division of Metropolitan HIV/AIDS Programs Core Values
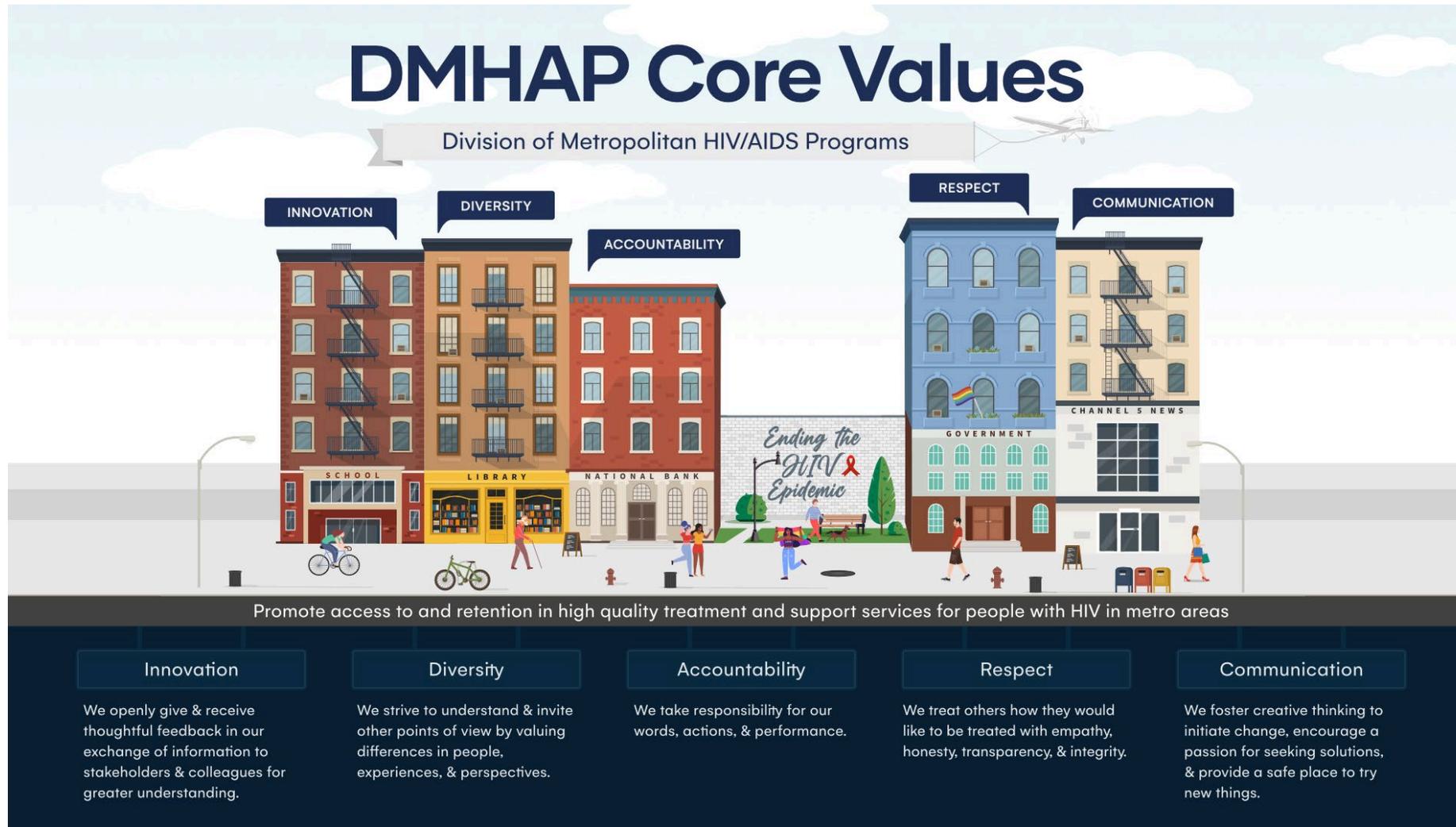
# Non-Competing Continuation Reports

# RWHAP Part A Non-Competing Continuation

- In order to reduce administrative burden, HRSA HAB transitioned the RWHAP Part A program to a three-year period of performance in FY2022

**FY2022 Year 1**
- **Competitive Application – Grants.gov**
- March 1, 2022 – February 28, 2023

**FY2023 Year 2**
- **NCC Progress Report – HRSA EHBs**
- March 1, 2023 – February 29, 2024

**FY2024 Year 3**
- **NCC Progress Report – HRSA EHBs**
- March 1, 2024 – February 28, 2025

| Submission | Due Date |
|---|---|
| FY2023 NCC Progress Report available in HRSA EHBs | 9/2/2022 |
| FY2023 NCC Progress Report submission due in HRSA EHBs | 10/3/2022 |

Ryan White HIV/AIDS Program

# Ryan White HIV/AIDS Program (RWHAP) Part A Alternative Resource Allocation Methodology *"Supplemental Methodology"*- Report to Congress

# Background on Supplemental Funding

## Supplemental Award

- Calculation is based on appropriation amount, relative proportion of living cases of HIV/AIDS reported, and ORC Scores
    - Part A Grant (Appropriation)
        - 1/3 of Part A grant is for Supplemental award (remainder of Part A grant, after formula amount to EMAs and TGAs is determined)

# Supplemental Funding: Current Process

**Current Process:**

- RWHAP Part A supplemental funding awarded via competitive grant applications
  - Application review criteria primarily focused on demonstrated need
  - Applications are objectively reviewed and scored
    - Scores used to calculate supplemental funding

**Issues with Current Process:**

- ORC scores are consistently high and tightly grouped—limits variation in funding
- Limited ability to incentivize recipient performance
- Similar to RWHAP Part A formula funding methodology
  - Not optimally responsive to the Congressional intent for supplemental funds

# Supplemental Funding: Options for Improvement

## Completed: Transition to a Multi-Year Program

- In FY 2022, RWHAP Part A transitioned to a 3-year period of performance
  - Competing application (e.g., a full application that is scored) will be submitted in the first year
  - NCC progress reports submitted for years two and three
- Application score attained with the competitive application used to calculate the supplemental award for years two and three
- UOB penalties still apply for each budget period in the 3-year period of performance

## Pending: Implement the Supplemental Methodology

- Modification of the method for distributing supplemental funds for RWHAP Part A eligible jurisdictions
  - Based on objective measures of jurisdictional need and program performance (data driven)
- Eliminates the competitive application

# RWHAP Part A National Monitoring Standards Update

# National Monitoring Standards (NMS)

- Updated June 2022
- Provide a compilation of all major federal and Ryan White HIV/AIDS Program requirements for program and fiscal management, monitoring, and reporting
- Assist recipients with program compliance and oversight
- Serve as a reference for HRSA consultants and POs in conducting site visits

**Program and fiscal management**

**Monitoring**

**Reporting**

**Program Compliance and Oversight**

| Note | Administrative/Program, Fiscal, Clinical Quality Management and Subrecipient Site Visit Monitoring Tools were developed to monitor compliance with legislative and programmatic requirements. |

# National Monitoring Standards (NMS): Structure

| Part A |
|---|
| Executive Summary |
| Program Standards |
| Fiscal Standards |
| Universal Standards |

**National Monitoring Standard and Citation**

- Performance Measure/Method
- Recipient Responsibility
- Subrecipient Responsibility
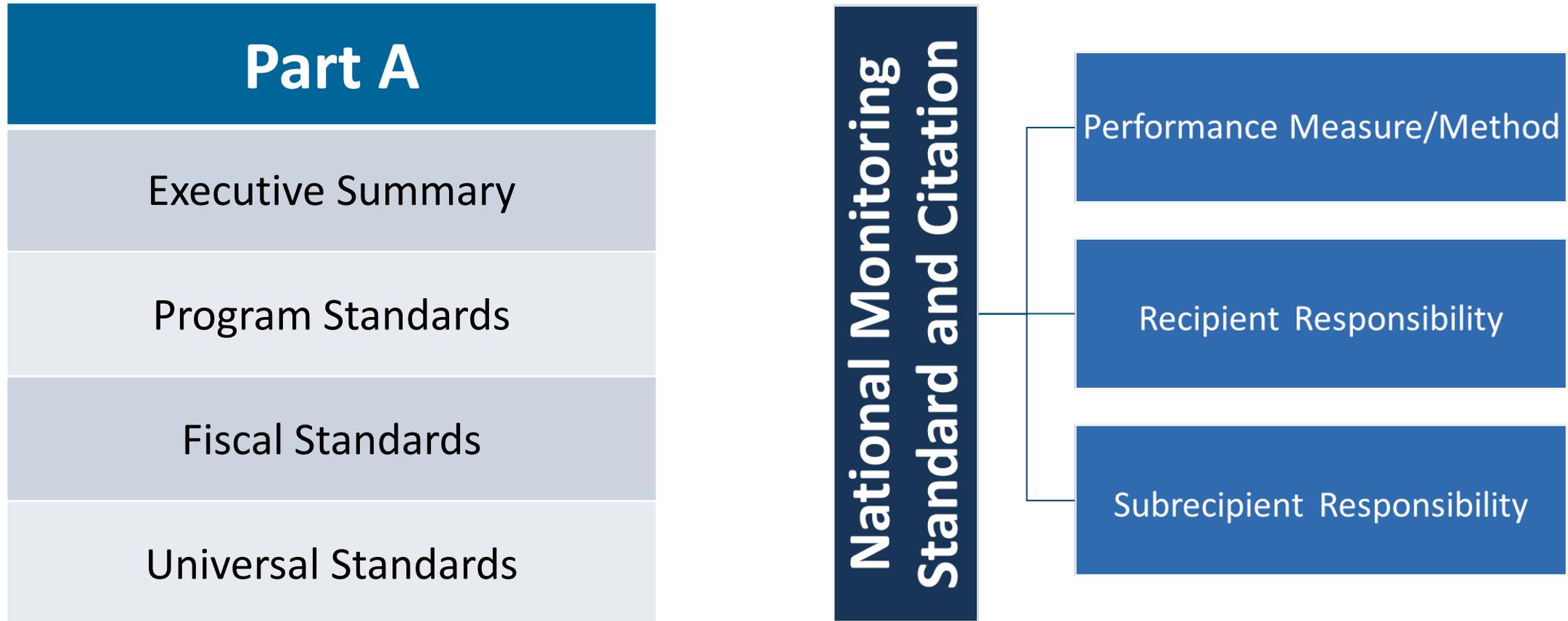
# National Monitoring Standards (NMS): Implementation

Recipients are encouraged to:

- Share and review the NMS with program and fiscal staff who have monitoring responsibilities

- Hold meetings with subrecipients to introduce the NMS and clarify compliance issues

- Make the NMS easily accessible to subrecipients

- Share the NMS with legal, contracts, procurement, finance and other local government staff to familiarize them with federal and RWHAP Part A requirements

# National Monitoring Standards (NMS): Implementation (cont.)

- Review procurement documents (e.g. RFPs) and contract language to ensure compliance with federal and RWHAP Part A requirements as cited in the NMS
- Review current monitoring systems, procedures, and tools for potential revision/updates/changes
- Fully implement any needed changes in subrecipient monitoring
- Implement recipient and subrecipient responsibilities
- Contact Project Officer if there are additional questions or concerns

# RWHAP Part A Manual Update

# Part A Manual: Overview

- Informational resource for RWHAP Part A recipients and subrecipients that serves as:
  - An orientation guide for new RWHAP Part A staff
  - A reference document for legislative, regulatory, and programmatic requirements
  - A guide for implementation and management of RWHAP Part A fiscal and programmatic components
    - Includes supporting and facilitating Planning Council and Planning Bodies
  - A source for obtaining additional information and technical assistance

# Part A Manual: Update

- Currently undergoing updates (last update 2013)
- Projected publication: Fall 2022
- Summary of key changes:
  - Incorporates requirements set forth in the Uniform Administrative Requirements codified by HHS in 45 CFR part 75
  - Updates information to reflect HRSA HAB Policy Clarification Notices (PCNs)
  - Updates language to reflect current RWHAP Part A policies and procedures
  - Restructures the manual to reduce duplication and increase readability
  - Includes additional information to ensure recipient understanding of key issues

# Site Visits

# Site Visits



DMHAP
Site Visits

- DMHAP uses site visits to support the effective oversight of federal awards.
- Site visits provide an objective assessment of the recipient's compliance with the statutory and regulatory requirements cited in the Notice of Award

# Types of Site Visits

DMHAP conducts multiple types of site visits for Part A and EHE recipients:
- Comprehensive
- Diagnostic
- Technical Assistance
- Programmatic Site Reviews (EHE only)

# Virtual Site Visits



DMHAP Virtual Site Visits

- FY 2021
  - o 13 Part A comprehensive virtual site visits
  - o 28 EHE programmatic site reviews
- FY2022
  - o 15 Part A comprehensive virtual site visits
  - o 19 EHE programmatic site reviews
  - o 4 EHE comprehensive site visits (1 in person)

# Resources for Recipients

# ACCESSTA - Technical Assistance Initiative

## Goal
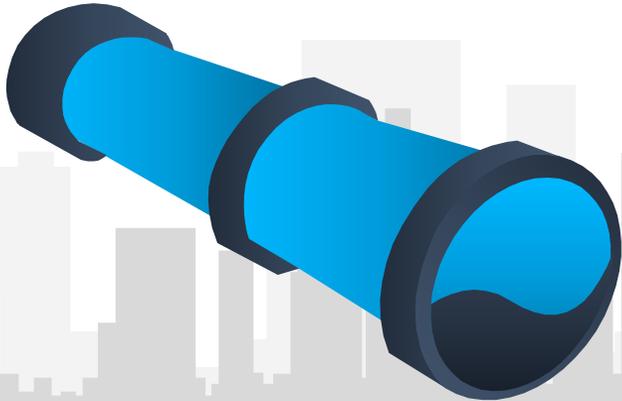
Promote utilization of technical assistance resources to HAB staff, recipients, and national partners

## Audience
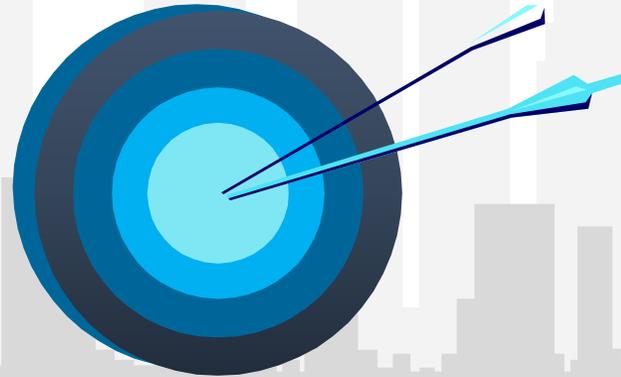
HAB staff, recipients, subrecipients, and national partners

## AccessTA Open House

19 HAB TA programs and 423 unique participants in attendance; 68% from priority EHE jurisdictions

# Resources from the Division of Policy and Data

- Data Support, Technical Assistance, and Dissemination Resources
- Resources for Program Implementation and Innovative Strategies
- Policy Resources
- Clinical Quality Management Resources
- Other Announcements

# Data Support, Technical Assistance, and Dissemination Resources

# Data Technical Assistance (TA) Resources

**TargetHIV**

- The TargetHIV website is the one-stop shop for technical assistance (TA) and training resources.
- Resources include webinars, tools, training materials, manuals, and guidelines that focus on RWHAP service delivery and agency operations.

All data TA Resources can be found at www.TargetHIV.org

**CAREWare Help Desk**

- The CAREWare Help Desk addresses issues related to the CAREWare data collection system. Topics include generating a compliant XML file, creating custom reports, and viewing sample client summary files.

1-877-294-3571 (MWF 12-5 PM ET; Tues./Thurs. 10:30 AM-6:30 PM ET)
cwhelp@jprog.com

# Data TA Resources (cont.)

**Data Integration, Systems & Quality (DISQ) Team** provides TA focused on data management and submissions:

- Guiding new users on where to start

- Mapping source data to required reporting schema

- Integrating data from multiple sources Identifying and addressing data quality issues

- Developing year-long processes for data collection, management, quality checks, and utilization

Data.TA@caiglobal.org    www.targetHIV.org/DISQ

# Data TA Resources (cont.)

**Ryan White HIV/AIDS Program Data Support** provides TA focused on report administration and submissions:

- Interpretation of the Instruction Manuals and HRSA HAB reporting requirements
- Allowable responses for data elements in the Recipient Reports, Provider Reports and client-level data files
- Managing recipient-provider relationships in the Web System and Grantee Contract Management System

1-888-640-9356 (Mon.-Fri. 10 AM-6:30 PM ET)

RyanWhiteDataSupport@wrma.com

# RWHAP Compass Dashboards and Benchmarking

# Data Products and Other Dissemination Activities

- New data products: https://ryanwhite.hrsa.gov/data
  - RWHAP COVID-19 Data Report – released
  - 2020 AETC Annual Data Report – released
  - 2019 RWHAP ADAP Annual Client-Level Data Report – released
  - RWHAP Compass Dashboard – updated data coming soon
- Coming soon
  - 2020 RWHAP ADAP Annual Client-Level Data Report
  - Oral Health Data Report (2017-2020)
  - EHE Qualitative Data Summary
- Dissemination:
  - eLibrary – continually updated
  - E2i toolkits – released
  - Best Practices Compilation – continued updates
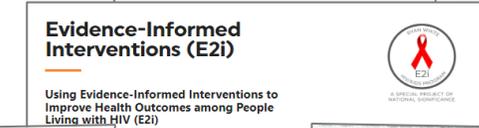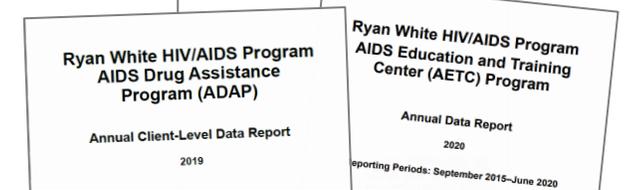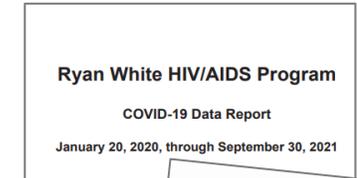
# Resources for Program Implementation and Innovative Strategies

# Recipient Best Practices Compilation



**The RWHAP Best Practices Compilation** gathers and disseminates interventions that improve outcomes along the HIV care continuum.

**Search and share today!**
targethiv.org/bestpractices/search

## RWHAP Best Practices Compilation
TargetHIV.org/bestpractices

**Search**
The RWHAP community can easily search and identify intervention strategies that have been successful in improving HIV care for clients.

**Share**
RWHAP-funded organizations can submit information about interventions that have worked in their program to support replication by other RWHAP recipients or subrecipients. **Submit yours today!**
TargetHIV.org/bestpractices/submission-form

**Share feedback on the RWHAP Best Practices Compilation**

The John Snow, Inc. (JSI) and TargetHIV.org team is gathering feedback from the RWHAP community about the Compilation in March and April, 2022.

We would like to hear from you!

**Learn more and sign up today!**
targethiv.org/blog/share-feedback-best-practices-compilation

# E2i Toolkits



- The E2i initiative was a **four-year** project to facilitate the rapid implementation and evaluation of **11 intervention strategies.**
- The **goal** was to understand whether these intervention strategies could improve outcomes for clients in **four focus areas** in Ryan White HIV/AIDS Program settings.

# Coordination, Dissemination and Replication of Innovative HIV Care Strategies in the RWHAP



https://targetHIV.org/IHIP

- **Purpose:** To support the coordination, dissemination, and replication of innovative HIV care strategies in the Ryan White HIV/AIDS Program (RWHAP) through the development and dissemination of implementation tools and resources.
  - **Contractor: The MayaTech Corporation**
- **Key Resources and Assistance Available to RWHAP Recipients and Providers:**
  - Implementation tools and resources
  - Capacity building TA webinars
  - Peer-to-peer TA on the featured interventions
  - Support in the development and dissemination of implementation tools and resources
    - Webinars
    - One-on-one TA
  - Helpdesk (**ihiphelpdesk@mayatech.com**)

# SPNS STI Initiative


Addressing STIs: Ask. Test. Treat. Repeat.

Four evidence-based interventions:

1. Sexual history taking using audio computer assisted self-intervention
2. Patient self collection of urine and extragential specimens
3. Provider education
4. Sexual and gender minority welcoming measures

Sign-up to receive a "starter kit" bag of resources for Addressing STIs:
Ask. Test. Treat. Repeat.

https://docs.google.com/forms/u/0/d/1RkPqF4ZAqalFfY66VdvhaGaOPnSWhSKrDKxvEiiFVN0/viewform?edit_requested=true#settings

# New SPNS Initiatives in 2022

- **Supporting Replication (SURE) of Housing Interventions in the Ryan White HIV/AIDS Program,** *2022-2026*
- **Emerging Strategies to Improve Health Outcomes for People Aging with HIV,** *2022-2025*
- **Telehealth Strategies to Maximize HIV Care,** *2022-2025*

# SPNS Initiatives – Additional Information

**Descriptions of SPNS Initiatives can be found at:**

Part F: Special Projects of National Significance (SPNS) Program | Ryan White HIV/AIDS Program (hrsa.gov)

IHIP: Integrating HIV Innovative Practices | TargetHIV

# Policy Resources

# Policy Clarification Notices and Program Letters

- Policy Notices (PN) and Policy Clarification Notices (PCN)
  - https://ryanwhite.hrsa.gov/grants/policy-notices
  - Recently released PCNs include:
    - PCN 21-02: Determining Client Eligibility & Payor of Last Resort in the Ryan White HIV/AIDS Program
    - PN 21-01: Waiver of the Ryan White HIV/AIDS Program Core Medical Services Expenditure Requirement
- Program Letters
  - https://ryanwhite.hrsa.gov/grants/program-letters

# Policy Questions

Policy Clarification Notice (PCN) or Program Letter Questions?

- RWHAPPolicy@hrsa.gov

# Listening Session: Policy Clarification Notice 16-02
## Ryan White HIV/AIDS Program Services: Eligible Individuals & Allowable Uses of Funds

- Have you experienced challenges or barriers in providing or accessing services based on the service category descriptions outlined in Policy Clarification Notice 16-02?

- Are there new or emerging needs or service delivery models that pertain to the service categories that HAB should consider?



Please join HAB's Division of Policy and Data during our **listening session at the NRWC to learn how to access, provide, and improve services and service delivery in the Ryan White HIV/AIDS Program!**

# Technical Expert Panels

- **Optimizing HUD-assisted Housing among People in Need of HIV Care and Prevention Services – Technical Expert Panel (TEP)**
  - **August 2022**
    - Examine the facilitators and barriers for accessing HUD-assisted housing (including, but not limited to the Housing Opportunities for Persons with AIDS program) for communities affected by or living with HIV
    - Explore systemic and social housing barriers, understand known and needed community resources to help foster coordination, examine ways to incorporate trauma-informed care approaches that reduces stigma, and inform future areas of collaboration between HRSA, HUD and CDC
- **SPNS Health Information Technology TEP**
  - **July 2022**
- **Implementation Science in the Ryan White HIV/AIDS Program TEP**
  - **May 2022; Executive Summary Forthcoming**

# Technical Expert Panels (Cont.)

- **Addressing the Health Care and Social Support Needs of People Aging with HIV (November 2020)**
  - https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/resources/hrsa-aging-tep-summary.pdf
- **Dimensions of HIV Prevention and Treatment for Black Women (October 2020)**
  - https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/resources/hrsa-black-women-hiv-tep-summary-508.pdf

# Clinical Quality Management (CQM) TA and Policy

# Requesting CQM TA

<https://targethiv.org/ta/cqm>

# RWHAP CQM Listserv

- Place for people to:
  - Share ideas and resources
  - Make announcements
  - Ask questions
  - Seek resources
- More information and link to sign up:
  - https://ryanwhite.hrsa.gov/grants/quality-of-care

# Clinical Quality Management Questions

Clinical Quality Management Questions???

- RWHAPQuality@hrsa.gov

# Other Announcements

# Call for CHAC Nominations

- HRSA accepts nominations for the CDC/HRSA Advisory Committee on HIV, Viral Hepatitis and STD Prevention and Treatment (CHAC) on open-continuous basis.

- To nominate yourself or someone else, submit:
  - A letter of interest or personal statement from the nominee stating how their expertise would inform the work of CHAC;
  - A biographical sketch of the nominee (500 words or fewer);
  - A copy of the nominee's resume or curriculum vitae; and
  - The nominee's contact information (address, daytime telephone number, and email address).

- All nominations will be kept on file for two years.

- For questions about CHAC or to submit a nomination, email **CHACAdvisoryComm@hrsa.gov**.
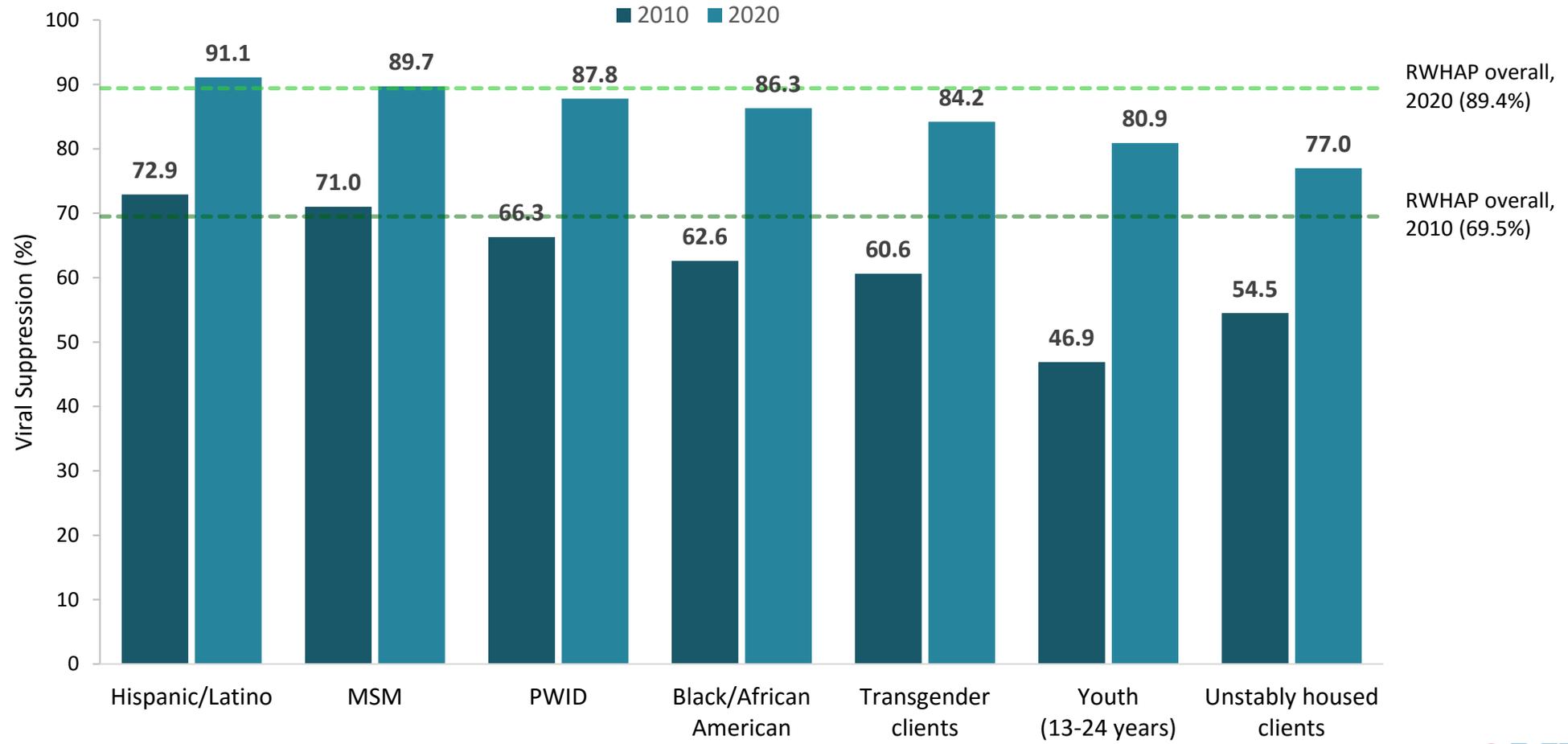
*For additional information visit* **https://www.cdc.gov/faca/committees/chachspt.html**

# Break

# Part A Jurisdiction Data

# Viral Suppression among Key Populations Receiving RWHAP Services in EMA/TGAs, 2010 and 2020



Legend: 2010, 2020
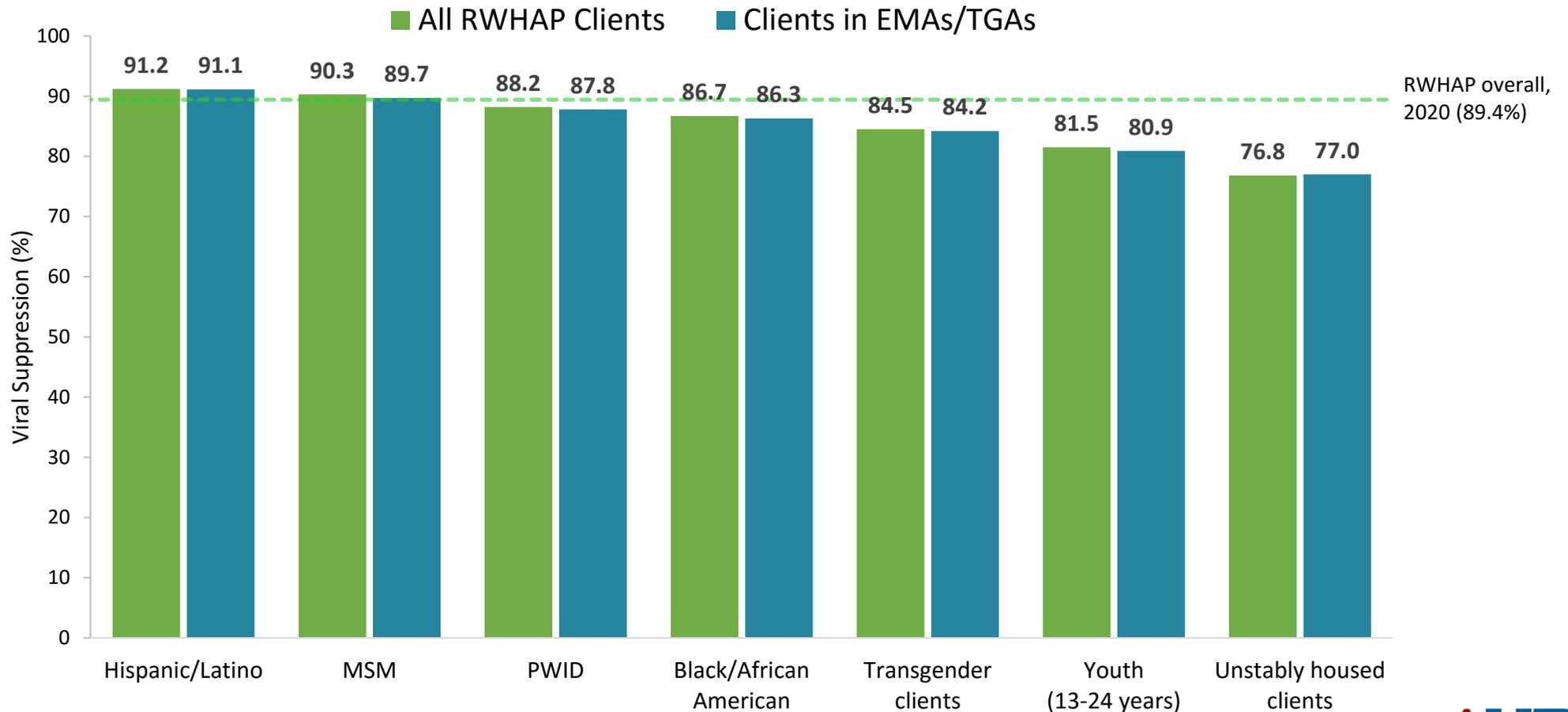
| Population | 2010 | 2020 |
|---|---|---|
| Hispanic/Latino | 72.9 | 91.1 |
| MSM | 71.0 | 89.7 |
| PWID | 66.3 | 87.8 |
| Black/African American | 62.6 | 86.3 |
| Transgender clients | 60.6 | 84.2 |
| Youth (13-24 years) | 46.9 | 80.9 |
| Unstably housed clients | 54.5 | 77.0 |

RWHAP overall, 2020 (89.4%)

RWHAP overall, 2010 (69.5%)

Y-axis: Viral Suppression (%)

Hispanics/Latinos can be of any race.
*Viral suppression:* ≥1 OAHS visit during the calendar year and ≥1 viral load reported, with the last viral load result <200 copies/mL.

HRSA Ryan White HIV/AIDS Program

# Viral Suppression among Key Populations: Comparison of All RWHAP Clients and RWHAP Clients Receiving Services in EMA/TGAs, 2020



Legend: ■ All RWHAP Clients  ■ Clients in EMAs/TGAs

Y-axis: Viral Suppression (%)

RWHAP overall, 2020 (89.4%)

| Population | All RWHAP Clients | Clients in EMAs/TGAs |
|---|---|---|
| Hispanic/Latino | 91.2 | 91.1 |
| MSM | 90.3 | 89.7 |
| PWID | 88.2 | 87.8 |
| Black/African American | 86.7 | 86.3 |
| Transgender clients | 84.5 | 84.2 |
| Youth (13-24 years) | 81.5 | 80.9 |
| Unstably housed clients | 76.8 | 77.0 |

Hispanics/Latinos can be of any race.
Viral suppression: ≥1 OAHS visit during the calendar year and ≥1 viral load reported, with the last viral load result <200 copies/mL.

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# Using Data for Programming

# Why Focus on Data?
## Viral Suppression among RWHAP Clients, by State, 2010 and 2020



IN 2020
# 89.4%
**VIRALLY SUPPRESSED**
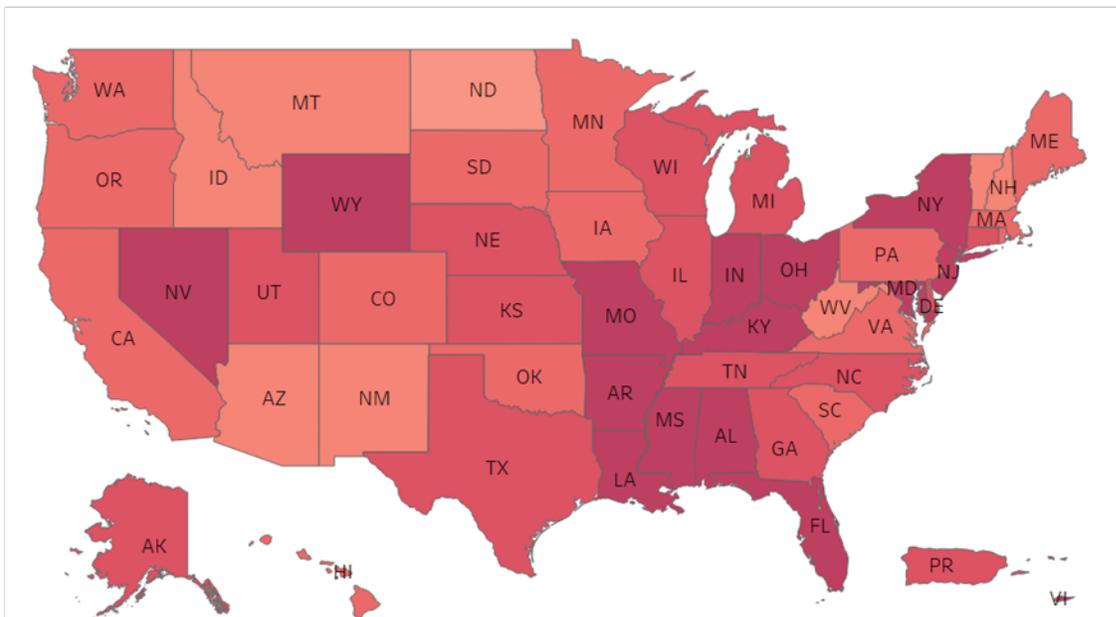
IN 2010
# 69.5%
**VIRALLY SUPPRESSED**

Viral Suppression (%)
- 52.9-66.9
- 70.0-72.9
- 73.0-79.9
- 80.0-87.9
- 88.0-89.9
- 90.0-92.9
- 93.0-98.8

*Viral suppression:* ≥1 OAHS visit during the calendar year and ≥1 viral load reported, with the last viral load result <200 copies/mL.
ª Puerto Rico and the U.S. Virgin Islands.

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# Data Challenges

- **Data System Interoperability**
  - Different data systems require effort and funds to bridge
  - Federal, state and local programs use different definitions making it hard to compare data

- **Data Sharing Agreements**
  - Client confidentiality concerns can be complicated
  - Not always enough staff to create and implement agreements

- **Data Quality**
  - Staff churn places a burden on recipients for ongoing TA to staff and to subrecipients
  - Analyzing for and addressing data quality issues is an additional staff burden

- **Incorporating Qualitative Data**
  - Often involves coordinating clients representative of priority populations
  - Data systems often not set up to use this type of data.

# Solutions

- **Build data collection and analysis into all aspects of programs**
  - There is space to incorporate data into program, planning, fiscal operations as well as CQM
  - Create champions across your agency

- **Dedicate staff to collect and analyze data and to provide TA to subrecipients**
  - Could be internal staff or a third party contract
  - University systems often have research arms and interns that could be a part of the process.
  - How can you leverage different funding sources to update and revise data systems
  - Sharing and Integrating HIV Client Data Across Provider Organizations to Improve Service Coordination: **https://targethiv.org/sites/default/files/file-upload/resources/SPNS_HOPWA_Data_integration.pdf**

- **Create a data feedback with key stakeholders and subrecipients**
  - By letting people know how their data is used you create buy-in
  - Clients know that you take their feedback seriously

# Introducing the Innovators

- Maricopa County Department of Public Health
- Cuyahoga County Board of Health

# Introduction to Maricopa County of the RWPA Phoenix EMA
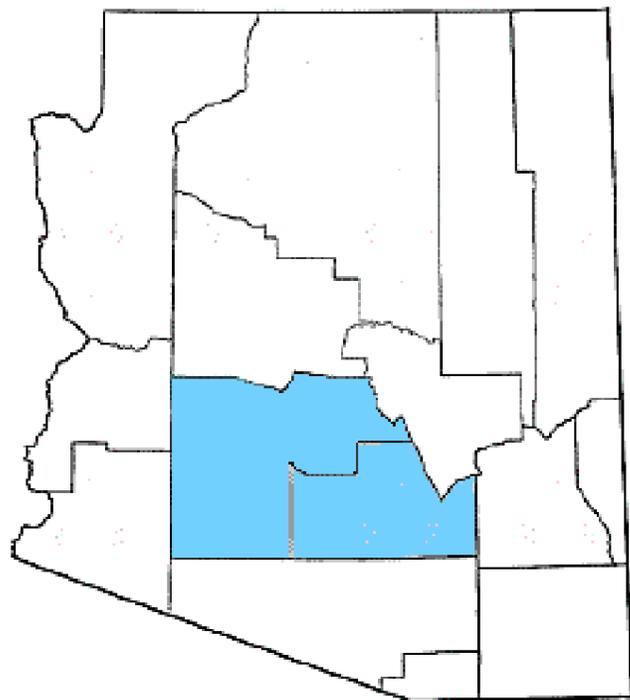
2 Counties (Maricopa & Pinal County)

~4th Largest County in the Country

14,182 People living with HIV

3 Quality Management Staff

13 Sub-Recipient Agencies

~1/2 are Community Based Organizations

1 EHE jurisdiction: Maricopa County

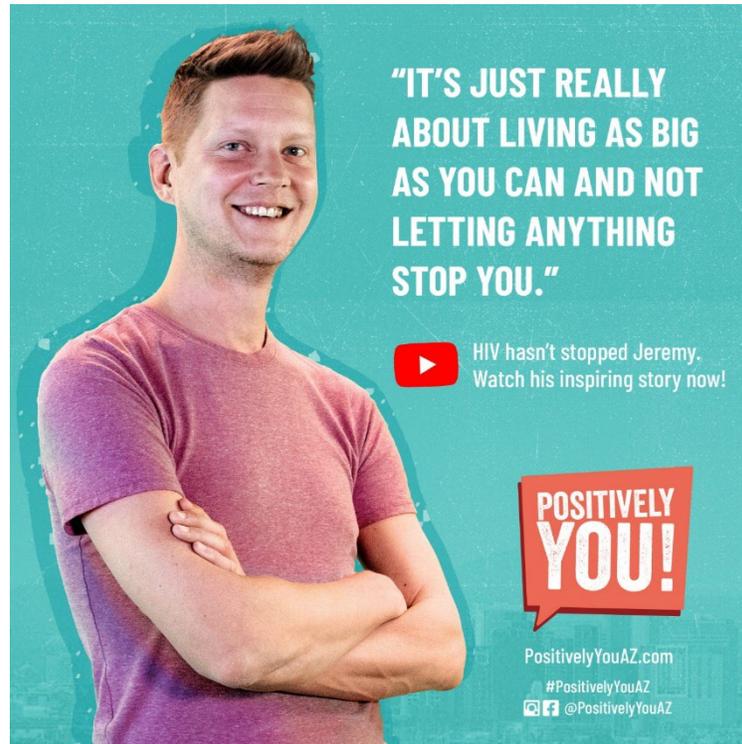# A strengths-based approach to data partnerships

**Sub-recipient**

**Recipient**

## *People with HIV*



"IT'S JUST REALLY ABOUT LIVING AS BIG AS YOU CAN AND NOT LETTING ANYTHING STOP YOU."

HIV hasn't stopped Jeremy. Watch his inspiring story now!

POSITIVELY YOU!

PositivelyYouAZ.com
#PositivelyYouAZ
@PositivelyYouAZ

**Connection to Community**

**Subject Matter Expertise**

**Ability to Execute on Data**

**Identify strengths & weaknesses, eligibility data, shared purpose**

**QM Coaching**

**Create platforms for people to share their learning**

**Make templates & fancy graphs**

# Data Philosophy and Values in Maricopa County

## Data Points Represent People

Remember that every data point represents a person's life, health and well-being.

## Meet Sub-Recipients where they are

Work to minimize Sub-recipient time away from clients. Maricopa considers it a Recipient responsibility to provide more complex analysis and training.

## People like to see their own data

Where possible, present data breakouts for the specific agencies or for interest groups. Make it pretty and shareable. People connect more strongly with their own data.

## Use Data to Tell Stories

When sharing data, Recipient staff show AND tell – what's important. We keep a constant eye on the impact of erasure, equity and our own biases.

# Tools the Team Uses to Create Data Visualization and Reports

## Tools/Software

- CAREWare
- Web-based Continuum Tool
- Excel (including some automated tools)
- Piktochart
- Canva
- Access databases (including some automation)

**Ryan White Clients have viral load suppression rates that are 14% higher than the state average**

- Arizona
  N=16602
- Maricopa-Pinal
  N=12424
- RWPA-Phoenix EMA
  N=4600

69%   68%   83%

Suppression
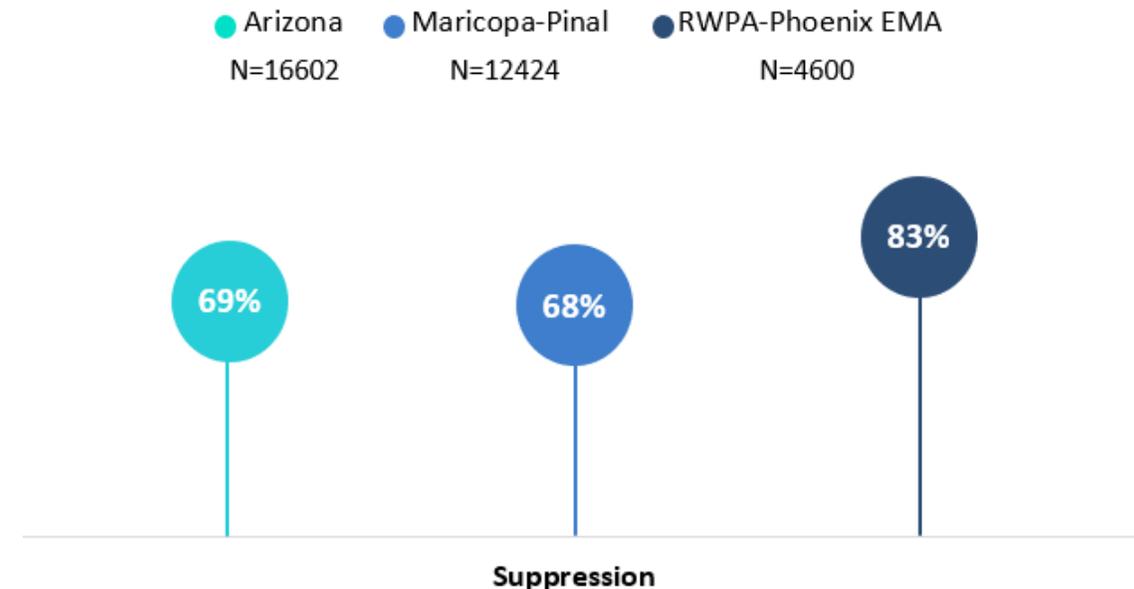
# Maricopa Data Strengths, Limitations and Opportunities

- Maricopa County has a Central Eligibility system that houses all client eligibility application data.
  - Major CAREWare upgrades → Major report, system testing and work!
  - Even with the Central Eligibility data repository – each year our data gets stronger as we identify gaps and limitations and ways to address them.

- Most Maricopa clients are not accessing Ryan White Part A funded Outpatient Ambulatory Health Services.
  - Choose to require lab copies with eligibility applications.
  - Thanks to state for working out how to import directly from surveillance.

- EHE funds can be used for data infrastructure initiatives.
  - Building new automated data tools with vendors or IT programs are staff intensive projects.
  - Our best data is Ryan White specific. Need more real-time data from prevention and surveillance if we're going to fully measure progress towards ending the epidemic.

# Two Focuses for Maricopa Data

## Aggregate Data



## Individual, Named Data

# Roadmap for aggregate data

Data entered & extracted from CAREWare

Identify priority populations from calculator

Client eligibility Application

Data loaded into health disparity calculator

Use the aggregate data!

# Key Aggregate Data Strategy: Health Disparity Calculator



- Analyzes almost 200 unique population groups

- Automated excel sheet that speeds up calculations

- The calculator is featured in a session titled "Let the Data Do the Work for You: Designing an Automated Disparities Calculator"

# Leveraging Aggregate Data for Conversation and Change

- Use health disparity calculator, paired with surveillance data, to identify priority populations that experience significant disparities. Health Disparity calculator informs and helps monitor progress with:
  - Minority AIDS Initiatives
  - EIIHA priority populations
  - EHE populations

- Create engaging provider dashboards
  - Helps Sub-recipients answer questions about "how I am doing?" and "how do we compare to others?"
  - Some Sub-recipients post on their walls for all clients to see, share with their Community Advisory Boards, clients, agency leadership and boards

- Focus EHE media campaigns model/ambassador selection and social media placements.

- Report on progress and gaps to Planning Bodies for annual planning and allocations.

- Engage political leadership with jurisdiction specific data.

# Framework for extracting named data

**1. Client Eligibility**

Eligibility application is entered into CAREWare

**2. Unsuppressed Reports created from CAREWare extract**

Named, individual data is sorted into system/provider Unsuppressed Reports. Could use linkage or retention instead.

**3. Flag Clients in Priority Populations**

Flag clients that match priority populations identified through the health disparity calculator

Provider and QM teams are given Unsuppressed Reports and instructions through Provider Data Labs

Sub-recipients develop Plan, Do, Study Act projects focused on individuals from the Unsuppressed Reports

Sub-recipients report out on their projects and outcomes during CQM meetings

**4. Distribute Unsuppressed Reports**

**5. PDSAs**

**6. Improve Processes or Eliminate small disparities**

# Using Named Data to Improve Processes and Eliminate Small Disparities

Approach translates continuum data to actionable and specific follow up. Interventions include:

- Recipient development and secure transfer of agency specific Unsuppressed Report.  Could be created for other indicators (linkage, retention, etc.)

- Host Provider Data Labs/Office Hours to support agencies in reviewing and understanding data

- Can choose to zoom in on smaller disparities and eliminate them

- Use a case investigation model with named data and redesign services for those most at risk

# Key Individual Strategy:
# Case Investigations



GY22 Care Directions Table of Gaps/Barriers (N =36)
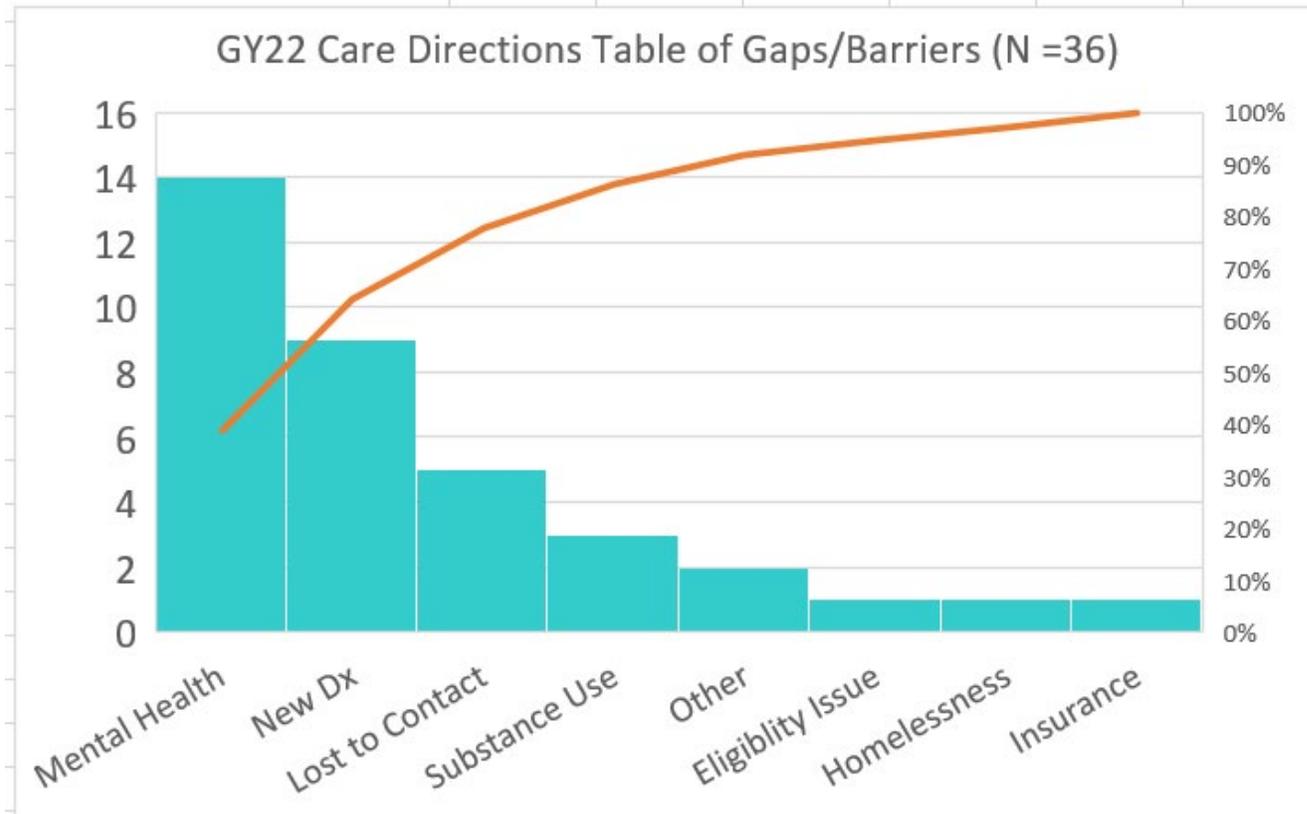
- Uses the Pareto Principle to redesign system for those most at risk
  - Sub-recipients work a list of clients that are not meeting desired indicator
  - Identify reasons each client doesn't meet our criteria
  - Tally reasons and create a pareto chart
  - Develop targeted plans to address most common issues
- Shout out to Kennedy Health EIP in New Jersey's Kennedy Health who has done this before!

# Interested in more?

- Like and follow @PositivelyYouAZ!
- Credit to our Quality Management Team!
  - Jeremy Hyvärinen, Quality Manager, Jeremy.Hyvarinen@maricopa.gov
  - Karina Tello-Medina, Quality Management Analyst, Karina.TelloMedina@maricopa.gov
  - Javier Marquez, Community Engagement Coordinator, Javier.Marquez@maricopa.gov
- Contact
  - Carmen Batista, Ryan White Part A Manager at Carmen.Batista@maricopa.gov

# How to Use Plans to End the Epidemic

Cuyahoga County Board of Health
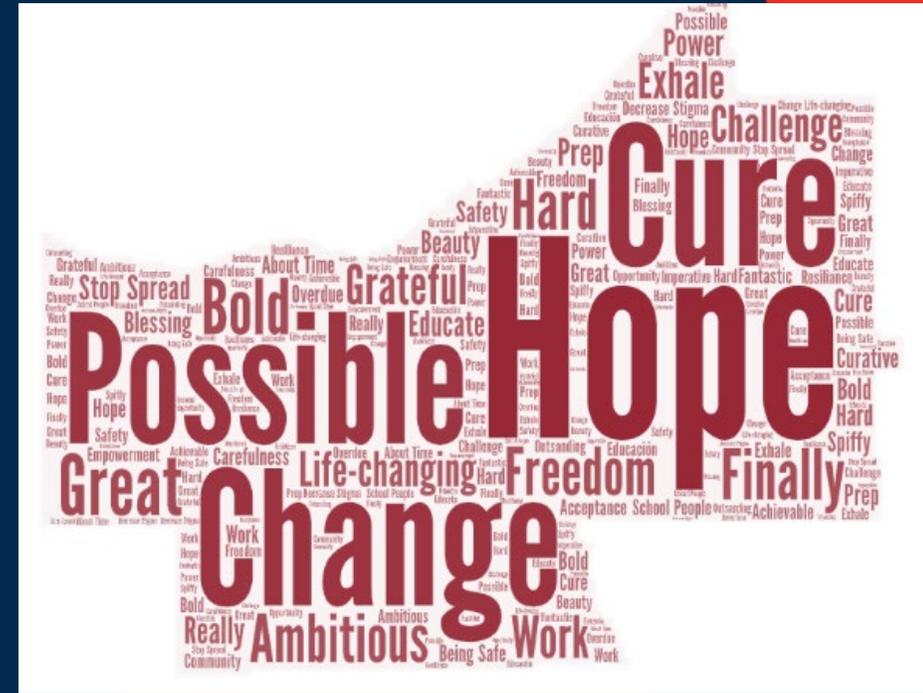
# Cuyahoga County, Ohio: Profile

- Located in northeast Ohio (Cleveland area)
- Population: 1,264,817
- Demographics:
  - Black - 370,895 (29%)
  - Hispanic - 83,327 (6.5%)
- 17% Poverty Level
- HIV Priority Populations:
  - Under age 30
  - African American
  - MSM

# Organizational Structure

Board Members

Appointed by an Advisory Council

Health Commissioner

Medical Director

Administration Services

Epidemiology, Surveillance, and Informatics

Environmental Public Health

Nursing Services

Population Health
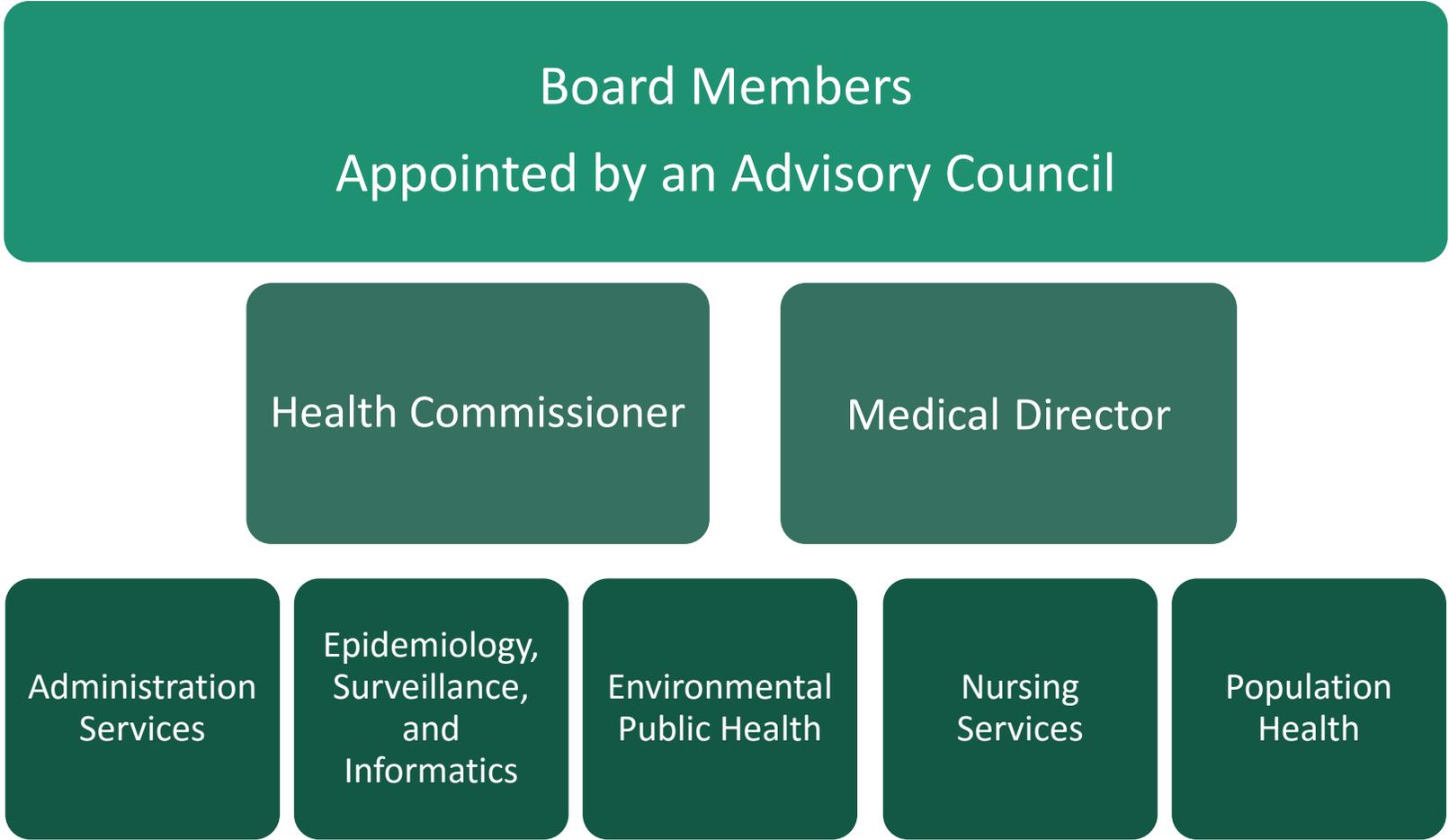
# HIV Programs, a Timeline

- **2010-2012 to Present**
  - Ryan White: Part A (est. TGA 1996)
  - Title X (est. ODH 1970)
- **2020**
  - EHE Care: HRSA
  - HIV/STI Prevention
  - STI Supplemental
- **2021**
  - EHE Prevention: ODH/CDC
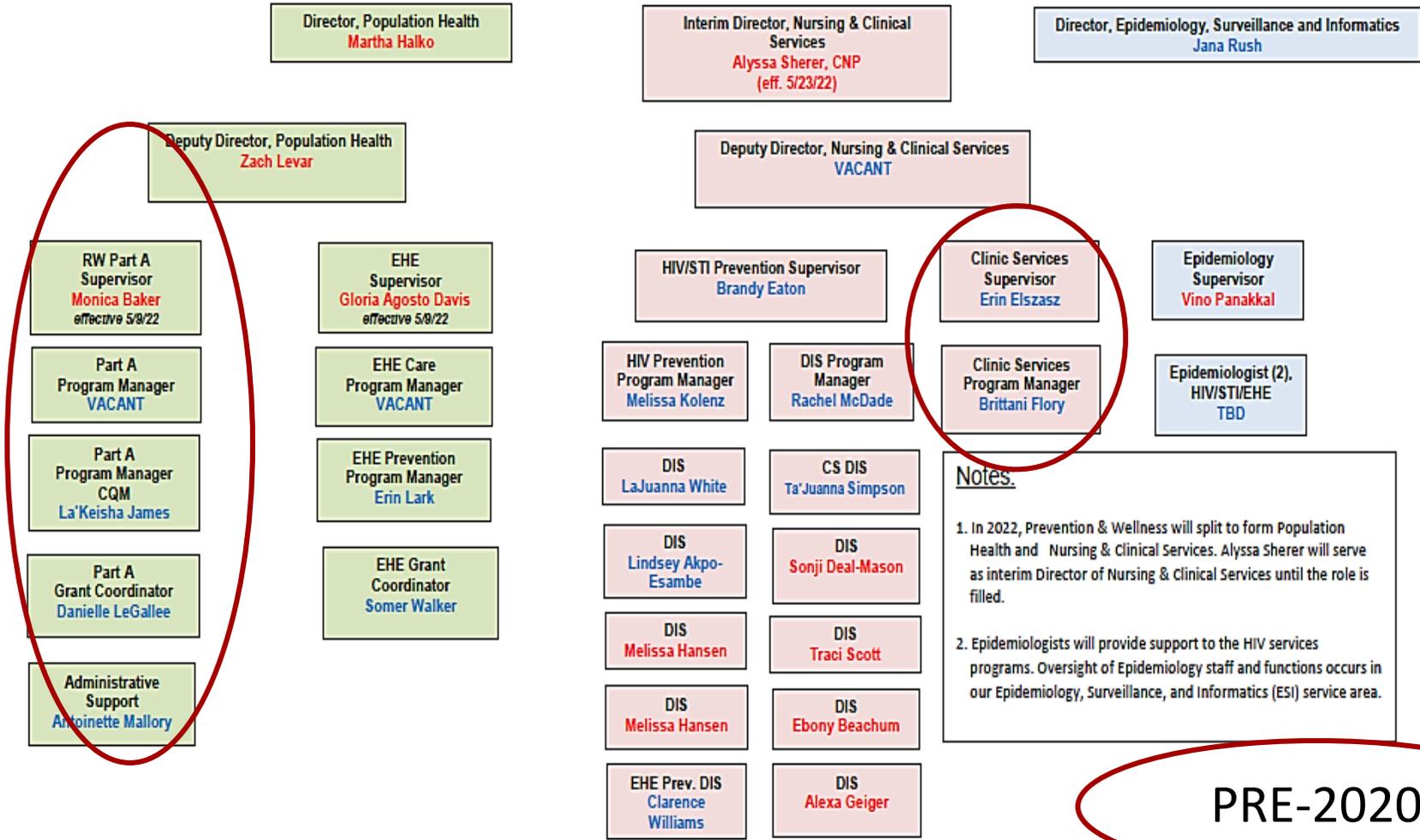
# Other Local HIV Funding

- Ryan White Part B, Part C, Part D
- HOPWA
- EHE FQHCs
- CDC Foundation: CBOs
- Gilead
- National Institutes of Health: CFAR
- SAMHSA
- AIDS Funding Collaborative
- CDBG

# Plans. Plans. And More Plans.

- EHE Cuyahoga Community Plan
- EHE Care Work Plan
- EHE Prevention / CDC Work Plan
- HIV Prevention Work Plan
- STI Prevention Work Plan
- FQHC EHE Work Plans
- AIDS Funding Collaborative Strategic Plan
- ODH Integrated Plan

# Internal Re-Organization

- Large Influx of Funding
- Build Increased Capacity
- Re-Structuring of Programs
  - Integrate EHE Care and Prevention
  - Manageable in Scope/Size
  - Increased Collaboration

FUNDING

# Program Integration

- Creating point of contact for systems (not just grants)
- Management Teams
- Multi-Grant Contracts
- Joint Websites
- Integrated Marketing
- Strategic Partnerships
- Community Advisory Group

# Contact

CUYAHOGA COUNTY

BOARD OF HEALTH

YOUR TRUSTED SOURCE FOR PUBLIC HEALTH INFORMATION

5550 Venture Drive   Parma, Ohio 44130
216-201-2000  www.ccbh.net

# Break

# Approaches to End the Epidemic

# Ending the HIV epidemic

| People with HIV not virally suppressed | People newly diagnosed with HIV | People with HIV not in care |
| --- | --- | --- |
| • Improve viral suppression rates<br>• Decrease disparities | • Enhance linkage to care<br>• Enhance engagement in care | • Expand re-engagement in care<br>• Improve retention in care |

# Approaches

- Implement allowable activities
- Maximize funding sources and technical assistance resources
- Communication
- Collaborate with community partners
- Be creative and innovative

# Status Neutral Approach

New York City

# Implementing a Status Neutral Approach Lessons Learned from the New York Eligible Metropolitan Area

Gina Gambone, MPH

Director of Quality Management and Program Implementation, HIV Care and Treatment Program

2022

Bureau of Hepatitis, HIV, and Sexually Transmitted Infections
*Envisioning a New York City without transmission or illness related to viral hepatitis, HIV, and sexually transmitted infections.*

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# Today's Presentation

- New York City's HIV Status Neutral Framework

- Status Neutral Care Coordination Program
  - Program Overview
    - Adapted from New York City's RWPA Medical Case Management Program (Care Coordination Program)
  - Successes
  - Challenges

# New York City's HIV Status Neutral Prevention and Treatment Cycle
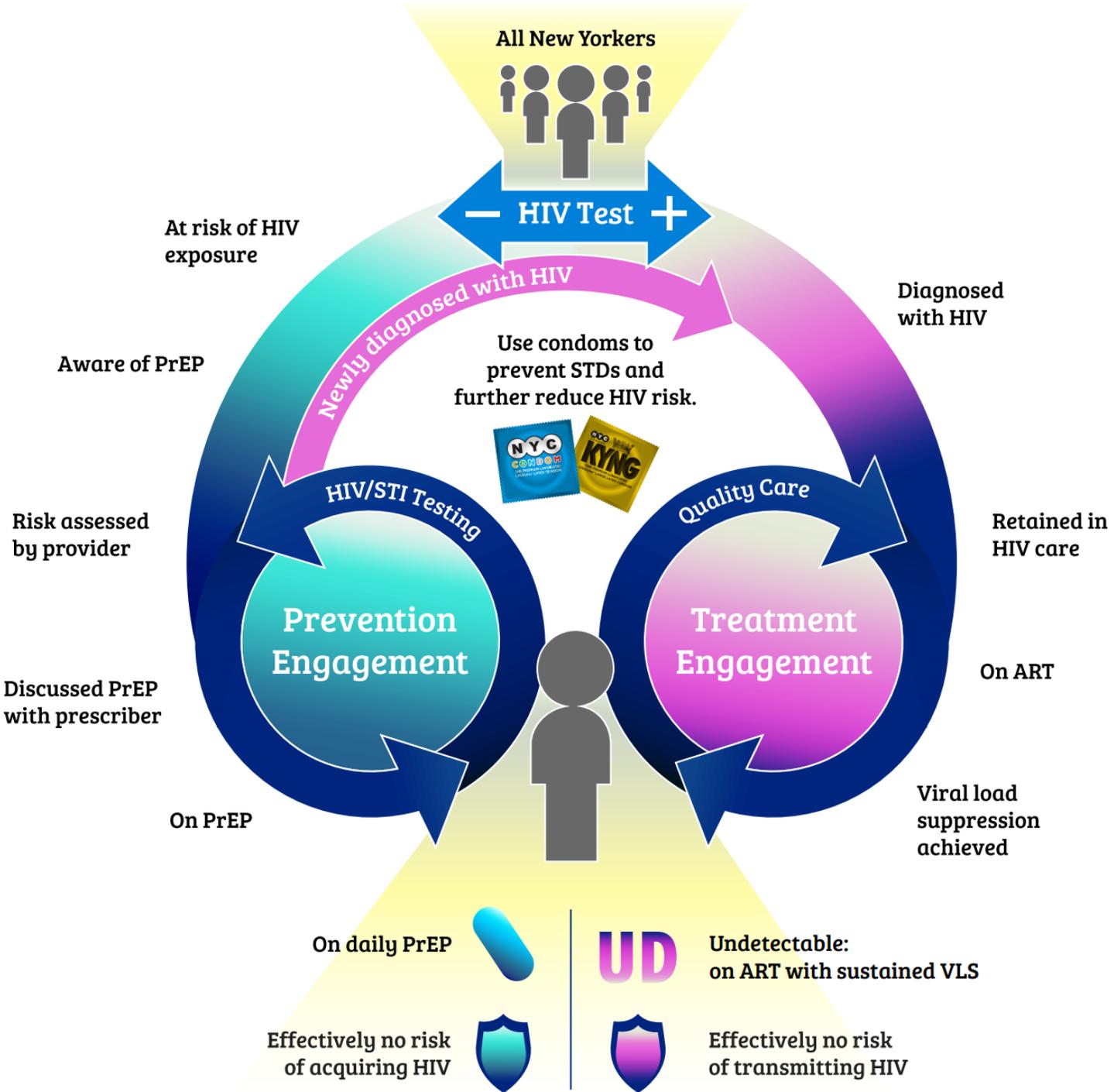
# PROGRAM OVERVIEW – Status Neutral Care Coordination Program

Status Neutral Care Coordination (SNC) utilizes a client-centered patient navigation approach to connect individuals at risk of HIV infection to effective biomedical tools to prevent HIV as well as needed medical and social support services.

- **Adapted from New York City's RWPA Care Coordination Program**, which has been designated by the CDC as a structural evidence-based intervention to improve HIV outcomes [1]

1. https://www.cdc.gov/hiv/pdf/research/interventionresearch/compendium/si/cdc-hiv-HIV_Care_Coordination_Program_CCP_SI_EBI.pd

# PROGRAM OVERVIEW – Status Neutral Care Coordination Program

## Funding Source

- New York City Tax Levy Ending the Epidemic funding: $1.07 million (annually)

- Funding period: July 2016 – June 2022

- 8 SNC contracts:
  - 2 Community-based organizations
  - 2 Community health centers
  - 4 Medical centers

## Program Model

- Short-term patient navigation to provide clients at risk for HIV with access to entitlements/benefits (including health insurance and patient assistance programs), linkages to needed medical and social support services (e.g., PrEP, PEP, testing/ treatment for HCV and STIs, behavioral health, housing), and initial support with engagement in services

## Program Goals

- Increase awareness of and access to PrEP and PEP
- Provide linkage to needed medical and social support services; and
- Ensure clients have mechanisms to pay for indicated services

## Priority populations

- Individuals with HIV-positive partner(s)
- Young MSM
- Black and Latino MSM
- Transgender women and men who have sex with men
- Individuals with recent IDU and/or crystal meth use
- Individuals who engage in transactional sex
- Cisgender Black and Latina women

# PROGRAM OVERVIEW – Status Neutral Care Coordination Program

### SNC Priority Populations through 12/31/2021 (N=3,441)*



Bar chart — Client Count (y-axis, 0 to 1600) vs Priority Populations (x-axis):

- Individuals with an HIV-positive partner: 8.7%
- Young MSM**: 12.5%
- Black and Latino MSM: 23.9%
- Transgender women and men who have sex with men: 1.0%
- Individuals with recent IDU and/or crystal meth use: 2.1%
- Individuals who engage in transactional sex: 4.8%
- Black and Latina cisgender women: 22.1%
- All other clients: 41.4%
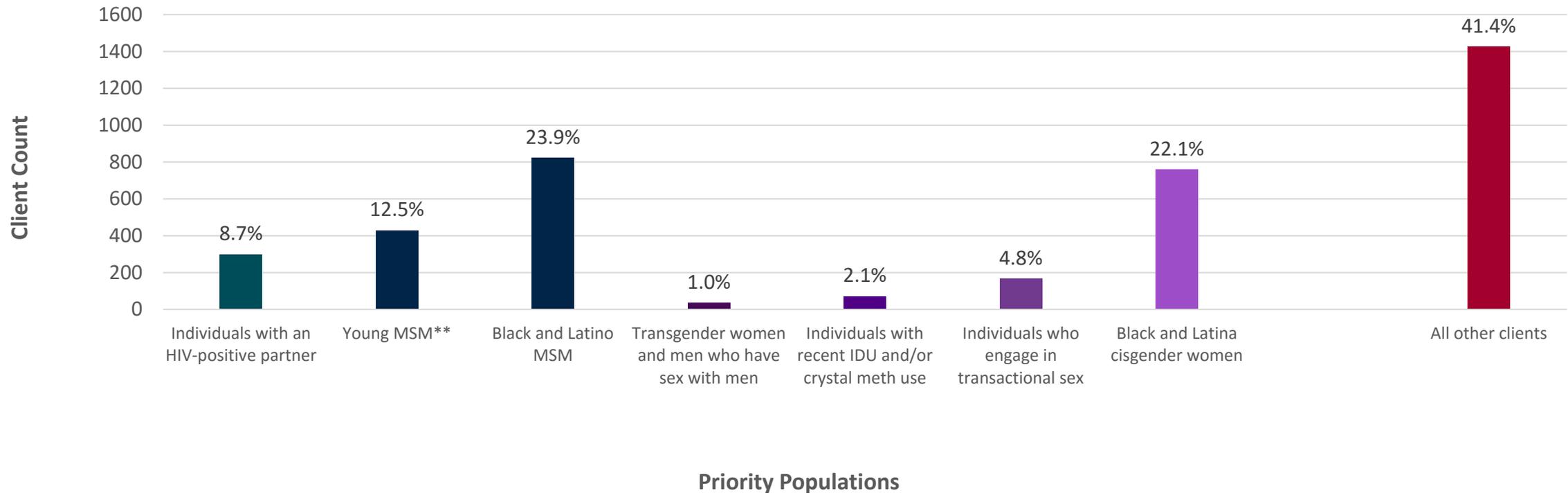
*Total unique clients enrolled in SNC through 12/31/2021. Percentages do not equal 100% because clients can fit within >1 priority population category
**Young MSM defined as MSM ages 18-29 years old

# Adapted from NYC's RWPA Medical Case Management Program

**RWPA CARE COORDINATION**

**HIV+**

Address HIV Healthcare disparities by facilitating access to care and other services

Leads orientation, **assessment** and **care planning**
Verifies program eligibility
**Coordinates** with medical providers
Facilitates **case conferences**

Provides **health education**
Provides mDOT and **accompaniment** to appointments
Provides **navigation** and **support** to clients
Provides **appointment reminders** and follow-up
Provides **linkages** to needed services
Leads client **engagement** and **re-engagement** in service elements
Participates in **planning** and **assessment** activities

**CARE COORDINATOR / CASE MANAGER**

**NAVIGATOR**

**STATUS NEUTRAL CARE COORDINATION**

**HIV-**

Address disparities in HIV incidence by facilitating access to PrEP and other services

Leads orientation, **assessment** and **care planning**
Verifies program eligibility
**Coordinates** with medical providers

Provides **health education**
Provides **accompaniment** to appointments
Provides **navigation** and **support** to clients
Provides **appointment reminders** and follow-up
Provides **linkages** to needed services
Leads client **engagement** and **re-engagement** in service elements
Conducts **outreach** activities to identify new clients

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# Successes

- Practical assistance provided to those seeking to initiate PrEP by assessing their health care coverage needs and helping them cover the cost of PrEP, if needed

- High PrEP linkage rates among Black and Latino MSM, young MSM, transgender women, and persons who use crystal meth

- High social support linkage rates among Black and Latina cisgender women and persons who engage in transactional sex

# Challenges

- Lower PrEP navigation and linkage rates among Black and Latina cisgender women and persons who engage in transactional sex

- Leveraging Ryan White medical case management to implement SNC
  - Mixed results

- Significant time and effort required for outreach
  - Addressed in contract updates made at renewals

- Clinical protocols for PrEP initiation/recall visits vary
  - Technical assistance recommendations to programs: at minimum, ensure patients start PrEP and return for follow-up visit

# Acknowledgements

**National RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT**

**New York City Department of Health, Bureau of Hepatitis, HIV, and STIs**

- Jelani Cheek
- Matthew Feldman
- Jennifer Carmona
- Mary Irvine
- Guadalupe Dominguez Plummer

**Status Neutral Care Coordination Programs in NYC**

- Argus Community, Inc.
- Callen-Lorde Community Health Center
- Community Health Action of Staten Island
- Institute for Family Health
- New York-Presbyterian Hospital
- St. Barnabas Medical Center
- SUNY Downstate Medical Center
- Wyckoff Heights Medical Center

# THANK YOU

Gina Gambone, MPH

ggambone1@health.nyc.gov

# Gender Affirming Care

San Francisco Department of Public Health

# Transgender Excellence Programs

San Francisco Department of Public Health

Nicky "Tita Aida" Calma, Director of Programs, SFCHC

Jenna Rapues, Director of Gender Health, SFDPH

Bill Blum, Director of HIV Health Services, SFDPH

2022

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ON HIV CARE & TREATMENT

# San Francisco Department of Public Health

- **HIV HEALTH SERVICES**
  - $15,202,489 in 2022-23 HRSA HAB Ryan White Part A funding
  - $2,000,400 in 2022-23 HRSA HAB Ending the HIV Epidemic funding
  - Services delivered to 5,622 unduplicated clients in the past year
  - 283 identify as Trans Women (5%)
- **Two RWPA/EHE Funded Programs focused on Trans Women:**
- **Trans Access** at the San Francisco Community Health Center
  - *Medical Case Management & Support Groups*
- **Gender Health** at San Francisco General Hospital/UCSF
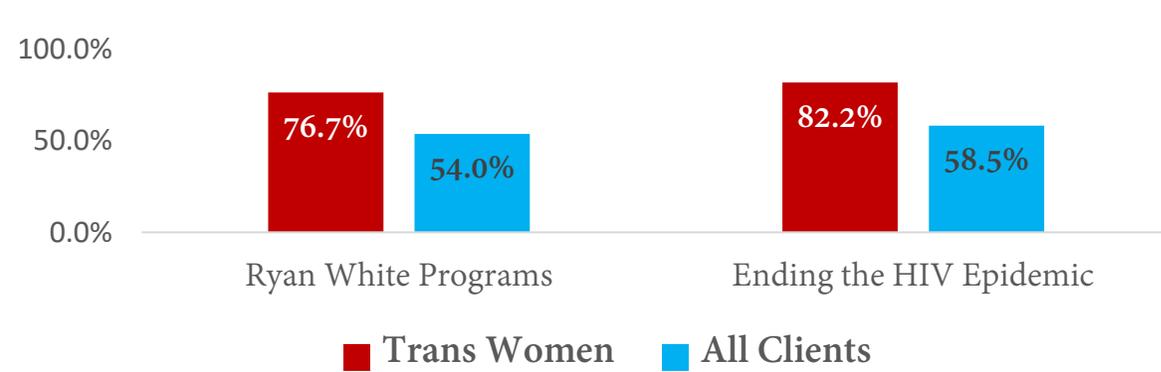  - *Peer Patient Access Navigation*

# Demographics of Transgender & Cis Gender Clients
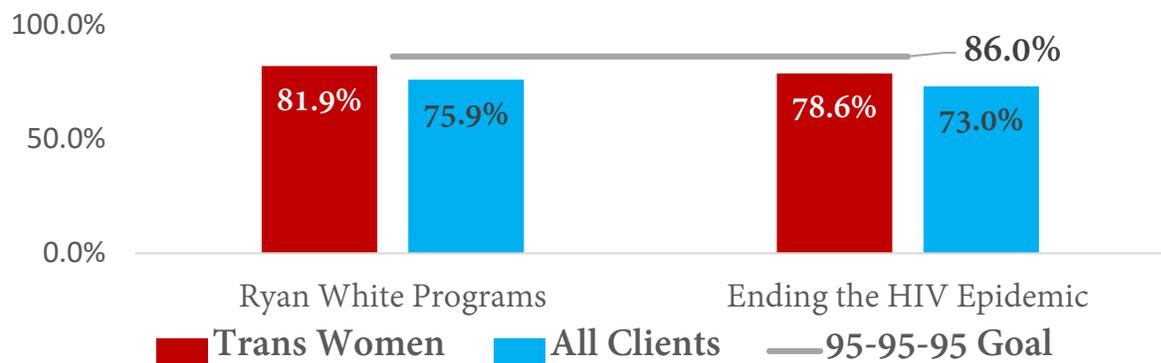
All data from ARIES, 6/1/2021 - 6/1/2022

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## Identify as POC - *(RW N = 270 , EHE N = 56)*



- Ryan White Programs: Trans Women 76.7%, All Clients 54.0%
- Ending the HIV Epidemic: Trans Women 82.2%, All Clients 58.5%

■ Trans Women  ■ All Clients

Compared to the total client population, Trans Women within the HIV Health Services system of care are more likely to:

- identify as persons of color
- be virally suppressed
- be younger in age

## Viral Suppression - *(RW N = 270 , EHE N = 56)*



- Ryan White Programs: Trans Women 81.9%, All Clients 75.9%
- Ending the HIV Epidemic: Trans Women 78.6%, All Clients 73.0%
- 86.0%

■ Trans Women  ■ All Clients  — 95-95-95 Goal

## Age Breakdown - *(Trans Women N = 283)*



| | 0-24 | 25-44 | 45-64 | 65+ |
|---|---|---|---|---|
| Trans Women | 0.7% | 43.0% | 50.2% | 6.1% |
| All Clients | 0.7% | 26.5% | 53.6% | 19.2% |

■ Trans Women  ■ All Clients

# Program Overview

TransAccess is a program to promote better health for Transgender Women of Color living HIV in San Francisco.
Happens every Thursday, from 2:00pm- 5:00pm at 730 Polk Street, 4th Floor, San Francisco.

Core Values:

- Trans affirming care

- Self-actualizing services

- Mindful medicine

- Care coordination and continuity

- Harm reduction

- Community-centered

- Radical healthcare

# Trans Access One Stop Shop

## Onsite Mental & Medical Services

- **HIV Care**: diagnosing HIV; monitor disease progression; provide and oversee HIV antiretroviral therapy and opportunistic infection prophylaxis; address adherence challenges.
- **Transgender Health Care:** providing care to transgender and gender non-conforming client populations, with special emphasis on assessing appropriateness and readiness for gender transition treatments and therapies.
- **Primary Care:** providing primary care services including management of all general medical conditions not covered above, such as hypertension, diabetes, and other medical problems.
- **Mental Health Care:** Social worker conducts psychosocial & mental health assessment and health needs & referral to services.
- coordinating complex care plans especially as it related to mental health and substance use

## Safe Space

- Safe, welcoming and respectful.
- Trans staffing or competent.

## TRANS ACCESS
### One Stop Shop

## Social Support Network

Drop-in Setting
Safe, welcoming and respectful.

## Case Management

- CM creates care/treatment plans in conjunction with client full care team.
- Providing referrals to services
  emergency housing/ shelter
  transitional housing
  permanent housing
  health insurance
  financial benefits/resources
  food assistance

## Care Navigation

- supporting client to actualize the care/treatment plan
- care/treatment plans are established at client entry
- plans are modified every 6 months or more frequently, as needed
- assisting clients in attending appointments
- conducting outreach including home visits for clients who have fallen out of care.

# SHE Boutique

Health Care That Never Goes Out of Style

**She Boutique** is a once a month extravagant shopping experience created by trans women for trans women.

Conceptualized by former staff member, Khilynn Fowler and current staff member, Erica Reyes. Staff of Trans Services hosts once a month free shopping extravaganza for trans women to have a unique shopping experience from carefully curated new and slightly used clothing, shoes, custom jewelry, make-up, skincare and hair care.

For Trans Access clients, after their medical appointments, they get priority to shop and enjoy the benefits of the **SHE BOUTIQUE.**

# TRANS ACCESS

## Strengths

- Supports SF's Ending the Epidemic Initiative by engaging trans women of color living with HIV to healthcare to access a variety relevant life saving services from medication adherence, viral suppression and taking charge of their health outcomes.

- Identifies members of the focus community who has dropped off from the medical bandwagon due to bad experiences in medical settings.

- Provides clients a comprehensive "wrap-around, one stop shop" in regards to their overall healthcare.

- Meeting clients where they are at in their lives- client centered.

## Challenges

- Gaining the trust of community members especially those who had bad experiences with the medical sector.

- Vulnerability of the community to substance use.

- Housing needs are scarce.

- Clients who do not see healthcare as priority due to other life issues.

- Disclosure of HIV status of clients to others creates stigma and animosity.

# Mission Statement

- Gender Health SF's mission is to increase access to quality gender-affirming health care for underserved transgender and non-binary people in San Francisco, regardless of immigration status and/or lack of income.

- Values:

  o Social justice

  o Community investment

  o Peer led

  o Harm reduction

  o Wellness

  o Advocacy

  o Compassionate whole-person care

# Integrated System-wide Access



- Culturally congruent patient programming
- Trans and nonbinary workforce development – "peer to professional"
- Wrap-around peer navigation under Behavioral Health Services, Mental Health Services Act
- Integrated, interdisciplinary care coordination (e.g., Nurse Practitioner, Behavioral Health Clinician)
- Pre-Surgical Assessments and Addendums
- Peer health education (bilingual, group, and one-on-one)
- Systems of care capacity building and training

# Peer Patient Navigation



- Assist patients realize their options for surgery

- Navigate intense paperwork and insurance requirements

- Proving peer-patient emotional and moral support

- Respond to patients' questions, informed consent process, and surgical education

- Assist with ensuring patients are prepared before and after surgery

# San Francisco Ending the HIV/HCV/STI Epidemics (ETH) Initiative
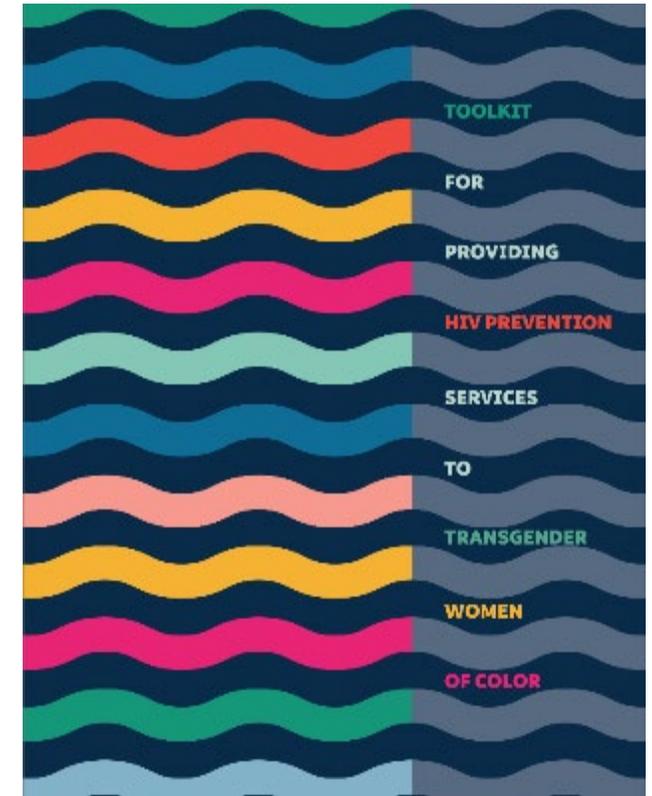
- Peer patient navigator to provide support for admission and retention in the program, including helping clients stabilize their lives through harm reduction strategies and accessing HIV/HCV/STI prevention and care

- Patient referrals to GHSF initiated by the patent's primary care provider and/or behavioral health clinician

- Referrals and linkages to HIV/HCV/STI prevention and care services

- Enhanced patient education and wellness programming

# Comprehensive Client-Centered Care and Services for TPLWH

- Understanding Competing Priorities
- Meeting Trans Women of Color where they are
- Social Determinants of Health for Trans Women of Color

**Best Practices**

1) Assess individual needs of trans women of color
2) Address client-identified needs in addition to offering HIV prevention and care services
3) Offer comprehensive services
4) Provide gender-affirming care and services

TOOLKIT FOR PROVIDING HIV PREVENTION SERVICES TO TRANSGENDER WOMEN OF COLOR

Centers for Disease Control and Prevention, 2019

https://www.cdc.gov/hiv/effective-interventions/library/toolkit-transgender-women-of-color/implementation-materials/cdc-hiv-ei-twoc-toolkit.pdf

# Thank you

- Bill Blum, Bill.Blum@sfdph.org
- Nicky "Tita Aida" Calma titaaida@sfcommunityhealth.org
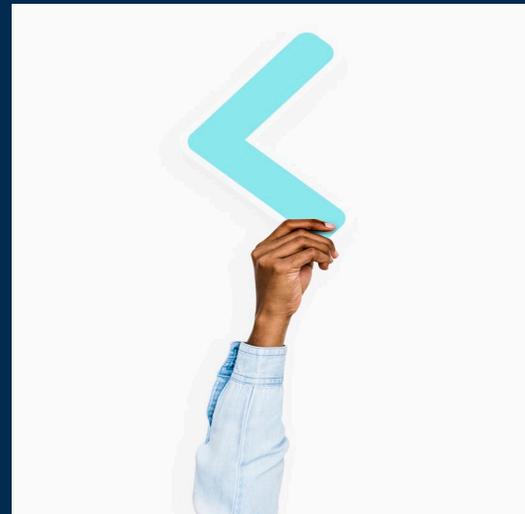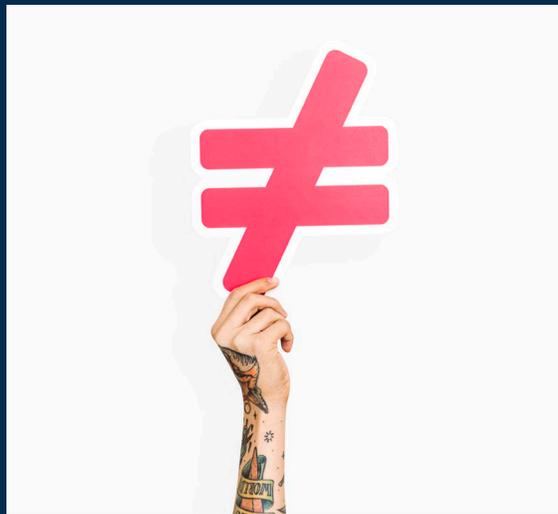- Jenna Rapues, jenna.rapues@sfdph.org

# Health Equity

Philadelphia

# Equity Work

- Health Equity Policy

- Drafting and execution of health equity assessments for providers & grantees

- Execution of equity plans for grantees

- Cross collaborations and trainings on health equity with several PDPH departments

- Drafting and finalization of HIV Low Health Literacy guide and training

- Ongoing All Staff Explored Identity Series conversations

- Surveying staff of providers post equity plans execution

- Continued trainings on intersectional and diverse marginalized groups

- QIP reporting tracking efficacy of equity plans

# AACO's Equity Policy

- **AACO Health Equity Values**
  - Principles we are committed to
  - Areas of advocacy
  - Collaboration and relationships
  - Provisions and resources that best reflect and support a myriad of identities and individuals
  - Addressing bias
  - Setting an example and leadership
- **Guidelines and Standards**
  - Specifics pertaining to execution of programs and initiatives
  - Competency goals
  - Diversity and inclusion
  - Investment in the development and growth of diverse internal talent
  - Benchmarks, assessments, and evaluations
  - Data

# Explored Identity Series

- Raises the intersectional competency across AACO staff and leadership

- Learning about systemic and oppression-based barriers

- Creates a space to discuss and ask questions

- Workshops ways to address barriers that can then be collected and used foundationally for future projects
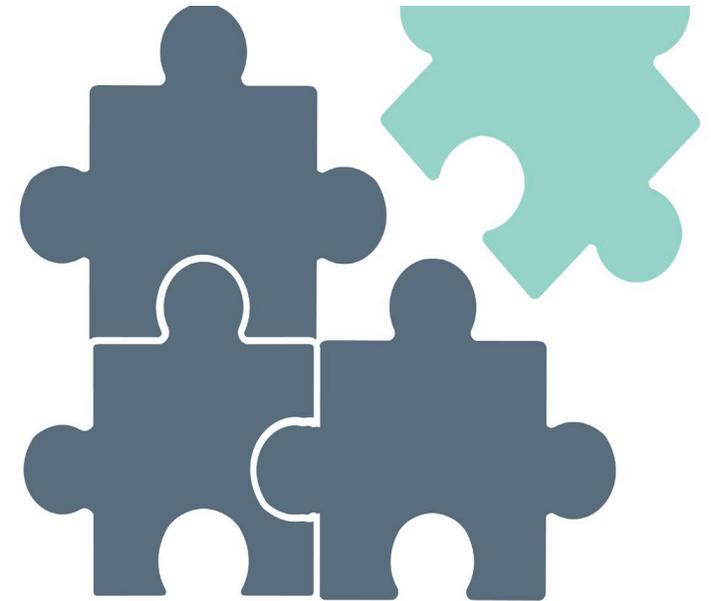
# RFPs, Assessments, Benchmarks, Climate Surveys, & QIPs
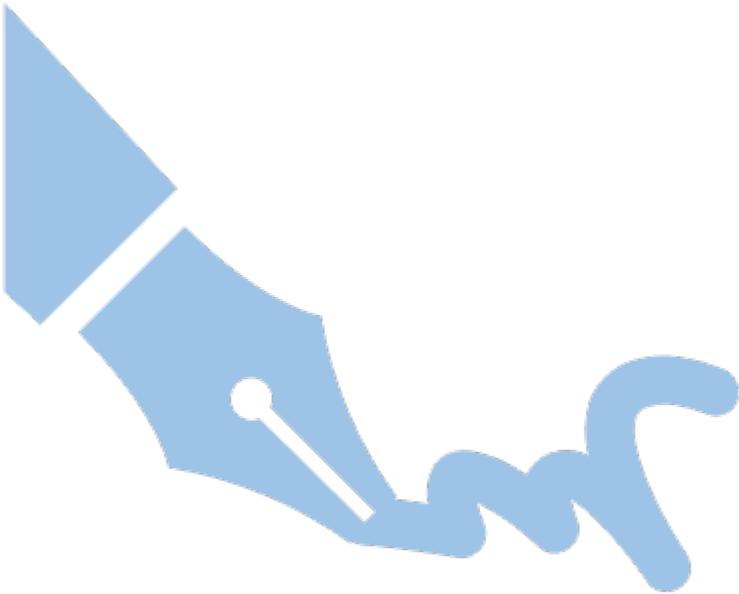
- Compare and Contrast-ability
- Stimulating ongoing growth and competency
- Learning challenges and where to improve design
- Continual monitoring that builds long term accountability and sustainability
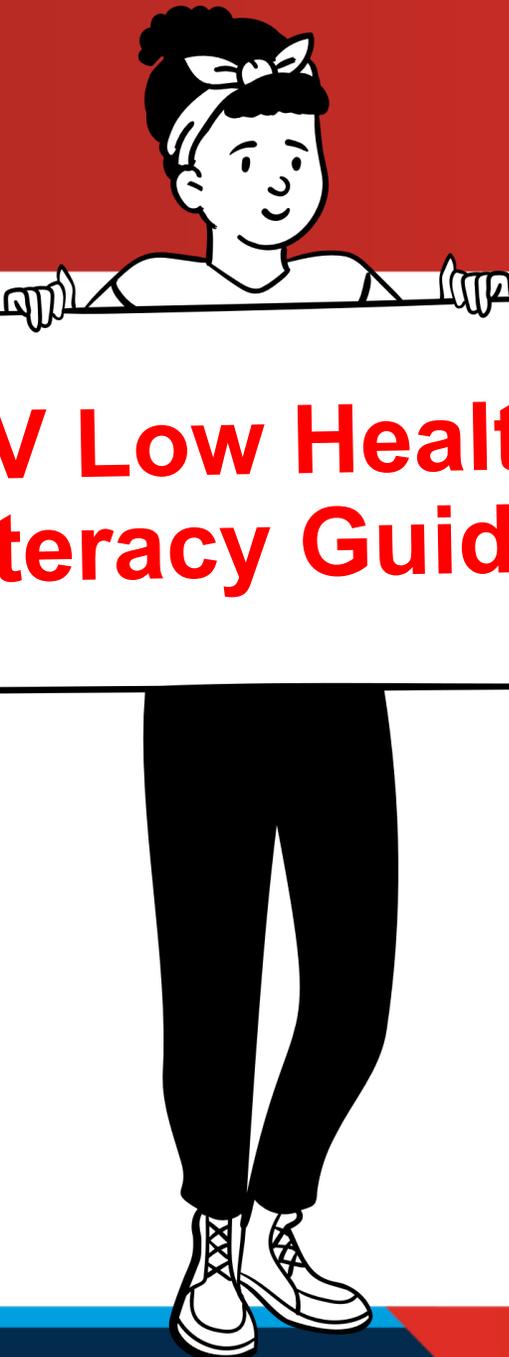
# HIV Low Health Literacy Guide

- Low health literacy greatly impacts consumers' ability to make decisions regarding their care, their consistency with care and medication adherence, and any necessary behavior adjustments.

- The Low HIV Health Literacy Guide is a collected set of standard best practices for clinical spaces to provide resources, diagnoses, case management, prescriptions, and care at a more universal literacy range for all consumers to best understand

- The guide includes:
  - **A quick HIV specific literacy, numeracy, and color perception test that can be given by any clinician**
  - **Standards for print and digital resource materials**
  - **Standards for verbal communication**

- AACO has a 1/1.5-hour training that teaches case managers and clinicians how to utilize the guide and what low literacy looks like

# What's on the Horizon?

- Elder and Aging needs of PLWH
- Conceptualizing wellness within HIV clinical care to create more sustainable engagement services
- Surveying consumers post equity benchmark execution
- Assessing consumers' health literacy in clinical spaces

# Thoughts, Questions, Concerns?

**Evan Thornburg, (she/they)**
**Evan.Thornburg@phila.gov**

# Break

# Interactive activity

Guess the jurisdiction

# Fun Facts Quiz

**How well do you know the Part A EMA or TGAs?**

# This city is the birthplace city of Super Man...

- A. Dallas
- B. Miami
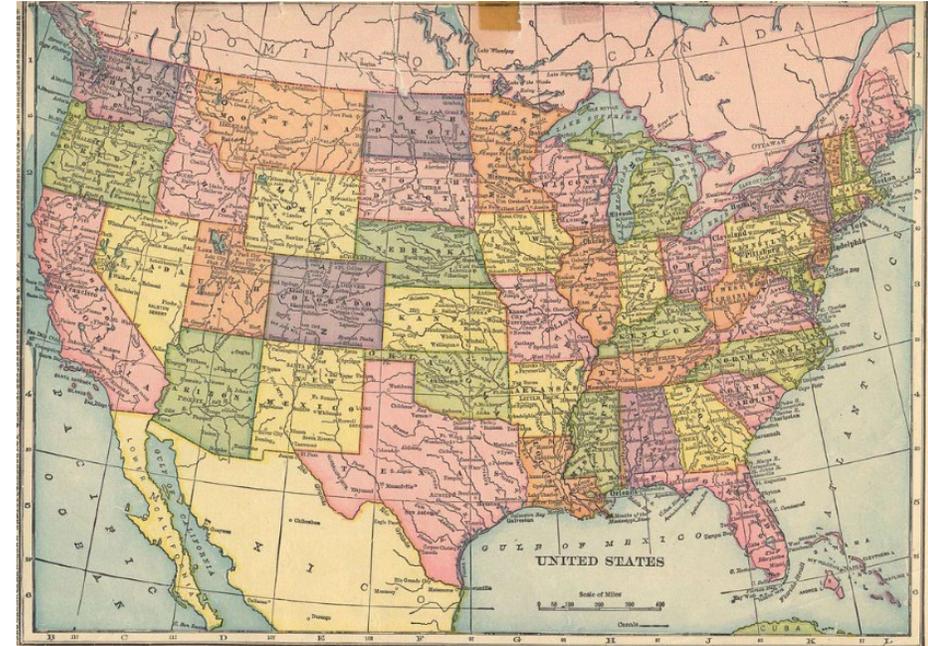- C. Cleveland
- D. Chicago
- E. Seattle

# *CORRECT!*

- Nice job, move on to the next question.

# This county is composed of 88 cities and 26 health districts...

- A. Orange County
- B. Miami Dade County
- C. Howard County
- D. New York City County
- E. Los Angeles County

# *CORRECT!*

- Nice job, move on to the next question.

# This city is the 17<sup>th</sup> most visited city in the United States…

- A. Orlando

- B. New York City

- C. Phoenix

- D. San Antonio

- E. Newark

# *CORRECT!*

- Nice job, move on to the next question.

# This city hosts over 22,000 conventions annually...

- A. Los Angeles
- B. Las Vegas
- C. Chicago
- D. Seattle
- E. Newark

# *CORRECT!*

- Nice job, move on to the next question.

# This city ranks #2 behind Washington, DC in the number of monuments and memorials...

- A. San Juan
- B. Indianapolis
- C. Chicago
- D. Baltimore
- E. San Francisco

# *CORRECT!*

- Nice job, move on to the next question.

# This city ranks #4 as the largest media market in the US...

- A. Norfolk, VA
- B. San Jose, CA
- C. Paterson, NJ
- D. Sacramento, CA
- E. Philadelphia, PA

# *CORRECT!*

- Nice job, move on to the next question.

# This city has 300 days of sunshine a year…

- A. Detroit, MI
- B. Denver, CO
- C. Hartford, CT
- D. Kansas City, MO
- E. Memphis, TN

# CORRECT!

- Nice job, move on to the next question.