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Health Resources & Services Administration

Enhancing HIV Care of Women, Infants, Children and Youth Trauma-Informed Care and Behavioral Health Community of Practice (CoP) Launch Event

April 17, 2024

Ijeamaka Ogbonna, MPH
Division of Community HIV/AIDS Programs
HIV/AIDS Bureau (HAB)

Vision: Healthy Communities, Healthy People

Agenda

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- Welcome from HAB Leadership
- HRSA Team Introductions
- CoP Team Introductions
- Background
- Community of Practice Overview
- CoP Participant Introductions
- Next Steps and Upcoming Events

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HIV/AIDS Bureau Vision & Mission

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Vision

Optimal HIV/AIDS 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.

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

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Welcome

- ***Opening Remarks***
  - *Dr. Laura Cheever, HAB Associate Administrator*
  - *CAPT Mahyar Mofidi, DCHAP Director*

DCHAP Leadership

CAPT Mahyar Mofidi, DMD, PhD
Director

Stephanie Yun, MPH, CHES
Acting Deputy Director and Supervisory Senior Advisor

RWHAP Part D CoP Team

Ijeamaka Ogbonna, MPH
Senior Advisor & Part D CoP Lead

Gail Glasser, MS
Senior Project Officer & COR

Lillian Bell, MPH
Branch Chief & Part D Lead

LCDR Tanya Grandison, MPH
Public Health Analyst & COR

Renee Hart, MPA
Management Analyst

CoP Team Introductions

Rhonda Waller, Ph.D.
Project Director

Fran Basche, M.A.
Deputy Project Director

Renée J. Ross
CoP Lead

Megan Williams
CoP Lead

Celeste Pleasant
CoP Coordinator

Katie Crowley
CoP Coordinator

Background

Leveraging the RWHAP Part D Women, Infants, Children and Youth (WICY)

- Two-year study conducted to determine factors to maximize the national impact of the RWHAP Part D
- Information collected through recipient listening sessions, literature review, analysis of RWHAP and surveillance data, and technical expert panel
- Recommendation from the study:
  - Provide training and technical assistance on RWHAP Part D legislative and program requirements
  - Capacity building in high impact areas: Communities of Practice
  - Implement a funding allocation methodology to determine FY 2022 RWHAP Part D award funding

Background (cont.)

- **Mental and Behavioral Health are White House Priorities**
  - ✓President Biden's National Mental Health Strategy
  - ✓HHS Roadmap for Behavioral Health Integration
  - ✓HRSA Strategy to Address Intimate Partner Violence
- **Trauma-Informed Care and Behavioral Health & HIV**
  - ✓Compared to the general population, people with HIV have more significant histories of trauma
  - ✓Trauma can impact health outcomes of people with HIV across the HIV care continuum

Source: https://nastad.org/sites/default/files/2022-12/PDF-NASTAD-Trauma-Informed-Approaches-TIA-Toolkit-2022_0.pdf

Recipient Overview

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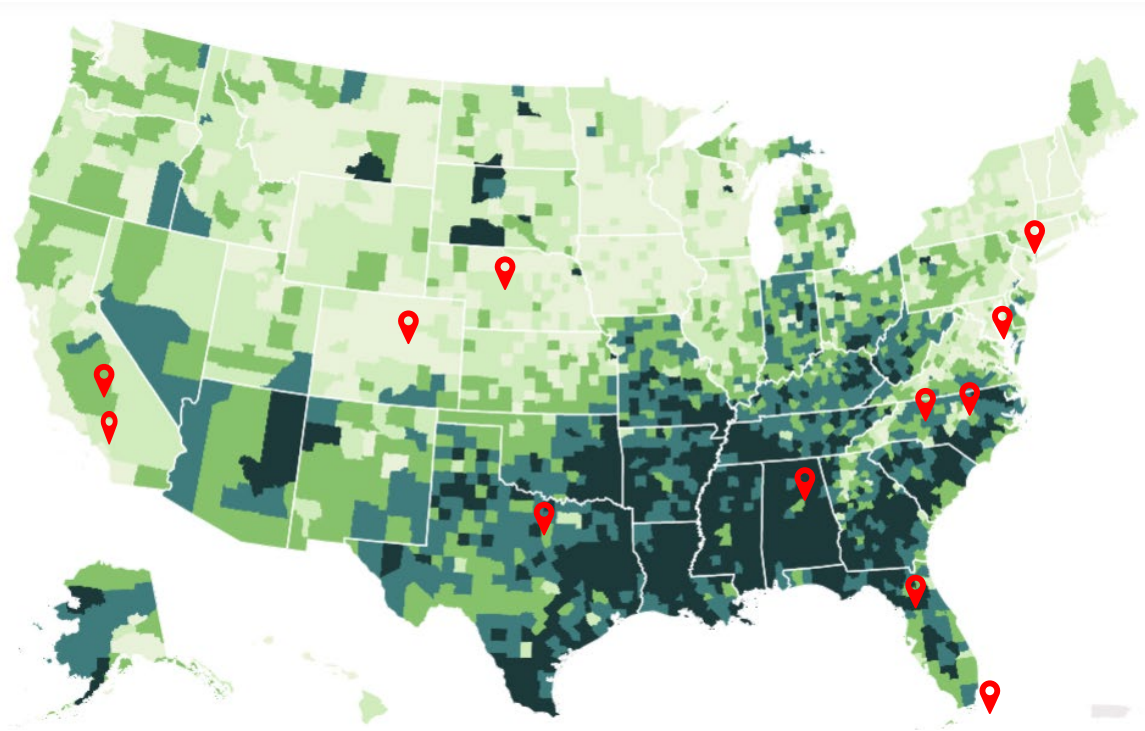
- **13 Recipients**

- **RWHAP Part(s):**
  - Part D only: 10
  - Parts C/D: 3

- **Recipient locations**: 1 NY, 1 NE, 2 NC, 1 WDC, 3CA, 1 CO, 1 AL, 1 FL, 1TX, 1PR,

- **HHS Regions:**
  - Region 2: 2
  - Region 3: 1
  - Region 4: 4
  - Region 6: 1
  - Region 7: 1
  - Region 8: 1
  - Region 9: 3



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What is a Community of Practice (CoP)?

- A place for recipient teams to engage in collaborative learning sessions with subject matter and implementation experts to **select**, **test**, and **implement changes in protocols** or **practices in providing direct care.**
- Teams work collectively to solve a recognized challenge or enhance a practice.

What happens in this CoP?

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- Core Teams **collect**, **analyze,** and **provide updates** on intervention data
- Recipient Core team of up to 10, including:
  - Project Director or Manager
  - HIV Case Manager
  - Clinical Provider
  - Part D WICY Participant
  - QI Lead
- Virtual Learning Sessions (5) that will include didactic presentations and discussions.
- Action Periods (3) focused on implementing program improvement and enhancements.
  - 1-on-1 leadership calls with assigned CoP Lead team
  - Conduct Plan, Do, Study, Act (PDSA) cycles to enhance pre-conception counseling (PCC) and sexual health practices

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CoP Sessions

SESSIONS *Leadership calls will occur throughout sessions

01 Intro to Trauma-Informed Care (TIC) and Behavioral Health (BH)

02 Understanding Trauma & Implementing TIC and BH

Action Period 1

03 TIC and BH Interventions for Action Periods

Action Period 2

04 Peer-to-Peer Presentations

Action Period 3

05 Peer-to-Peer Presentations

What Are Benefits of CoP Participation?

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- Learn about, design, and pilot process improvement strategies
- Review and discuss established and emerging best practices in trauma-Informed approaches.
- Create action plans supported by peer-to-peer learning
- Collaborate with SMEs and other RWHAP recipients

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RWHAP Part D Recipient Introductions

Alabama
- University of South Alabama

California
- Clinica Sierra Vista /Kern Lifeline
- University of California, Los Angeles
- University of Southern California

Colorado
- University of Regents Colorado, Children's Hospital Immunodeficiency Program

Florida
- University of South Florida

Nebraska
- University of Nebraska Medical Center

New York
- New York Presbyterian Hospital Comprehensive Health Program

North Carolina
- Duke University
- Western North Carolina Community Health Services

Puerto Rico
- University of Puerto Rico, Medical Science Campus

Texas
- Tarrant County Health Department

Washington, D.C.
- Medstar Health Research Institute

University of South Alabama

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Program Description

The University of South Alabama Family Specialty Clinic (UAFSC) utilizes the medical home model of care with our services designed around patient needs. We make every effort to provide services that are patient-centered, team-based, comprehensive, coordinated, accessible, and focused on quality and safety. The medical home model of care allows our patients and their families to actively participate in their care and creates an environment where patients feel comfortable speaking with all members of their care team.

- Clients see Mental Health/Behavioral Health Counselors and Social Workers at their HIV care appointments
- Clients can make appointments with Mental Health/Behavioral Health for counseling outside of HIV care appointments
- The Social Worker is available by phone or scheduled case management appointments Monday-Friday from 8 AM-5 PM

Core Team

- Project Director/Manager – Theresa Miller, PA
- HIV Case Manager – Sherri Tolbert
- Clinical Provider – Robin Normand
- Quality Improvement Lead – Carly Davis

SMART Goals for CoP Involvement

- By the end of the CoP, 100% of USA Family Specialty Clinic staff and community partners will participate in two trauma-informed care trainings conducted by USA Psychological Clinic.
- By the end of the CoP, USA Family Specialty Clinic will pilot a standard screening protocol for mental health and substance abuse screenings to be conducted with 100% of all patients at their initial HIV care visit of each calendar year.
- By the end of the CoP, USA Family Specialty Clinic will establish a follow-up protocol for patient referrals to mental health/behavioral health providers, and 80% of patients will have made it to their referral appointment.

Kern Lifeline Ryan White Program Bakersfield

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Program Description

At Kern Lifeline we offer coordination of care for individuals living or newly diagnosed with HIV/AIDS. The program offers HIV/primary care services, medical and non-medical case management, mental health, ADAP linkage and support, food, medical transportation, individual health education, HIV/STI testing linkage, partner prevention linkage, PrEP Navigation linkage, and medication adherence.

Core Team

- Veronica Hernandez, Manager
- Eloina Mack, HIV Case Manager
- Ashton Chase, Infectious Disease Provider
- Marlina Aran, Licensed Marriage & Family Therapist
- Vanessa Perez, QI Lead
- Deborah Davis, WICY Participant

SMART Goals for CoP Involvement

- By December 2025, the program will have provided education on TIC and BH for administering screening tools for staff.
- By December 2025, IPV screening will be in the EHR for all WICY participants and linkage to care will be provided as needed.
- By December 2025, staff will include the screening tool E-HITS (Extended- Hurt, Insulted, Threaten, Scream) during initial enrollment in the program and at medical visits. Staff will learn administration methods, scoring procedures, and referrals to services.
- By May 2024, staff will identify local providers of services for IPV victims, including shelters and legal advocates. Staff will develop or utilize the existing referral process and establish communication with local providers.

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The University of California, Los Angeles

Program Description

The UCLA Family AIDS Network (FAN) is the longest-standing network of HIV service providers aimed at providing coordinated family-centered care for Women, Infants, Children, and Youth living with HIV/AIDS since 1988. UCLA Health became the lead agency of LAFAN and the Ryan White Part D Program in 2015 and is housed in the Department of Pediatrics Infectious Diseases.

Core Team

- Natalie Sanchez, Program Director, Lead
- Elia Silveyra, HIV Case Manager
- Dr. Jamie Deville, Clinical Provider
- Jazman Rojano, Quality Improvement Lead

SMART Goals for CoP Involvement

- By February 2025, train 80-100 staff members in a trauma-informed approach for use in the clinic.
- By November 30, 2024, develop and implement a patient satisfaction form focused on creating a safe and welcoming environment.
- By February 14, 2025, 80% of patients will complete the patient satisfaction form.
- By February 14, 2025, create a social media plan to increase viewership from 1,330 – 5,000 for “Confessions” a podcast focused on living with HIV which includes processing trauma.

University of Southern California - Maternal, Child, and Adolescent Center

Program Description

The USC Maternal Child and Adolescent/Adult Center for Infectious Diseases and Virology (MCA) at the Los Angeles County and University of Southern California Medical Center (LAC+USC) supports outpatient primary care and supports services for LAC's HIV-WICY and indeterminate newborns. MCA's comprehensive family-centered model of care includes a continuum of primary care services, including HIV counseling and testing.

Core Team

- Jessica Lizama – Behavioral Lead
- Yvonne Morales, LVN – CQI Lead
- Sonia Gray, NP – Provider Lead
- Jane Cabison, MSPM - Project Lead

SMART Goals for CoP Involvement

- Develop and implement a trauma-informed care training program for a minimum of 75% of members within the organization to maximize patient care, and track attendance and completion rates for the training sessions by Feb 2025.
- Increase trauma-informed communication by 50% with patients by incorporating trauma-informed language in all patient interactions and monitor patient feedback and surveys to gauge the effectiveness of new communication strategies by 12/2025.
- Enhance trauma screening and assessment protocols to identify 100% of the patients in need of trauma-informed care by revising existing screening tools and integrating trauma-informed assessment criteria by Feb 2025.

Children's Hospital Immunodeficiency Program (CHIP) - Children's Hospital CO

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Program Description

- CHIP is an integrated inter-disciplinary team providing HIV medical care, case management, and behavioral health.
- Process established for annual screening for and addressing behavioral health and substance use concerns.
- All CHIP personnel completed Trauma Informed Care (TIC) training in 2019 (one session) and 2023 (3 sessions).
- Process for annual education and assessment for intimate partner violence (IPV).

Core Team

- Erin Hilgier, LCSW
- Betsy McFarland, MD
- Amber Bunch, LPC
- Chloe Weber, LSW

SMART Goals for CoP Involvement

- Trauma Informed Care (TIC): 80% of CHIP team members with client contact will attend both sessions of the cultural humility training scheduled for April 4 and 11, 2024.
- Behavioral Health (BH): Create and implement a process, including a data monitoring system, that includes demographics for clients enrolled at the University of Colorado Health (UCH) Infectious Diseases Group Practice (IDGP) to be referred for behavioral health care therapy at CHIP by July 1, 2024.
- Trauma Informed Care (TIC): Transition the current CHIP IPV Screening to an assigned patient questionnaire format in Electronic Medical Record (EPIC) by December 20, 2024.
- Trauma Informed Care/Behavioral Health (TIC/BH): Incorporate TIC best practices into the standard operating procedure (SOP) for referrals for BH from IDGP to CHIP by February 1, 2025

USF Health Pediatric/Adolescent HIV Program

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Program Description

The program provides comprehensive, wrap-around services for infants, children, youth, and young adults exposed to or living with HIV ages 0 to 24 years living in the Tampa Bay catchment area.

Services include on-site infectious disease care, access to clinical trials, Ryan White eligibility, medical and non-medical case management, HIV testing, and extensive psychosocial support. The behavioral team provides screening for depression, substance misuse, quality of life indicators, and anxiety and is expanding trauma-informed services for intimate partner violence. A comprehensive referral network supplements on-site care.

Core Team

- Alicia Marion, APRN- Project Director/Manager
- Bernard Washington Jr.- HIV Case Manager
- Dr. Carina Rodriguez- Clinical Provider
- Anica Colon, MSW- Quality Improvement Lead

SMART Goals for CoP Involvement

- By the end of 2024, administer a psychosocial screener protocol to 90% of eligible patients, including a post-traumatic stress screener to patients aged 11-25, to expand holistic care and address potential barriers to treatment adherence and psychosocial well-being.

- By the end of 2024, implement a pilot program to administer the Adverse Childhood Experiences (ACEs) and a resilience measure (TBD) to 30 patients aged 11-25, and evaluate their correlation with viral suppression.

University of Nebraska Medical Center (UNMC)

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Program Description

The University of Nebraska Medical Center provides specialty HIV care and primary care for over 1200 people with HIV in Nebraska and Iowa. Integrated behavioral health services were incorporated in 2023.

Core Team (aka UNMC Task Force)

- Nikki Regan, APRN/CoP Project Director
- Lance Burwell, MHP
- Tacy Slater, Part D Coordinator
- Emmanuel Nazaire, QI Manager
- Deanna M. Hansen, Program Manager
- Eva Williams, Medical Case Manager
- Agustine Delgado Jimenez, CHW
- WICY consumers, TBD

SMART Goals

- By August 1, 2024, research TIC by gathering 10 resources regarding TIC policy and procedures, staff and patient education, and screening and referral processes.
- By October 30, 2024, develop, deliver, and document one training (at minimum) to clinic staff on Trauma Informed Care, including secondary or vicarious trauma, using information gathered from research and Learning Sessions.
- By October 30, 2024, create at least two visible patient education/resource materials about a safe environment for display in the HIV clinic.
- By January 1, 2025, create and share clinical policies and procedures regarding safe environment and TIC for staff and patients at the UNMC Specialty Care Center.

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New York Presbyterian Hospital Comprehensive Health Program

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Program Description

The mission of the Comprehensive Health Program (CHP) in the Division of Infectious Diseases is to provide integrated, equity-focused, status-neutral, gender-affirming care to individuals living with HIV, at risk for HIV, or in need of sexual health services. CHP functions as a patient-centered medical home (PCMH) and integrates Primary Care with specialty Infectious Disease services as well as collocated Behavior Health/Mental Health and Substance Use Disorder (SUD) services provided by multidisciplinary teams.

Core Team

- Susan Olender MD (Clinical Provider)
- Johanna Hernandez (Project Manager)
- Dionna Thomas (Quality Improvement Lead)
- Jenny Rodriguez (HIV Case Manager)

SMART Goals for CoP Involvement

- GOAL 1: Develop and implement a comprehensive training program on Trauma-Informed Care (TIC) approaches for all staff members by February 14, 2025.
- GOAL 2: Implement the HARK (humiliation, afraid, rape, kick) Intimate partner violence screening assessment for at least 75% women, transwomen, and LGBTQ+ identifying patients at least one time as a part of their intake assessment by February 14, 2025.
- GOAL 3: Within the next 6 months, establish a referral workflow for all patients who have a positive screen during the HARK assessment directly to our integrated Behavioral Health Clinician Team for further assessment and evaluation of their needs. Strengthen our existing partnerships with the DOVE program (internal referral).

Duke University Medical Center

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Program Description

Duke University Medical Center (DUMC) is a leader in HIV-related patient care, research, and teaching with over 30 years of experience providing medical care for women, infants, children, and youth (WICY) with HIV, and care of HIV-exposed infants.

Core Team

- Kammy McGann, MD, Director
- Paula Bell, MSW, Coordinator
- Rachel Dizney, Laura Gallaher, and Destiny Little, Social Workers for Part D
- Jennie Dougherty, NP and Mary Jo Hassett, RN for Part D

SMART Goals for CoP Involvement

- By the end of this CoP, 80% of RWD Pediatric staff members will attend at least one trauma-informed care education session and attendance will be tracked on our RWD Pediatric education training tracking sheet.
- By the end of this CoP, 80% of RWD will develop a trauma-informed care written script/template for pediatric providers to use to validate patients' feelings regarding a mental health concern in a timely manner and successfully provide a warm handoff to clinical social workers for further assessment and follow up.
- By September 2024, will translate 100% of the office signage and patient materials into Spanish to incorporate principles of trauma-informed care.

Western North Carolina Community Health Services (WNCCHS)

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Program Description

- An integrated care community health center focused on the core values of compassion, diversity, quality, integrity, and teamwork.
- The Behavioral Health (BH) department interacts with patients through a trauma-informed lens and assists in providing staff with guidance on the widespread impact of trauma and the importance of avoiding re-traumatization.

Core Team

- Project Director – Jessica Parsil / Yani Pyszniak
- HIV Case Manager – Lindsey Googer / Christa Phillips
- BH Health Providers – Nathan Rice / Aryana Calcagni
- QI Leads – Heather Harmon / Cora Haas

SMART Goals for CoP Involvement

- BH Staff will provide Trauma Informed Care (TIC) training to each department by the end of February 2025.
- Conduct TIC screenings with 100% of patients at behavioral health intakes/assessments and with 80% of patients at their medical appointments bi-annually by December 31, 2024.
- Create two support groups, an HIV support group for young adults/youth and a Transgender support group, by December 31, 2024.
- By December 31, 2024, Referrals to the newly created HIV support group for young adults/youth and the Transgender support group will be accepted from all departments.

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University of Puerto Rico – Medical Science Campus (MSC)

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Program Description

CEMI stands out as a leading women's health clinic in Puerto Rico, delivering holistic and comprehensive HIV care to women across the island with services that include primary and specialty medical care, case management, behavioral interventions, and other support services. Through these efforts, the clinic directly addresses the unique challenges faced by women living with HIV which include lower viral suppression rates, mental health concerns, and vulnerability to violence. CEMI utilizes a four-pronged approach to address intimate partner violence (IPV) screening and counseling:

1) universal screening, 2) clinical staff training, 3) patient empowerment workshops, and 4) timely case management.

Core Team

- Project Director/Manager: Dr. Carmen Zorrilla; Dr. Ana Mosquera
- Clinical Provider: Dr. Jessica Ibarra and Dr. Marianela Rodríguez
- Quality Improvement Lead: Dr. Vicmarie Vargas
- HIV Case Manager and Part D WICY participants – TBD

SMART Goals for CoP Involvement

- By February 14, 2025, we aim to implement the Women Abuse Screening Tool (WAST) for intimate partner violence screening in 80% of our female patients who disclose having a partner during their routine care visits.
- By December 13, 2025, we aim to implement annual training on identifying, managing, and screening for intimate partner violence (IPV) into the routine care practices of all clinical staff, supplemented by biannual refresher courses.
- By February 14, 2025, our goal is to identify, adapt and distribute ten informative resources to enhance understanding and educate staff about intimate partner violence (IPV).

Tarrant County HIV Administrative Agency

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Program Description

The Tarrant County HIV Administrative Agency (HIVAA) connects those living with HIV with resources that put wellness within their reach – from health care and medications to financial support, housing, counseling and much more. The HIVAA does not deliver services but is the direct Ryan White Part D recipient and has sub-recipients.

CAN Community Health is the Tarrant County RWHAP Part C/D subrecipient. Their mission is to inspire and contribute to the health and well-being of those affected by HIV, Hepatitis C, and other sexually transmitted diseases by providing the best care through outreach, integrated clinical practice, advocacy, education, and research while incorporating TIC in all the work they do.

Core Team

- Project Director/Manager –Kaitlin Lopez
- HIV Case Manager – TBD
- Clinical Provider – Nadia Winston
- Quality Improvement Lead – Kaitlyn Malec
- Part D WICY Participants – Health Improvement Team (HIT) HIV Consumer Advisory Board Members (2)

SMART Goals for CoP Involvement

- Develop pre-and post-training assessments to measure staff knowledge of trauma-informed care principles by July 1, 2024
- Research and identify Trauma Informed Care and Behavioral Health training materials and resources that align with the organization's budget and capacity by August 30, 2024.
- By December 30, 2024, train at least 95% of CAN staff in trauma-informed care principles focused on behavioral health.
- By February 2025 provide a report of the pre-and post-test evaluation results.

MedStar Health Research Institute

Program Description

MedStar Health Research Institute (MHRI) at MedStar Washington Hospital Center (MWHC) is the largest acute care facility in DC. Serving DC's most diverse patient populations provides the full array of medical and surgical subspecialties and subspecialties, and provides a home for the largest hospital-based outpatient HIV primary care clinic in DC.

Part D Initiatives Related to Trauma Informed Care (TIC), including Behavioral Health (BH)

- The team creates a culture of warmth and safe space.
- Initially screenings for TIC/psych-social assessments; referrals to an on-site psychologist

Core Team

- **Allison Daly**, LICSW Lead
- **Leon Lai**, MD-- Clinical Director
- **Chizoba Anako,** DNP Quality Lead
- **Emma Arons,** PsyD. BH Specialist
- **Ziara Battle,** LGSW MCM/SW

SMART Goals for CoP Involvement

- Identify and implement a Trauma Informed Care (TIC) screening tool by September 30, 2024.
- Conduct a randomized audit on 20 patient charts to ensure Part A, D and C Ryan White staff are utilizing the screening by January 31, 2025.
- Train 100% of Part A, D, and C Ryan White staff on TIC and selected TIC screening tool by November 30, 2024.
- Assess the implementation of TIC by developing and distributing a staff and patient TIC satisfaction survey to 100% of Part A, D, and C Ryan White staff and 80% of Part D patients by February 14, 2025.

Upcoming Events

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CoP Activities

- **February – March 2024** Virtual kick-off and onboarding: Explanation of program, intro, and overview of CoP, and program expectations
- **March – April 2024** Getting Started: Prework, building infrastructure, and leadership calls with the Bizzell/AHP CoP team.

CoP Learning Sessions and Action Periods (tentative dates)

- **May 15, 2024** – Learning Session #1
- **June 26, 2024** – Learning Session #2
- **July through August 2024** – Action Period #1 (PDSA specific activities, data collection and analysis)
- **September 25, 2024** – Learning Session #3
- **October through November 2024** – Action Period #2 (PDSA specific activities, data collection and analysis)
- **December 18, 2024** – Learning Session #4 – Peer-to-Peer report out/combined summary session
- **January 2025** – Action Period #3 (PDSA specific activities, data collection and analysis)
- **February 19, 2025** – Learning Session #5 - Final Presentations from each CoP Core Team

Leadership Check-in Calls with the Bizzell Team will be scheduled and occur monthly.

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Contacts & Support

If you have questions, please contact:

Bizzell	HRSA/HAB/DCHAP
Rhonda Waller, PhD Bizzell US, Managing Director-Maternal and Child Health Enhancing HIV Project Director Email: Rwaller@BizzellUS.com	Ijeamaka Ogbonna Senior Advisor, Division of Community HIV/AIDS Programs Email: AskPartD@hrsa.gov

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