

VIDEO TRANSCRIPT

DHHS / Health Resources and Services Administration (HRSA)

Innovative HIV Care Strategies Using a Comprehensive Approach to Address the Needs of Priority Populations

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ANGEL JOHNSON: So, good morning. And welcome to the Integrating HIV Innovative Practices webinar series on replicating innovative HIV care strategies and the Ryan White HIV/AIDS program. Today's webinar features two interventions focused on innovative HIV care strategies using a comprehensive approach to address the needs of priority populations.

I'm Angel Johnson with the Mayatech corporation, and I'll be moderating this webinar series. Before we meet our presenters, we're going to do a little housekeeping and go over the webinar logistics and the agenda, and get a brief overview of the SPNS iHiP from our project director, Shelly Kowalczyk.

Please note that this webinar is being recorded. All participant microphones are currently muted. We will hold all questions until the Q&A period and all our presenters have spoken. So before we hear from our speakers, Shelly will give a brief overview about the SPNS iHiP project. Next, our presenters will talk about their interventions. Following the presentations, we'll take questions. And finally, I'll give more detail on how to give your feedback on today's presentations. Shelly.

SHELLY KOWALCZYK: Thank you, Angel. Hi, everyone. Thank you for joining today's webinar. We look forward to sharing some great innovations with you today. So this webinar is being coordinated by the Integrated HIV Innovative Practices project, and we support the coordination, replication, and dissemination of innovative HIV care strategies in the Ryan White HIV/AIDS program.

So our project aligns with the third component of the SPNS framework, focusing on developing tools and resources to assist Ryan White providers in replication and integration of these innovative strategies into their systems. So we also coordinate with the best practices compilation to ensure that our tools and resources developed through iHiP can be accessed through the compilation for any interventions that you might identify that we've featured throughout the year.

So some of the tools and resources we develop include intervention implementation guides. We have fact sheets, as well as video spotlights that are about 5 to 6 minute videos of the interventions speaking about the intervention. We also provide capacity building technical assistance, including webinars such as this one today, where the interventionists present about their models.

We also offer one-on-one TA. So anyone who might be interested in learning more about the specific interventions that iHiP features, you can put a request into us and we can help coordinate interaction and technical assistance with the interventionists. We also provide support in the development and dissemination of tools and resources. So if you're interested in developing your own tools and resources, whether that be guides or other types of materials, we can also assist.

We will have some webinars coming up on topics to help you with that. But again, we also provide one-on-one assistance in that area. So you can use our ihiphelpdesk@mayatech.com email to email us for any questions or requests on individualized technical assistance. And I will turn things back over to Angel.

ANGEL JOHNSON: Thank you, Shelly. Please note that the opinions expressed during these presentations are those of the presenters and do not necessarily represent the views of the webinar sponsors and planners. And the information presented is not meant to serve as a guideline for patient management. Additionally, our presenters have nothing to disclose and no conflicts of interest.

Now it's time to meet our presenters. So our first group of presenters is with Positive Impact Health Centers, Atlanta, Georgia, presenting the Black Women's Project. Erik Moore is a medical case manager with 12 years of experience working with homeless populations and people living with HIV.

Sevyn Jones is a data analyst with more than seven years of experience working in HIV patient and health advocacy. Beautiful Devynne is a community health worker with decades of experience working with the transgender community. Letitia Burr is an intensive case manager with 24 years of experience working with clients experiencing domestic violence and mental health needs. And Dr. Gwen Davies is a licensed psychologist and was the principal investigator for the Black Women's Project. The Black Women's Project serves Black women with a high need for wraparound care to maintain overall health and an undetectable HIV viral load.

Following the Black Women's Project, Dr. Merceditas Villanueva and Mr. Ralph Brooks with Yale School of Medicine will share the purpose, lessons learned, and successes and outcomes of the Curing Hepatitis C Among People of Color Living with HIV Initiative. Dr. Villanueva is a professor of Medicine at Yale School of Medicine and director of the Yale Medicine AIDS Care Program. She is an infectious disease specialist with a clinical focus on HIV.

Mr. Brooks is a data manager with the Yale School of Medicine AIDS Care Program. His work is focused on this endemic intersection of HIV, hepatitis C and substance use, as well as TB, both in the US and internationally. The purpose of this initiative was to leverage data to identify people co-infected HIV and HCV and link them to HCV treatment.

We're now going to hear from Erik Moore with the Black Woman's Project. Erik.

ERIK MOORE: Morning, everyone. Hope everyone's having a great day. No matter where you are, it's Friday, so I think we can all agree that's a good thing. So I'm just going to start off here quick. As Angel said, I am a medical case manager here for the project. I was a program manager. I've been working with SPNS project for the past six years. And this particular project, the Black Women's Project or Black Women's Initiative, was funded through Ryan White Part F, which is the SPNS grants. That's obviously part of Ryan White.

We also have at our agency Ryan White Part A, B and C-- excuse me-- as well as 340B funding through our pharmacy program. Our translate care initiative was funded through AIDS Atlanta-- or I'm sorry, AIDS United. Our priority population, which was mentioned, is cisgender and transgender Black women with HIV. And also previously mentioned, we were serving a higher need Black women populations with wraparound care to help them achieve viral suppression and maintain overall health.

This is a quick overview of our agency. We are a positive impact health centers. We have three clinics across Georgia based right around Atlanta, inside and outside of Atlanta, and we have one admin office, so four total locations. We have a suburban location, a more urban location, and one that's a little more rural. So we're trying to cover all the different demographics and populations around Atlanta, Atlanta metro area.

And our mission is we are a patient-centered care for HIV community to create a life worth living. So this is just a quick overview of what the Black Women's first initiative was. The way we kind got involved with it is we saw the need for specific services to be tailored to Black women living in Atlanta.

Quick statistic, we look at Black cisgender women do make up 50% of the newly diagnosed women with HIV. So if you think about it, how disproportionate that is, 57% are Black women, whereas Black women pretty much only make up about 13% to 15% of the actual cisgender woman population. So just think about how skewed that is, just that one statistic, and how much of a need there is for care for them.

And then also, transgender Black women are 50 times more likely than other adults to be diagnosed, as well. We kind of saw a lot of the reasons for these poor outcomes are the social determinants of the outcomes, HIV stigma, a need for child care, a lack of affordable child care, higher levels of depression, and access to mental health services, poverty, and then the effects of institutional racism.

So as we wrote up this grant and got involved with it, we were looking at what our project goals and outcomes would be. So I just wanted to give you a real brief overview. Basically what we did was we put together what we call bundled interventions. There's four interventions in the Black Women's Project. Everybody received at a minimum intensive case management. So they had access to a case manager to help with all those things associated with social services, housing, employment, medical assistance, pharmacy assistance, food assistance, all those kinds of things.

We also had part of the bundled interventions was for our transgender clients. They could engage in Trans Life Care Program. Letitia, the partner here, she helped a lot with the other bundled intervention, which was domestic violence or intimate partner violence, resources for that and ways to help clients manage that situation if there if they needed that help, as well as cognitive process therapy, general mental health care, PTSD care. Gwen's going to talk about that more towards the end of the presentation.

But those were the four bundles-- so trans life care, case management, ED services, and mental health services. So the idea was, or our theory was that the more that folks engage with the bundle, the more services they receive tailored to their needs, the more likely they would be to become virally suppressed and maintain good health care or good health outcomes.

So just a few of the outcomes that we did that we are going to note, 90% of the clients retained or achieved viral suppression, which was a pretty big deal, because I think when we started off, I think our baseline was about 70%, 73%, 76%, maybe. So being able to come up to 90%, I think that was one of the bigger achievements of the program.

We enrolled 100. It says 113 here. I think it might have been 115. We were in that range. So we met our goal to serve that many clients. Out of that population, 58 individuals were Black transgender women. Our agency just saw a big uptick in Black transgender women seeking care. So this was also, I think, one of the big successes that we were able to serve that many people within this program.

And then overall, 76 of the 113, 115 clients did receive some type of PTSD or CPT processing mental health services. And we found that a lot with our SPNS interventions that regardless of what the demographic is, regardless of what the services were offering, we really have a huge need for mental health services as far as our enrollees go.

I am going to hand over the next slide here to Sevyn Jones. And he's going to give you a little bit of a perspective from his perspective. He was the enrollment and data manager, so he had pretty intimate conversations with every one of the enrollees in the program. So he's going to give you a little more in depth experience about how that happened. Sevyn.

SEVYN JONES: Hello, everybody. Again, my name is Sevyn Jones. Thank you for the introduction, Erik. Just introduce my job role, so I'm not going to go over that again. But I was the data analysis and did a series of qualitative interviewing on a baseline six month and 12 month basis with our clients. I'll get into a little bit more of that after this initial polling question. So this is our first polling question out of three in a series.

And we just wanted to ask the audience to think about your experience in providing services for the population of cisgender and transgendered clients. And we wanted to ask the question of what ingredients provide the best bundle interventions tailored for cis and trans Black women living with HIV. You would choose all that apply or you can choose all that apply or select the one that best fits your service experience.

It looks like quite a few of us, or quite a few of you all decided on A, which is a collaborative interdisciplinary team, which is extremely important. And in our experience, we did experience that. We did have some for all of the above, D, for soft blankets. I saw a question in the chat that asks what soft blankets for bundling was. I think that was a little jokey joke to play around with the idea of bundling. So when you're in a blanket, you kind of bundle up.

But moving forward with the next slide, we'll talk a little bit about how all of these things are essential in a SPNS initiative, especially one like this one. So the intervention, this was an intervention dedicated to Black women. It was a red carpet experience, which means that we wanted to pull together bundles that would serve the whole person. So within this, we had peer and patient navigation, which was provided by the intensive case managers on this project. Like Erik said earlier, IPV and domestic violence interventions, which was also provided by those intensive case managers, Letitia and another one of our case managers.

Self-efficacy, which showed up in a way of the trans life specialist which provided our individuals of trans experience with an intensive-- with the same intensive care, but more so focused on serving the whole person, making sure that they had a gender specific care in our clinic and gender affirming care within our clinic, offering hormones and also other intervention services such as name changes and HRT and then trauma-informed care, which was provided by the process cognitive therapy.

When these bundles were applied, the interventions worked together to increase the engagement in HIV care, in which we received 90% of our clients with viral suppression, reduced stigma, achieve and maintain viral suppression. And then in intensive case management, also help to reduce barriers to care, satisfy unmet needs, and increase overall well-being by reducing traumatic distress and providing a path to recovery from substance abuse and IPV.

During these interventions, there were qualitative interviewing in which we asked a series of questions to, of course, come up with these results. Through our qualitative interviewing, we come to conclusions in which we will be able to assess the clients' experiences. So based on this case study, this client was identified by rapid entry through case manager and medical provider and medical, mental health provider as high need acuity Black woman. She was then referred to the Black Women First Program and then through the baseline intervention interview.

I would ask a series of questions to gather her current experience with HIV, stigma, resiliency, and also her ideologies around contracting HIV. She would then, after that, be admitted to the program and then meet with an intensive case manager. And in this sense, it would be Letitia. Letitia would then enroll her, continue the enrollment process. She would then come back to me for a six month update on how the process went after experiencing said bundled interventions. And then after that, finally, she would receive the needed services on a continuing basis until the end of the program, which would be peer navigation, trauma informed care, IPV services, and/or trans life care.

All right, so the intake and eligibility process. So piggybacking off the last slide, it would typically be the baseline eligibility criteria, which is being a Black woman of either cis or trans experience. You will have to be HIV positive and in need of two or more bundled interventions. So that could either be the process cognitive therapy, and/or trans life specialist care, or the intensive case management, and the IPV DV.

So you would then, through that process, get referrals, get referred into the program. And then we'll talk about the services that were offered throughout the program. So throughout the course of the 12 month process, each of our enrolled clients would have access through through IPV and DV services, safety planning, abuse assessment screenings, and referrals to DV shelters for emergency housing and/or exit out of violent situations through the housing services provided by the Black Woman's First Project.

We have housing, housing assessment, homelessness, diversion, emergency hotel lodging, permanent housing, behavioral health. That's the process. Cognitive therapy, it would be an on site therapy. We would meet with, at the time, Rosie. Psychiatry and PTSD assessment, substance abuse, employment and income assistance through applications, and also navigating different open employment options, and then clinical care all provided by IHC, which would be pharmacy care, pilot screening, HIV treatment dropout, HRT for our clients who are trans, and access to community health workers, Beautiful, and then also social support education groups, such as faith community, volunteering options, safe space in youth, and also the trans life specialist care group, and then the intervention challenges.

So retention and recruitment, as you all know, working in health care, perceived barriers to health, to access and health are real. So therefore, transportation, housing, food, resources, all of these were experienced barriers that affected the retention for our clients to complete sometimes six month and 12 month updates to arrive at scheduled appointments with the intensive case managers and the community health workers.

We experienced a lot of issues developing integrated care, bringing together both the transgender cisgender population. There was a little hesitancy in there in terms of the experience being-- each experience being displayed correctly. Transportation, of course, another barrier to the access of this program, and also the impact of COVID-19, which challenged our agency a lot. And one of the solutions to that was-- the solutions to these were helping clients anticipate barriers. Case managers help avoid this barrier by providing transportation and telehealth.

We offer poker cards to fight back some of the food insecurity. We also offered telehealth in case of COVID, and also monitor cards and gas cards for our clients who are experiencing transportation issues. So I'm going to pass it off to our next presenter.

BEAUTIFULL DEVYNNE: Hello, everyone. My name is Beautiful with two L's, so I was a community health worker here for the Black Women's Project. And we're going to talk about intervention successes. So we have cultural tailored approach, a deeper understanding of the cultural norms, beliefs, and values of Black women, community involvement, engaging influential figures within the Black transgender community to create a sense of trust, accessible and equitable services, insurance navigation, peer support, mentoring, and comprehensive education.

So therefore, we will have empower-- I like to call it empowerment groups. So we love to empower each other. And we would talk about how we have this community of Black trans women. And also if we needed to assist our cis women in resources within the community, if we could assist them with whatever needs that they needed. And we also made sure with our transgender women, if they needed HRT, which is hormone replacement therapy, that we would make sure we would navigate the insurance issues so they can get whatever needs they have.

Intervention success and outcomes, intersectionality approach, acknowledging and addressing the intersectionality of identities. So sometimes in our trans community, we may have individuals that show up looking a certain way, but then they want to be perceived in a different way. They might want to be makeup and hair, but they still want to consider or using their male name. And then we have some others that is the opposite.

So we just meet everyone where they are and acknowledge however they want to be addressed. And we go from there. So therefore, they can be comfortable. They know that they're in a safe space. And then we can help them with whatever barriers that they may have within their health care.

Holistic health support. Dealing with anyone on the holistic health support is treating the whole person. It's not just about maybe your HIV. But it may be about-- you might have some mental health issues. We also educate on sexual health, how to abstain from having risky behaviors, and also reproductive health or gender affirming care, just to make sure that everyone is seen as they are and however they want to be perceived in life.

Stigma reduction. Stigma, that is like the big bully from high school has always acknowledged it to be. And basically, with our whole team approach, we make sure that anyone that comes into our program, that anything they have to alleviate that stigma, then they become a better person. So alleviate that stigma, alleviate the barriers they have to health care that makes you a better, whole person.

Personalized care plans for high acuity clients. So we do have or had some clients that may need a little extra help. So those ones who had high acuity levels, we just had to give them an extra helping hand. And that's where I come in as the community health worker. Sometimes we have individuals that might not feel as comfortable coming into the facility.

So I would go out into the community, meet them where they are, whether it's Starbucks, McDonald's, or their home, or go to any specialized appointments they may have outside of our agency. So therefore, they feel like family. They have support all the way around because at Positive Impact Health Centers, we have wraparound services to meet each and every individual where they are.

Long term follow up. Long term follow up, that's basically when the intuitive case manager or the community health worker myself will actually check in with individuals, make sure they come to their appointments. We do reminder text messages or call them just to make sure that everything is still going great and they have any issues that we can tackle on before coming to their appointment. So therefore, they can come to their appointment. They can be at ease. And it's less stress. And then they can get where they actually need.

Outcomes. These are the numbers from our bundle interventions. And it just shows here how our peer support navigation, trans life care, trauma informed care DV and IPV services. So this just shows a list of how many people that we had engaged in those services and the percentage that we had after from the beginning to the end outcomes.

Trans life care. We have an amazing trans life care department here, and this is just a fact sheet of a year of going through and taking the numbers from the beginning to the end of our project. Over the past 12 months, the gender inclusivity team has implemented trans health care interventions with the below noted accomplishments and outcomes. The team provided services to 40% of the Black Women's Project enrollees.

So we have a drop in center at our Decatur location, 77% viral load suppression, 70% accessing HRT, which is hormone replacement therapy services. There is a support group on Wednesdays along at our drop in center. So we create that safe space. And for holidays or any Trans Day of Visibility, we do different programs or events to acknowledge those holidays. And so people can come in. And they can have lunch. And they can chill with like-minded individuals and their peers.

We have expanded our staff to having bilingual case management. And we established community outreach efforts at our community ballroom scene. So now we're more incorporated our ballroom scene because that's where we know a lot of our trans individuals, walk balls is like a competition within a community that people have built through the years to make people feel comfortable when they couldn't go to other places.

And this slide right here is a testimonial from one of our clients that is still in the program right now. Thank you.

[VIDEO PLAYBACK]

- I had a great experience with the program. I'm still having a great experience with the program. And Beautifull treats me lovely. I see her like family. She's very well hands on. I continue to be with the program and enjoy being with Beautifull. Every time I see her, she puts a smile on my face. The whole team does, really. But she does more than any.

[END PLAYBACK]

BEAUTIFULL DEVYNNE: Thank you. And that was just one of our enrollees that was in the program and just to do wraparound services. This individual-- we had individuals that may have got a new job and they might not have clothing or proper work clothes. So we would go out and shop with them so they can feel their best selves starting a new job.

And that's what I say when we have wraparound services. And we did everything within the Black Women's Project, the whole team, as a family, to cater to our enrollees to make them feel like family

and not just a number of patients or clients. And that's how we build that rapport. And that's how we have this sustainability and retain people in care.

And now my part is over. And I'm going to send it over to my home girl, Letitia Burr.

LETITIA BURR: Good afternoon, everyone. I would like to-- My name is Leticia Burr. I was the intensive case manager on the Black Women's Project. And I would like to introduce everyone to Miss Jordan. Miss Jordan was a transgender woman that came to the Black Woman's Project through an internal referral. As stated by her provider, Ms. Jordan had multiple barriers to care.

She was viremic, living with her sisters and her sister's family, and about to be evicted. Basically, the sister was taking money from Ms. Jordan, saying it's for rent, but she wasn't paying the rent. She was using the money for her own personal needs. Ms. Jordan did not have employment at the time, though she did receive a disability check. And she had no transportation.

The area that she was living in, which is Gwinnett county, has very little public transportation. So she was at basically at the beck and call of her sister to provide transportation. She also had no other family support or community support. In addition to all that, Ms. Jordan had cystic fibrosis.

During the course of this case-- excuse me-- during the course of the services and the project, Ms. Jordan participated in trans life care, peer support, case management, with myself and community health work with Beautiful. We also assisted her with housing and also behavioral health. Ms. Jordan, she and her sister eventually did get evicted, even though we had provided them with rental assistance. And they were left with no housing at all.

She participated in behavioral health to talk out some of the issues she had not only with her family, but from childhood trauma. Some results of the services that we provided in the Black Women's Project, Ms. Jordan was able to obtain her own housing separate from her sister.

She wanted to work part time in addition to getting her disability check, and she was able to find employment in a very small nonprofit agency in her area. That same employer actually donated a car to Ms. Jordan, and she was able to drive for the very first time. She told me that she just got in the car, prayed, and went for it.

She also became romantically involved with a partner. Her sister had always been against her having a boyfriend. But now that Ms. Jordan was independent and in her own place, she was left free to date. And most importantly, she was virally suppressed. Ms. Jordan was able to get her viral load in a safe space. So as you can see, overall, a lot of her needs were met just by being in the project.

I still hear from her now, even though the project has ended. But she's a prime example of how this project has touched the lives and the lives of women that may have not been helped otherwise. So this is a polling question number two. What strategies would work at your agency for effectively engaging Black women in bundled intervention for HIV care support? A, creating a dedicated interdisciplinary care team for high need Black women. B, hiring staff that with lived experiences. C, making domestic violence and intimate partner violence for-- excuse me-- a focus for screening and intervention. D, developing trans-specific services. And E, getting mental health providers trained in evidence-based information and trauma treatment. We're just going to give everyone a moment to respond.

I see that a great deal of you were for hiring staff with lived experiences and who mirror the patient. That was the greatest-- the choice that the greater of you chose. Next came creating a dedicated disciplinary team, and then the others were about equal.

GWEN DAVIES: So I'm Gwen Davies. I was the PI for the project and helped write it along with our other-- Sheila Trapp, our other grants manager. So thanks for doing the polling question. They're definitely all really, really important. But I think the first point that we have here about sustainability is that dedicated working within a team makes a huge difference.

Because if you do bundle the intervention but you're not talking to one another, there is a possible negative, as there is with any intervention. And the possible negative is that sometimes a client can have a bad experience with somebody in integrated care. Let's say they're disappointed by the answer they get from a housing case manager. And if you're not talking to each other, that can cause the person to drop out. So you sort of inadvertently bundled care.

And now what it's meant is that one bad experience can kind of poison it. When we work as a team, we're able to regularly consult on cases. If there's a rupture in that relationship, we think about who can best make that repair and pull them back in to maintain retention. It's also really critical that you have staff that mirror the population, particularly for first contact.

Sometimes people work fine with client with the population even if they don't mirror it. But that initial feeling of comfort is really critical. What do we plan to discontinue? We're now finished with the Black Women's Project as a formal intervention.

However, really all that's meant is that we're ending the research component. All of the care components stay in place. And we wanted to make sure that we still had that for everybody, because very much like Beautiful and Letitia and everybody were saying, we need to provide holistic care if we're going to work with people that are at high risk for dropout for their care.

Now, if you're trying to replicate this, the funding that's really required to sustain it, in our case, has been that we've been able to have funding that comes through the pharmacy program, so through 340B revenue. We also use our regular Ryan White funds, but they just don't cover enough of it. But you need to make sure that you have sufficient funds. And sometimes that means you need to go out for other money, or that, in our case, are able to use 340B funds.

In our case, the main sustainability has been that as the same time that we've been doing this project, we've become a Patient Centered Medical Home. Patient Centered Medical Home very much mirrors this whole idea of bundling. And so it's a team approach. What we want is to convince our clinic that we need a bundled intervention specific, a care team specific to Black women.

These are the lessons learned, really, that it's easiest to do this intervention if you are in a one stop shop like we have, and if it's big enough that recruitment is really not much of an issue. The other thing I would say about this is the culture and environment play a huge role. So making sure that staff is well cared for, that burnout is low, makes a huge difference.

The other thing that we really do, which is subtle and small, but if you saw a video of our clinic, you would see it, we really try to make the facility inviting and to make it not look like an institutional setting, that it really should look like private practice. We want to provide the kind of care to people,

whether they have means or not, that is equal or better than the care that you would get in a private practice environment.

This is the last slide that we have. And we wanted to show it to you with just the video, with the permission of the person who created it. As part of the Black Women's First Project, we did a project called Photovoice where clients could make their own videos or photos or art. And I'll read you what this client said.

"This tree symbolizes the beauty of life and the idea that we are all connected. I love that we are connected and that we inspire each other to grow. The love I have for positive impact, my family, and my friends are all showcased in this tree, proud and strong." And that's it. That's what we really wanted to make sure that we achieved. And it made such a difference for so many of our clients who are so isolated. And in many cases, especially by working through mental health and working through PTSD with evidence-based interventions, people are able to reconnect to new people, to friends, to family, and to have more of a root system and to grow.

I think the next is we just have references. And then you can go to the next slide. I believe that some of these slides will come out. And then these are our contact information. Some people had asked about that. The other question was about rapid entry, which is very quick. And it's just that we have a special way that people can enter the clinic and immediately connect to medical care or reconnect if they've been out more than six months.

ANGEL JOHNSON: Thank you, Gwen. And Thank you, Erik and Beautiful and Letitia and Sevyn. So now we're going to hear from Dr. Villanueva from the Yale School of Medicine.

MERCEDITAS VILLANUEVA: So good morning or good afternoon, everyone. I pleased to be able to talk to you about our project. It was really exciting to hear the Black Women's Project. Now for a shift gears. Our project really is related to an area of hepatitis C, which is a pretty deadly disease in people who have HIV.

So I want to describe the work that we've done on our spins grant related to this project. So we have five objectives this afternoon or this morning. First, to give you an overview of the grant, including our goals in the participants want to discuss the importance of a concept called the hepatitis C Care Cascade. We then want to demonstrate a tool that we created called the Case Conferencing Tool, which is an intervention we hope that many of you might consider adopting.

Then we want to provide a real world example of how we actually use the tool and end up with summarizing some of our lessons learned. So this SPNS project, which was HRSA 077, was entitled Leveraging a Data to Care Approach to Cure hepatitis C Within the Ryan White HIV/AIDS Program, a Multisite Partnership. The work actually occurred between September 1 of 2020 to November 29 of 2023. We at the Yale School of Medicine served as the technical assistance provider and we had the opportunity to work with seven participating jurisdictions that are highlighted on this map.

Our jurisdictional partners, that is health department partners were from Arizona, Connecticut, Florida, Orange County, Kentucky, Michigan, Nevada, and Puerto Rico-- so very diverse grouping of health departments. And we also worked with 18 Ryan White clinics, which were part of each of these seven jurisdictions, and they are outlined here in some of the states. We had one clinic and then some of the states we worked with four clinics. So it really gives us an overall diverse representation of different Ryan White clinics in these particular jurisdictions.

So the project really had two overall main components, and the first component was creating hepatitis C clearance cascades specifically for people with HIV and hepatitis C, and the second component was really based on outreach and linkage to care. So we'll start with polling question number one, just to get a sense of our audience here and what best describes where you work. And please select all that apply.

Are you in a Ryan White funded clinic? Are you in a Ryan White funded part A or part B recipient-- not necessarily a clinic? Are you working in a state or local HIV surveillance program or state or local hepatitis C surveillance program or other? We'll give you a few seconds to vote. OK, what are our results?

All right, so we have a mixture of audience panel, audience participants. A great deal are in the other category. So that really encompasses a lot of different folks-- and then the Ryan White Part A or Part B recipients, which could be programs or health departments. And health departments are pretty low, which would be C and D. And some of you are working within Ryan White clinics. OK, let's move on.

So I want to introduce this concept which many of you may or may not be familiar with, and that is the notion that the United States, through the Centers for Disease Control, the Division of Viral hepatitis has created a strategic plan. And the goal is really to eliminate hepatitis C. Why is this such an important goal?

Well, many of you may know that in the past decade or so, there have been some very active antiviral agents called direct antiviral agents, which can cure hepatitis C in the majority of people with a 95% efficacy. So the idea of eliminating hepatitis C in our country is really an achievable goal. And so the clearance goal or hepatitis C curing goal, if we can reach 80% in our population, would really help us start to eliminate hepatitis C.

So how do we know that we're making progress within this goal? And so I want to introduce the concept of a hepatitis C clearance cascade and why it's important. So overall, a clearance cascade is a tool that can help visualize diagnosis and treatment milestones. It can also help us identify gaps in care, monitor how we're doing with our elimination efforts. And As I said, it is a key step in this 2025 national hepatitis strategy.

And what is a clearance cascade? It's really a sequence of steps that follows the progression from testing for hepatitis C to viral clearance or cure. And so in 2021, the CDC developed a simplified cascade, a mechanism whereby we can visualize these milestones. So visualized here on the right is something that was published in the MMWR in 2023, which looked at the viral hepatitis cascade in the United States from 2013 to 2022.

And from left to right, what this shows is that in a database from Quest Diagnostic, which is a commercial laboratory across the entire country, there are roughly 1.7 million people in this time frame who had positive hepatitis C antibody, and so were ever infected. And of those, viral testing, which means that the PCR was done to show that the hepatitis C is chronic, 88% of those in that database had viral testing done. And 69% of those had a positive test that showed that about 1 million people had initial infection.

And then when you look to see of those one million or so people, how many were actually cured, that was 34%. Why is this important? Well, 34% is very far short of that 80% goal that the CDC had established. So I'm going to turn it over to Ralph Brooks, who is going to talk about the work that we did

in creating a clinic cascade of care based on that same model of viral clearance. So I'll turn it over to you, Ralph.

RALPH BROOKS: Thank you, Dr. Villanueva. So we are basically going to take that concept of the cascade and we will be applying it now to the specific cascade level. This methodology will then facilitate outreach and linkage to care. So first, starting with the poll question, if you work in a clinic, do you currently have the capacity to create a clinic-based hepatitis C cascade of care? A for yes. B for no. Or C for not sure.

We'll give folks a little bit of time to answer. How does our poll look? All right, so it looks like those who know would basically say that, no, they don't, with only a handful, too, saying that, yes, they can, and the majority of folks say they're not sure. And that's not really surprising. We did identify that when we were starting out this project, most of the clinics that we were working with either fell into the no or don't know camp. So that makes sense.

When we're starting this cascade clinic of care activity, we identified that this was really a data to care activity. So it requires a partnership with the Department of Health in some way. The degree of that partnership is what dictates whether you fall into model A, model B, or model C in this project. So model A, you have a list of individuals who have HIV. And you will match that, at the health department level, with your hepatitis C surveillance system. That will give you your co-infected patient list.

So part A is entirely done by the Health Department because they have a centralized HIV system. With part B, which is where most of our clinics fall, the clinic develops an HIV, persons living with HIV list. And they send it to the health department. The health department does a match against their hepatitis C surveillance list, and then sends that coinfection list back to the clinic. And then the clinic is able to act on those patients and track those.

And then with the model C, it's pretty much entirely done by the clinic. The clinic ends up taking the HIV information that they have and they match it to in house hepatitis C information. And then they put together a list of coinfecting individuals and they send that up to the health department, or they just keep it themselves if the health department doesn't need it. And then they work on outreach and linkage.

And so it depends on how good your relationship is with your health department and what sort of statutory limitations exist. But this is basically where we start. The starting point is you start with the list of HIV infected individuals, persons living with HIV, and you match it with those folks who are coinfecting with hepatitis c.

All right, once you have that list, you're able to populate the case conferencing data tool. Now, the case conferencing data tool is available at the QR code here and at the link that you'll see on the next slide. And it's a tool that we developed to allow the health departments and the clinics to have a dialogue on those individuals who are living with coinfection for HIV and hepatitis C.

And there's a lot of information that gets collected within the data tool. It allows you to match for ID using demographics, gender, sex at birth, age, race and ethnicity. It allows you to record things like barriers to care so that you can try to figure out if a person hasn't entered care, why not. It allows you to understand their treatment status and their outcome as they move through the cascade.

And the key point here is if you fill in the yellow fields, those yellow columns, that's basically the patient outcome and the date of their outcome, as well as obviously their name or identifier. You are able to, at a minimum, using those two pieces of information, generate a cascade of care on your own within the clinic. You put in the information and it just spits it out.

And here, in order to use the case conference call and give a little bit of background, we've developed a mini e-learning module. This is available at the web link there on targethiv.org. It's a four module set of curricula, basically. And the modules each have videos associated with the different steps. Module 4 is specifically assigned for case conferencing. And we will see a small clip of video for now, just how to generate and use the clinic care cascade.

[VIDEO PLAYBACK]

[MUSIC PLAYING]

- Generating and using the Care Cascade. What can we learn from the newly populated tool? The tool's information is used to automatically create two charts. First, a pie graph identifying treatment eligible individuals in green compared to the various subcategories of non treatment eligible individuals, those who are deceased, out of jurisdiction, incarcerated, those needing PCR, self-cleared or previously cured, and those who have had their care transferred to another clinic.

Note that a patient who stopped showing up to clinic should not automatically be considered transferred, but instead be labeled as lost. And then they can remain considered as treatment eligible. Detailed descriptions of these categories are on the instruction tab of the case conference tool.

The second chart is the clinic's hepatitis C treatment cascade bar graph, with treatment eligible patients broken down into sub categories, showing progress toward achieving cure and yielding five cascade steps-- eligible for treatment and active care at the clinic, treatment initiated, treatment completed, and SVR12 achieved.

[END PLAYBACK]

RALPH BROOKS: All right, so that's just a short snippet of the longer module. And it really delves into detail on how we build these cascades, what they mean. It goes a little bit into gaps and identifying opportunities for improvement in the cascade. So here is, again, the example of aggregate results that we experienced with our project. We have 14 clinics as of 11/30/2021 with a total of 1,543 patients across all of those jurisdictions that Dr. Villanueva highlighted at the beginning.

And you can see that here in this specific example, at the end, we had 956 folks who were considered treatment eligible because they didn't fit into one of the other pie pieces-- the deceased, the relocated out of state, they didn't need PCR anymore, and they weren't found to be antibody negative or transferred. And so then if we considered those 956 treatment eligible persons and we move over to the right hand chart, we can follow those folks through the cascade and see where they fall off.

And any place where they fall off, that ends up being the gap. That ends up being the person that we need to reach out to if they're not yet treated, if they're lost, if they're managed elsewhere, et cetera, until finally, with regard to our project, we weren't at the national average of 34%. But we were closer to 50%. And now Dr. Villanueva will be taking a deeper dive in to one clinic in particular.

MERCEDITAS VILLANUEVA: So I wanted to know whether or not using this tool would really be very useful. Because many of you out there who have not even looked at this tool may say, my god, this is so complicated. I'm never going to be able to do it. But actually, once you get familiar with the tool, it is actually a pretty user friendly. So I want to talk about a real life clinic example. This is the clinic that I work here in New haven, Connecticut.

And we actually published a paper looking at a cohort of 173 patients who had HIV and hepatitis c. So these were treatment eligible patients that were seen in our clinic between 2014 and 2017. And we published this in Open Forum Infectious Disease. So we created our own list. So that was the model C that Ralph was talking about. But it was a very labor intensive process because we didn't have the tool at this point in time.

And as you can see at the far right end of this cascade, we had around 56% of those clients actually had achieved SVR. And then the gap, which is represented in those yellow, gray and orange rectangles, shows that those folks were what we call not engaged in care. And we didn't really have any details about why was it that this gap existed.

And so what I did was I took these same 173 clients in the next slide. I plugged them into our treatment cascade. And so I used the tool with the same original data that we had generated back in 2018 and found that about 51 we put into that lost category that Ralph was talking about. These were not engaged in care. We really just sort of put them in a whole group of these guys were not cured.

And what was that? And so I was then able to look at these 51 so-called lost clients and see what can we learn about these? So this is the power of the tool. So that, in fact, on the left hand slide is that pie graph that Ralph had mentioned, and then relooking at the cascade based on some much more granular data.

So for example, we found out that of those 173 clients originally in the project, that there were actually only 163 that were treatment eligible. Why? Because seven had been deceased without treatment. So they really were not treatment eligible. And then some had relocated out of the state. And so we really configured our denominator so that 163 were eligible for care, for treatment.

And then by just diving into the granularities of it, the so-called loss were only 9. And then there were 32 who were not yet treated. And by adjusting the denominator, we actually had a cure rate of 62%. 62% versus 56% is not much of a difference. But I think the major impact of using the tool was that we found that there were 32 people who truly were not yet treated, and we wanted to do a deep dive into why did this gap happen.

And so I analyze these groups of people. And this is the power of the tool. You could look at those 32 and say, well, what's their barrier? And so, in fact, those 32 people, 11 had active substance use. 7 just said they were not ready. 6 had comorbidities, like hepatocellular carcinoma, decompensated liver disease, or other comorbidities like for example, cancer or other comorbidities. Three refused. One had an active mental health issue and 4 were unclear as to why they were not treated.

So I updated our original cohort up into 2024, again, using the tool. So the tool is a convenient way to update the information. So you go through your list of clients. And then you look to see what's happened to them since 2018. And, in fact, when you look at them, an additional four, unfortunately, were deceased. And so that change our treatment eligible denominator to 159.

And then when we looked at those folks, those 32 had not yet been treated as of 2018. We found that not yet treated group had shrunk to 11. And so that's progress. So we went from 32 to 11 who were not yet treated. And then our cure rate went from around that original 56% to 84%. And so that meets the goal of 80%. And so we can say 84% of our treatment completed group had actually achieved the cure. So we were happy about that.

But we still had 11 who were not yet treated. That was 7% of the population. So this brings us to our poll question number 3. So we went from 32 who are not yet treated just to 11. And you said, well, how did we make progress and get more people cured? So in this question, what top two approaches of those listed below would you suggest to promote hep C treatment in persons who are untreated? So you could choose more than one.

Would it be asking the clinic staff to call up the patients and remind them? Would be, would you work with your health department to find these patients who are lost to care? Would you use motivational interviewing to promote entry into care? Would you engage peer advocates? Would you have a clinic champion? Or would you have other approaches? What would you think would be the top two things that would help get people who are untreated into hepatitis C care?

So a real range of results. The top vote getter was engaging peer advocates, which was very much reminiscent of the theme of the Black Women's Project. Using motivational interviewing was next up, followed by working with health departments and then asking clinic staff, the sort of traditional calling them up to remind them to show up to clinic.

OK, thank you. So what accounts for that improved SVR rate in our clinic? So in the course of six years, we approached the target of 80% And what we found, interestingly enough, is that many of our patients who are previously untreated in 2018 ended up getting treated in a long term care facility, like a residential facility that we have in our area called Leeway. And believe it or not, many of our clients were treated within the jail setting.

The other thing that was very important was many of our clients initiated treatment for their substance use disorder, for example, entering methadone program. And that got them into a place where they could be ready to undergo treatment for their hepatitis C. We also had a model of care where our team - we had a hepatitis C team that was constantly monitoring to make sure that folks who had not been treated got reminded so that we didn't lose them because we didn't know that they were untreated.

And then we would always assess readiness for treatment in an ongoing fashion. Because I know I have many patients who will tell me they're just not ready. Life is too complex at this point. But I don't drop it there. And our team will then just say, maybe six months later, are you ready? And often, people are now at a point in their lives where they are ready. But by constantly asking that question to make sure that people are ready in their own time frame, I think that's very important.

The other thing that we found was using a specialty pharmacy that's specializes in hepatitis C So that our pharmacy can actually also help us in making sure that our clients are getting their medications on time and checking in with them just to say, how are you doing? How is your treatment going? Are there issues that we can address?

So we found that we did show improvement in our clinic. Using the tool was actually very helpful. And so we would encourage other Ryan White clinics to try using this tool as well. So to maintain

sustainability for this tool, we have developed these training modules on the HRSA target website. There are training modules for both health departments and for clinics.

And we're doing, just like this, ongoing presentations to key stakeholders to roll out the tool so that it's not so intimidating and to say this is actually a very helpful tool for quality improvement in your clinic. So I'd like to conclude by saying how we use the Case Conferencing tool and the lessons that we learned. And I just want to emphasize this Case Conferencing tool is your friend. I found that when I started using it myself for our own clinic, it made my life a lot easier because we could generate the cascade of care and change the cascade of care as we improve the care in our clinic.

But it's important to ensure that the persons who do fill out the tool complete the list that they understand hepatitis C, because there are some nuances about knowing about the treatment of hepatitis c. We should have dedicated staff who are knowledgeable about data, create regular updating sessions so that the tool gets populated and updated every four months, every six months, for example, and then implement the results, reach out to clients. When you know that they haven't been treated, you should see, well, why is that the case? And is there something that we, as a clinic, can do to improve that situation?

And so this brings us to outreach and linkage. So creating your cascade of care shouldn't be your main goal. It should be a way of saying, well, how can I reach out and link people who haven't been treated? And so you should use multiple methods for outreach and linkage. For example, can you leverage your health department jurisdictional staff to help find clients who may not be treated? Can you work with your clinic staff, your case managers, your peer navigators, to help you reach out to clients and say, hey, we noticed that you haven't been treated for hepatitis C. Let me walk you through the process.

You can also check with your health department staff to get more updated data on those so-called lost clients, and then use your multidisciplinary support staff to address these client barriers. For example, can you refer them to a long term care facility? Can you address their active substance use issues? Would that be the barrier to address to get them over the hump of getting their hepatitis C treated?

And I think it's very important within a clinic that you have a clinic champion who can be part of a comprehensive quality improvement efforts. In other words, if you don't prioritize curing hepatitis C within your clinic, you may not get to that goal. So having a champion who works on this is really an important thing.

So we have a few references here. As we mentioned, there's that targetHIV site. That is really a wealth of information. And I know iHiP really works on making sure people access this site. In this particular site for hepatitis C work, we have our recorded webinars. We have an implementation manual with steps and lessons to support replication of our work. Those videos that Ralph mentioned, which has also written companion text. And it has those Clearance Cascade and Case Conferencing tools that are applicable both for health departments and for clinics.

And so this is the contact information for myself and for Ralph if you want to reach us regarding details on using the tool and any other questions related to this work. So thank you again for involving us in this webinar. We hope that we've stimulated interest. Because hepatitis C is not going away. The country as a whole has not reached the goals that have been set by the Strategic National Plan. And so we still have work to do. And hopefully you'll be on board with this work. Thank you very much.

ANGEL JOHNSON: Thank you, Dr. V and Ralph, and thank you to all our presenters for their wonderful presentations today. So now we're going to open up the mics for questions. And if you have questions for our presenters, you may use the chat or Q&A feature, or you can raise your hand to speak to the presenters directly. We did have a few questions that were left in the chat earlier for Black Women's Project. I believe they were responded to, but I'm going to go ahead and go over them anyway. And then I think there was one question that was left in the Q&A for Dr. V or Ralph.

So the first question that we had was how do the non retained individuals differ from retained, where percentage of initial participants were non retained? The response-- we usually have 10% to 15% of the patients either drop out of care or just stop showing up. And if someone wants to elaborate a little bit more on that, that's absolutely fine, unless that was a sufficient response.

GWEN DAVIES: I'll just say that I know it's similar in terms of the viral suppression data, is that people with more barriers tend to be less likely to be retained. And Black trans women face such a number of intersectional stigmas that we always have a little bit higher dropout rate in that population. But it's not limited to that. It's stuff that you would normally think of-- active drug use, active mental health issues, higher stigma scores.

And if you're in a clinic and you're trying to predict who's going to drop out ahead, one question that is extremely helpful is to ask someone if their phone number has changed in the last year. If it has changed in the last year, it's sort of almost like a proxy for chaos in their life. And so if you have people like that, you can assign them to a community health worker early, like do those retention measures early before they drop out.

ANGEL JOHNSON: Thank you, Gwen. Another question we had, rapid entry is-- I'm sorry, what is rapid entry? is the question. The response, rapid entry is for patients that have been out of care for six plus months or off of meds for a prolonged period. We rapidly enter them back into the clinic services without a wait.

GWEN DAVIES: Yeah, and it's also for people that we test positive. We have a number of people who either show up in Atlanta and they are out of care because they've changed location or they've just tested positive. So it's for them, too. And it gets them into medical care immediately. Like they immediately have their labs drawn and they have the first available medical appointment, which is often same day.

ANGEL JOHNSON: Thank you. And again, if you have questions, please, you can place them in the chat. So we had a question. I believe this is for Dr. V or Ralph. I think this came later in the presentation. How do you guys make sure that all age groups are catered for, especially women under 18 who are still in the closet? I'm not really sure who this is for, but if the person who asks the questions wants to give a little more information, that's fine.

RALPH BROOKS: Angela, I think that actually came before us for the previous group because I saw--

ANGEL JOHNSON: Thank you, Ralph. So someone from the Black Women's Project can respond to that. How do you guys make sure that all age groups are catered for, especially women under 18 who are still in the closet?

ERIK MOORE: We do not serve anyone that is under 18. I don't believe-- Gwen might be able to clarify that. We will, I think, if they have parental consent. But as far as the project goes, I'm pretty sure you had to be 18 and above.

Depending on what your situation is with being out in the community and that kind of thing, that's kind of part that Beautifull spoke about. With support groups, you might not be able to be enrolled in the program. If you're not technically positive, you wouldn't be in the program. But we have a lot of different support groups for people that are questioning. The transgender support groups aren't just for people that are specifically trans. There's questioning, non-binary, different things like that. So we just pretty much try and accommodate anyone when they come in, meet them where they are, the usual social work response, and take it from there.

GWEN DAVIES: Yeah, I mean, Erik's very much right about that. We do see people younger than that for medical care. It's a little complicated. We can't for mental health, but we can for medical. And we have a program that's for young queer people that are living with HIV. And Beautifull, maybe you can say, have you seen anybody who's been under 18 outside of the project?

BEAUTIFULL DEVYNNE: I haven't. Most individuals are at least 18. But we do have a status neutral groups, as well, that our prevention department handles. But I think pretty much everyone is at least 18 and over. I haven't seen anyone under 18.

ANGEL JOHNSON: OK, thank you. I don't see any other questions or comments. So we would really appreciate your feedback on today's presentation, as well as the presenters. So if you could use this link that's on the screen to give us your feedback at another time, or if you can do it now.

So I'm trying to see, someone just spoke-- I'm excited to share this event with my colleagues and the hepatitis program.

ERIK MOORE: Can I say something real quick?

ANGEL JOHNSON: Absolutely.

ERIK MOORE: Sure. Just so everyone knows with regards to these projects, SPNS projects, the final outcome of all the data collection and that kind of stuff is we do write manuals, a how-to manual. So each SPNS project will write basically a whole manual, 30, 40, 50 pages on how to create or replicate the project if you want to. So you can take pieces of it, parts of it. You can take the whole thing, whatever you want.

But these manuals will be posted on Target HIV, I think our project director said sometime by the end of this month, maybe next month. So if you Google Black Women's First Initiative, target HIV, they'll have all 12 manuals from all the sites that did the projects. And like I said, you can download them. You can pass them around. And there's manuals for everything that you can possibly imagine. We've done housing and employment.

Like I said, we've done this Black Women's Project. So no matter what you're kind of looking for help on, somebody somewhere through HRSA and through SPNS has written a manual so you don't have to recreate the wheel. You can take all the things that we spoke about in bits and pieces and put it all together for yourself. But that's on Target HIV.

ANGEL JOHNSON: Thank you, Erik.

MERCEDITAS VILLANUEVA: Yeah, I just want to mention, Target HIV is actually a treasure trove of things. And HRSA has invested a lot. And I wonder how well utilized it is. It's our own manuals. We put a lot of work into our own manuals, creating our training videos. And we use animations in our training videos. So we really try to make it an engaging experience. So hopefully we can spread the word about those resources.

ANGEL JOHNSON: Thank you, Erik and Dr. V for sharing that information. No other questions. Thank you for attending this webinar. Our next webinar will be June the 27th at 2:00 PM Eastern time, and will feature interventions focused on innovative HIV care strategies for individuals who are not in care or have a new HIV diagnosis.

So we hope that you all will join us for that webinar, as well. All right, thanks, everyone, for joining us today. And enjoy the rest of your day and have a great weekend. Thank you.

ERIK MOORE: Thank you, everyone.