

WEBINAR VIDEO TRANSCRIPT

Brandy Martell Project & TransLife Care Project, Trans Women of Color July 2018

MODERATOR: Good afternoon, everyone. My name is Angel Johnson, and I'll be moderating today's webinar on "Improving Health Outcomes, Moving Patients Along the HIV-Care Continuum." This is the third webinar in a four-part series brought to you by the HRSA Special Projects of National Significance, SPNS program.

So as you can see by the agenda, I will provide a brief overview about SPNS and the Integrating HIV Innovative Practices Project, or IHIP. We will then hear from two presenters who will be discuss their SPNS interventions. Our first speaker today will be Josie Lynn Paul from Chicago House and Social Service Agency in Chicago, Illinois.

Josie has served as the director of the Translife Care Program since 2014, and previously served on the Translife Care Trans Advisory Board. She has almost 30 years experience providing clinical service, supervision, and program management. Josie provided administrative oversights and served as project director for the SPNS Trans Women of Color Initiative. She an out and proud woman of trans experience, and lover of all things purple.

We will also hear from Tiffany Woods from Tri-City Health Center, Fremont, California. Tiffany co-created Trans Vision, a nationally and internationally recognized primary health and HIV program at Tri-City Health Center for transgender, gender non-conforming individuals in 2002. As parent program manager for transgender services at the federally-qualified health center located in Fremont, California, Tiffany ensures the trans community has access to affirming, responsive health care and HIV prevention and care. Miss Woods is currently providing technical assistance to CDC International in Central America for their national transgender health service strategy in Guatemala and Panama.

Following these two presentations, we will open the line for questions. The SPNS program is funded through part F of the Ryan White HIV Program, and provides opportunities for developing, implementing, and assessing innovations designed to meet national goals to end the HIV epidemic, and address the evolving nature of our health-care delivery system.

The SPNS program remains current by addressing emerging issues and HIV care, and populations most affected by HIV. There are currently 57 grant recipients providing clinical and support services to over 9,000 individuals living with HIV. The SPNS demonstration models contribute to the advancement of public health knowledge and innovation designed to move people living with HIV along the HIV-care continuum, and ultimately achieving viral suppression.

The SPNS program funds initiatives along all stages of the HIV care continuum, from diagnosing and linking individuals to care, to medication and adherence and viral suppression, and supporting individual and system-level change to achieve desired outcomes.

Initially, the SPNS program was challenged by finding ways to effectively disseminate information about successful SPNS models of care, and the lessons learned to help other providers replicate these interventions. However, through the IHIP project, SPNS effectively promotes markets and disseminates strategies to support optimal implementation of these models.

The IHIP strategies used to disseminate SPNS models include developing tools and resources, such as implementation manuals, intervention guides, and fact sheets, to encourage replications, engage stakeholders to increase reach of these tools, and provide capacity building assistance to support the replication of SPNS intervention models.

Capacity Building Assistance includes the IHIP listserv that notifies recipients of new resources, trainings, and other upcoming events, knowledge exchange with our partner organizations to raise awareness and help promote this information, webinar trainings and best practices in developing and disseminating SPNS-focused publication, and peer-to-peer sharing of best practices, like this IHIP webinar series, and presentations at various conferences and grant recipient meetings to introduce these models and associated resources.

Here we have a list of IHIP resources that are available in the Target Center. The Target Center is the Ryan White Technical Assistance Clearinghouse where you can find these IHIP resources. Please keep in mind that if tools and technical assistance resources become available, they will be posted to the Target Center at <http://www.CareActTarget.org/IHIP>. So we encourage you to visit the Target Center if you haven't, and become familiar with it and what it has to offer.

As I prepare to turn things over to Josie, I want to provide you with some information on staying connected to SPNS and IHIP. If you have questions about any of the information that's shared during today's webinar, or anything related to the replication of SPNS intervention, please send your inquiries to SPNS@HRSA.gov.

For additional information on tools and resources, and to sign up for the IHIP listserv to receive the latest announcements about IHIP resources and webinar trainings, please visit the Target Center at <http://www.CareActTarget.org/IHIP>. And to learn more about HRSA and sign up for their newsletter, you can visit <http://www.HRSA.gov>.

Now, without further delay, I'm going to turn things over to today's first presenter, Josie Lynne Paul, from Chicago House and Social Service Agency. And immediately following Miss Paul, we'll hear from Tiffany Wood from Tri-City Health Center. Josie?

JOSIE LYNNE PAUL: Thank you, and well, good afternoon here. I don't think it's afternoon everywhere. But I am Josie Lynne Paul, the director of the TransLife Care Program for Chicago House and Social Service Agency in Chicago.

And our disclaimer. So just as a brief outline of what I'm going to cover, we're going to talk about just the basic overview of the TransLife Care Program, what kind of capacity requirements we found for running that program, our successes and challenges, and lessons learned in five years with the SPNS project. And then concerns and successes around sustainability of the program, take aways, some highlights, and resources.

Just an overview of Chicago House and Social Service Agency-- we were founded in 1985, our mission serving individuals and families disenfranchised by HIV and AIDS, LGBTQ marginalization, poverty, homelessness, and gender nonconformity. And the agency provides housing services, employment services, medical linkage, and retention to care services.

HIV prevention services, legal services, and other essential support types of programs, services. In the TransLife Care Program, we really had two main goals for our program going into the SPNS project. One was the engagement and retention of transgender women of color who were living with HIV, and gender-affirming HIV and medical care through the provision of essential support services.

And we also had a goal of increasing medical and social services provider capacity for providing transgender-affirming care. And we did that by providing transgender cultural competency trainings to those medical and social service providers.

In the TransLife Care model, we provided basically five different kinds of service buckets. We operated a TransSafe drop-in. It was a drop-in space held weekly in community spaces like the Community Center and other spaces that were in the communities of the trans population that we served. As part of our drop-in, all of our other providers were present in our drop-in so that folks who came in could engage in services with that provider. And it wasn't by referral or by appointment, but rather all of the services were available within that drop-in.

Our TransHealth services are drop-in services available during those TransSafe drop-in hours in partnership with the local FQHC. In our TransHousing program, we provided linkage to housing resources as well as Chicago House operating 15 scattered site units through HUD, dedicated to the trans community.

And our TransLegal program, a staff attorney providing assistance with legal issues such as name change, public benefits, discrimination cases, record expungement and sealing, and miscellaneous other kinds of legal challenges that were brought by the trans women that we served.

And then in TransWorks, a career specialist provides assistance with resumes, job readiness, job leads, and job coaching, as well as TransWorks job workshops and mentorship programs.

Our target population was transgender women of color living with HIV who are newly diagnosed or out of care. We're staffed with one full-time program director, one project manager, and four part-time, the equivalent of 1 and 1/4 FTE peer resource navigators and outreach workers.

We had additional staffing not funded through the SPNS project in partnership with medical provider. Our housing case manager with our TransHousing helped with housing information and referrals. Our employment specialists, legal attorney, were both part of our TransSafe drop-in. We have a part-time TransSafe coordinator who helped with the drop-in. And an HIV coordinator testing-- doing testing navigation and linkage to care as her specialty.

So in our intervention components, we did a lot of outreach. Our outreach was focused with our peer resource navigators who were out in community. They were hired from community to do outreach to the trans community and focus a lot on face-to-face relationship building kinds of outreach. We provided direct connection to essential support services-- legal housing, health care, employment, and the safe space-- centered in our TransSafe drop-in model.

Our focus was on provision of social determinants of health. We were looking at the drop-in as kind of the hub where we provided the kinds of support services that would assist trans women of color living with HIV engaging in care and remaining in care.

And we provided navigation services through our peer resource navigators, who would assist the trans women participants in connecting to and remaining connected to all of those different service components, as well as to the medical care.

In the implementation, really there was a number of things that we found to be really important in terms of our successes. One is that our programming was entirely trans-specific. Our drop-in and our services were marketed to, geared towards, and trans-specific so that it was a safe place for trans women of color to engage with that. And that we hire and engage staff members who are predominantly trans women of color.

We kept our space accessible and barrier-free. We didn't require appointments. As a drop-in space, it meant that the folks in community who desired services didn't have to come when we said we were available. We were available when they were ready to engage. And the other piece that's really important was that we did not determine what services that any of our participants were needing to engage in.

The services that we provided were those that our participants identified as their needs, not our need for them. We adopted our stigma-free intervention eligibility criteria. So for our TransSafe drop-in program, the eligibility criteria were really very simple. We served individuals who self-identified as transgender and gender non-conforming, and were 18 or over.

And so we served all individuals, and we did not work with individuals that-- we did not require identification of HIV status when coming in to the drop-in to engage in all of those axillary services.

We found that it was really important to have that one-stop shop kind of criteria where we had a bundling of services that, when the trans community participants came in, when they wanted legal, employment, housing, medical services, it was all in one place. And a lot of times what we found was an individual might come in saying, I need housing services. That was probably one of our greatest draws was connection to housing resources. And then would find out that we also offer, perhaps, legal services, and she would say, oh, well, I want a name change as well. Can I sign up to see the lawyer? And we would sign her up to see the lawyer that day to consult on being able to actually move towards getting that name change.

We took a very collaborative model. We worked very closely with our partners and community, the FQHC that we work with, the community spaces, and we really focused everything on relationship and connection. All of our outreach and all of our engagement strategies were really about building relationship. As a social worker, I'll often talk about how in real estate the buzz words are "location, location, location." But that in this work, it's "relationship, relationship, relationship"

So we faced a few challenges. One was staff turnover. And in an intervention based on relationships, staff turnover definitely provided a challenge in that the person that was building relationships with participants was no longer there, and we had to start over to some degree.

Because we had so many different providers of services present in our drop-in space, it meant needing a very accessible and adequate space for that drop-in. We needed private spaces for screening around housing, medical, legal, and employment services. And so it needed a number of private spaces as well as a larger gathering space.

And then when we were implementing our TransHealth, we found that it was so essential and absolutely required that we provide access to hormone therapy and the trans-affirming health-care partners.

So one of the lessons we learned was simply, as I mentioned, relationship, relationship, relationship. That we really focused on building trust and relationship with potential participants. That we went out and we would go into spaces where the trans community was gathered, and we required that we be patient and persistent and consistent in our presence.

We couldn't just show up once, say, here, here we are, put up a flyer and expect anybody to show up. Building relationship requires that patience and persistence over time. And that we needed to meet the trans communities in their community. That we could not do outreach from our offices. We had to go out to the community where folks were gathered.

I'm reminded of the movie Field of Dreams where there was a line, "Build it and they will come." Well, this is not build it and they will come. It was very much, go out to where they are, and tell folks what we do and build relationship with them. And that we were very client-centered and trauma-informed. We built our relationships around, what is it that you want and need from us?

Not, here is what we want to give you. I talked a little bit earlier about the stigma-free and inclusive eligibility criteria. And then essential was the building of relationships through peer services. Balancing community membership and professionalism was one of the challenges. Then needing to really focus on intentional professional development and mentoring with the folks that we hire so that we're not only providing staff members who look like the community, but are trusted because of professional presentation and deportment, in working with the community.

We also found that we really needed to not only build relationships but offer meaningful services. That the services we offered were those that were most often requested and desired by those most marginalized in the trans community. Trans women of color living with HIV came, and these were-- the services we provided were those most requested.

That the legal, the housing, the health care and employment, were really those things that were highly desired. And bundling them into this one place so that it's accessible, no appointment needed. And that it isn't a referral. We found that it's highly successful having a staff attorney on site as part of our drop-in. This is not, OK, we have this legal clinic that we can refer you to, but rather, we can have you see the lawyer today. That the medical providers were able to do outreach medicine and actually provide medical care at our drop-in site, and that we didn't have to refer to a clinic to get a beginning with actual care.

And that we didn't focus on HIV in order to address HIV by having folks come in. Because what we found amongst the trans women of color participants is, if we said, we will connect you to HIV care, they had no interest in our services. But when we said, here are the services such as housing and legal and employment services that we have, they would come in, and in the course of receiving those services and getting started, the conversations around HIV would happen, and we would begin the conversations about whether they were engaged in care, what we could do to assist those individuals in becoming engaged in care if they were newly diagnosed or out of care, or how to remain in care.

That we integrated with our community partners. We found that approaching our community partners, as those relationships being just as important as the trans community members that we serve. So we really focused on those relationships. We did find that it was a rather short-term intervention, and it favored identification and linkage over the retention and care. So we had to build in additional navigation services over time.

With sustainability, we found that we were able to succeed in securing a grant from the CDC 16-003 for the evaluation of home grown interventions for transgender persons, and we'll

reevaluate those services for primary prevention. And part of the challenge for this model is it doesn't fit seamlessly under traditional HIV prevention or care.

And information about our website, and my information if you want to get in contact. And I will turn it over to Tiffany.

TIFFANY WOODS: Thank you, Josie. That was a great presentation. I'm excited to be here to co-present with you. Good afternoon and good morning wherever you are located in this country, watching this webinar. Thank you so much for joining us and learning more about engaging and retaining transgender women-- especially trans women of color, into care.

So I'm going to present on the Brandy Martell Project. We have to do this disclaimer, so this is all funded by HRSA and our SPNS project. The five-year funding presentation outline. We're going to do a quick overview, as Josie also did, capacity, implementation, lessons learned, sustainability of the interventions, recommendations moving forward, and, of course, resources.

So I'm trying to move a little bit faster. What was the goal of TransVision? So TransVision is housed in a program at Tri-City Health Center in Fremont, California. Tri-City Health Center was originally founded in 1970 as a family clinic for low-income minority women living in Southern Alameda County. We became a federally qualified health center in 2003.

We offer primary medical, dental, behavioral health services. We've had HIV care prevention since the '90s. Tri-City's the only FQHC in the city of Fremont that offers health care home which emphasizes disease prevention and chronic disease management. TransVision is the transgender program. We are award-winning, nationally and internationally recognized. We received the SPNS funding for the Transwomen of Color Initiative in 2012 with the other eight projects across the country.

We are one of Alameda County's only community clinics serving the trans and gender nonconforming community. We have pretty much the standard interventions that everybody else has that serves the trans community, specifically. We did the informed consent model. We have trans-specific health hormones and assessments and intakes, prescriptions, pharmacy assistance, prevention services, safe sex, HIV testing, Hep-C testing.

We do PrEP access and navigation. We have partner services, group interventions. Peer-to-peer client navigation, we also do free name change assistance. We don't actually call it legal assistance because our staff do it and we don't use a lawyer. And we have about 450 active clients.

So the Brandy Martell Project morphed out of all of our work we've done since 2002. It was an intervention to reengage and retain trans women of color previously out of care. We actually get them focus studies and staff and client information on what they wanted to see in a program if we did get the funding. So they helped inform our intervention selections. Trans

women of color are disproportionately impacted by HIV, of course. Have low HIV care engagement, low survival rates compared to other populaces living with HIV.

Our experience with clients falling out of care to meet their basic needs underscores the significance of implementing comprehensive programs. So we based our interventions in our original application on the critical race theory, which provides a theoretical basis for understanding the issues of racialization, race consciousness, and social location with the intention to understand and eliminate health inequities.

Critical race theory encourages development solutions that bridge the gaps and help housing, employment, and other factors that lead to health disparities and health equity. So we thought it was a good fit for this innovation model.

We named it after Brandy Martell. Brandy Martell was a member of TransVision. I actually hired her in 2007. She was a domestic violence survivor. And she was shot and killed in Oakland on April 29, 2012. We were awarded the funding on Labor Day of 2012.

Many of the HIV positive women that we were going to be reaching out to engage in this project were friends of Brandy, clients she also served during outreach and as a peer advocate. And so we thought it was a way to honor her.

It was also a way to talk about violence against transgender women of color. We have an epidemic in this country. And we wanted to get her message and her story out. So it's kind of hard to talk about linkage to care or prep or treatment adherence when we can't have a conversation first about violence against transgender women. Because if they're dead in the street, we can't get them into the clinic to engage them in their care. So we love to tell her story and try to have that conversation.

Our intervention model. So the goal was to enroll 45 participants into the Brandy Martell Project, offer access to direct legal counsel, and participation in living real workshop sessions. We had two interventions. The criteria was the same across the board for all nine SPNS projects. Transgender women of color, ours was specifically African-American or Latina, assigned male at birth on your birth certificate, currently identifies as transgender, female, trans female, or trans women, self-identifies as nonwhite or mixed race ethnicity, has to be HIV-positive, and at least 18 years old.

So our target population is our Latina and African-American trans women living in Alameda County or neighboring counties. We included Contra Costa and Santa Clara County. They were also existing-- in the beginning, existing African-American transwomen clients at TCHC and our Latina, and then have dropped out of care or released from incarceration, which we had a significant amount over the years.

Our first intervention component was our legal services. Like Chicago House and Josie, we don't have access to a lawyer here. We've never had. Previously, to HRSA SPNS, I would go to court

and navigate for them. I'm good, but I'm not a lawyer. So I would manage to get them to come into this program and kind of delay or get them released from whatever legal criminal justice system.

So we were excited to be able to offer a legal liaison, which we called it, but it was actually a criminal justice attorney. David worked individually with the clients, help navigate the court system in Alameda County, which is a little different than San Francisco County. Help clients overcome existing legal structural barriers preventing them from staying consistently in HIV care. One of the issues that we had identified over the years was they would go away to jail. They'd get arrested for sex work. And then they'd just drop out for months and months. And then we'd find out that they were incarcerated, and it was hard to get them back into their care.

So this is one of the reasons I wanted to do a legal intervention. It's not a novel model. Other programs have it around the country. Tracy has never had that. So our lawyer, David, conducted a monthly legal clinic to help identify the legal issues, barriers. We did "know your rights" and expungement sessions in the Living Real curriculum. He did one-on-one 30 to 60-minute counseling sessions that were confidential. None of the staff ever had access to those sessions. Follow-up legal sessions on a case-by-case basis.

And one of the great things about our lawyer was that he gave us a \$50 per hour non-court rate, and a \$60 per rate in court. And that greatly impacted how many he could serve and where we were able to put a lot of our budget into. Because we never knew where these legal cases would go and how much effort it would take, including research, and then David's court time.

The BMP components, the second intervention was a 16-section, five-track workshops, kind of like a college curriculum. So the Living Real sessions based on a client CMAT, was issues that they wanted dealt with. They didn't want to talk about HIV and specific interventions. They wanted to talk about their substance abuse, domestic violence, police harassment, unemployment, and safer transition. We were able to design a curriculum with those subjects in mind.

Empowerment sessions facilitated by community or personal pride were designed to increase community involvement, job skills, healthy family, personal relationships, personal development. Sessions were designed to build off one another. And all participants received a \$50 gift card per session. The first sessions were \$25. They got \$50 for coming back. And then \$50 on from then on for attendance.

So that greatly increased our participation. They got a \$100 bonus for completing all 16 sessions, plus a graduation certificate. So when you hit your last 16th session, you go your \$50 plus an extra 100. So you got \$150 coming your last session. That was pretty powerful incentive to get them coming. We gave them in gift cards. We had different gift cards. They got to pick

out and customize it to use with whatever they wanted. They needed Target, Safeway, whatever, Walmart, Walgreens.

Optimal Capacity for the successful implementation included existing programming. We have full transgender staff and transgender-specific program. We have access to HIV prevention care treatment, and as I mentioned earlier. Access to affirming transgender primary care services, including HRT. And this is big because of our trans community-- trans women and men want all their care together. They don't want to have to go across town for hormones over here, and then specialty care or HIV care over here.

We've always had hormones since 2011 in protocols. It's a no-brainer. It should always be standard to offer hormones, in our opinion. Hormones and HIV prevention or care services, or any other services that you're offering.

Successful of transgender specific interventions that incorporate gender affirmation as key components. We've been doing that since 2002, and everything is based around your gender affirmation in a safe place. Capacity II. By year four, we were staffed by myself, the project manager, I was the project manager for this project. We had five full-time staff. All positions by year five were Health Education Specialists, and one was a medical assistant, Janet.

We utilize full and part-time volunteer peer advocates, which are all young trans women of color, Latina and African-American, in the first couple of years. Their primary responsibility was outreach recruitment and program assistance. They made the phone calls. They made all the reminder phone calls. They did the outreach. They accessed their social networks. They were all trained in social network-based recruiting. So that was crucial to engaging them and finding them.

All of the peer advocates eventually were promoted to Health Education Specialist in year four. So by the time the year five ended, everybody was a benefited full-time staff. Successes. Living Real was really the heart of care at TCHC. We bundled all of their appointments, their medical appointments, earlier in the day before the sessions, which were usually four to six in the evening.

We did systematic outreach, phone calls on Mondays, sometimes phone calls all day-- you know, three days before. If the sessions were on Thursday, we were making phone calls by Monday, reminding them the week before also.

We did social messaging reminders. We dropped off transportation BART in the Bay area A lot of our clients coming to these sessions were coming across from Oakland, so over 30 minutes. 45 minutes and about 30-plus miles. Picked up participants. We actually picked them up in our cars. So we did all of our data collection that we needed for the project. Our medical appointments were all done at the same time.

So we maximized our time here. We ended up doing five Living Real workshops, so five full 16-session cycles, with the third cycle all done in Spanish for our monolingual and Latina population. Living Real was our really-- we want to say it's a translation of sessions into knowledge and action.

We didn't want them to just get their \$50 gift card and, you know, hang out. A lot of times groups do that. That's great. It's support. We wanted them to see their knowledge gained and implemented. And so a lot of these sessions were really discussing these issues, whether it was trans health care, hormones, who was doing what, how many times they were doing it, what they shouldn't be doing, whether it was injection or pills, or how was it mixing with their HIV medication.

We had these discussions during the sessions. It was amazing to see, by the time they were towards graduation, correcting, no no no no no, that's not what the provider said during the session on hormones and HIV meds. You know, you're not supposed to mix it, or you know, there's not going to be any complications. They were using terms, like, medical terms that we were-- you know, your T-Cell counts and HRT instead of hormones or mones. So it was amazing to see them actually engage in their active learning.

Certificate completion, we had 16 sessions to complete. They had 20 graduates. So we had 20 actually do 15 to 16. By the time the last cycle, we knew some were having difficulties so we let them graduate at 15 sessions. 29 of the actual 47 enrolled participants attended at least one session, and we thought that was a win to at least get them involved.

Seven participants were working full-time and maintaining their care after graduation and after the five-year cycle ended. At the time of entry into this project, only one was working. So it was a huge success on our end. And we felt that that was really a testament of the power of the sessions and especially the employment sessions that we had, which were too built in. And so we thought that was really, really a huge accomplishment. They were also retained in their care.

For the legal interventions, 25 successfully accessed the clinic. Out of the 25 that accessed the clinic, 0% were incarcerated or went to jail. So we are excited about that. Out of the legal interventions, individual representation and referrals, many cases were civil. There were deaths, they were personal injuries, civil warranty, landlord, tenant, wrongful arrest-- things we hadn't considered.

We had really thought about-- when I had been going to court with them, they were all really solicitation offenses or excessive court fines they couldn't pay, and then they had a failure to appear. I thought that would be the bulk of the cases that we would be trying to solve. We weren't. Only about a third were warrants or failures to appear, clean record proceeding, traffic violations. So we were across the board seeing different cases that I thought were really interesting.

We thought that the legal intervention was really key as a game-changer to keep them in their HIV care. The surprise finding was that when we removed the legal issue out of the way, their HIV care priority didn't rise to the top or rise at all. Unfortunately, other issues such as housing and substance abuse were still priority issues, as you can see in this next slide. It didn't rise up. HIV priority care is still the lowest priority. So that was a really surprising finding.

Our challenges. Retention overall, we lost access to about 12 clients. In the beginning, they did the first round, and then we lost care completely. Those that never accessed any of the interventions were the ones that re-incarcerated or had been-- we found out later on they were incarcerated, but they never sought legal access.

We lost contact to cell phones. I mean, and it's kind of standard when you do this work for a long time. Probably the biggest challenge was engaging our Latina trans women into recruitment and retention. We have nine total. They were very difficult to engage in the group sessions, although they tended to more access the legal interventions than being in a 12, 16-week session group with other trans Latinas that were positive. We would find them on social media ads doing sex work, and they would block our calls or our messages. So I mean, at times, they just did not want to be engaged. And we respected that.

Some adaptations and modifications that we dealt with. Year two, we changed our enrollment into BMP from being Tri-City client only to open around the Bay Area. So they might have been involved in some of the other projects, but they were allowed to roll into our sessions, our legal and our Living Real sessions.

Year three, we decreased the Living Real sessions from 24 sessions to 15 by combining some of the sessions that were a little bit repetitive. Feed back through cycle one, through staff evaluator facilitator suggested several sessions could be collapsed from two to one, so we did that.

Year three, to increase referrals into legal services. We actually began to have a screener. So we came up with a screener of the questions that we knew that our clients had engaged in over the years. So when we would say, hey, do need to see David our lawyer? And they'd be like, no, I'm good, I don't have anything. And then we'd find out later on that they had failure to appear, or they had some fine that they had just conveniently forgotten.

And so we actually came up with a legal screener of all kinds of terms they use so that we would fill it out, we'd hand it over to our lawyer, and then he would contact them [? and ?] schedule the consultation. That was much more successful going that way, because we basically didn't give them an opt-out. Like, we know you have some issues. Let us help you.

And in year five, we increased our enrollment. A \$25 enrollment incentive was offered to participants who referred other participants, so then we wanted to increase our enrollment. And that was kind of successful, although I think we implemented it a little too late.

Lessons learned. Lots of lessons learned. We-- providing access to a range of legal support services can decrease the traditional barriers to care. Josie just talked about, you have a range of support services. Despite having active health insurance and health care, trans women living with HIV have competing needs far beyond those related to health that impact their HIV care engagement.

As demonstrated by the Brandy Martell Project, trans women of color face many daily structural issues that even challenge the most of our experienced staff. And I could probably say that's the same around the all-nine projects. A lot of our trans-specific trans staff were challenged also. And many were going through the same struggles of homelessness and other personal issues.

Services and care sites are needed to address instrumental needs for economic opportunities, education, legal services, and are a start-- these are a start for improving HIV care outcomes among trans woman. But we need to build on these. Organizations just beginning to work with trans community, engaging with trans peer leaders for program development and input as well hiring trans staff in the community is highly recommended to build trust in recruitment. Josie really talked about the trust and the relationship building. You need that before you do anything. So that needs to be one of the first things you do.

Consider creating a trans community advisory board to help guide organizationally. We did that in the beginning, and that really helped. Sustainability barriers. We determined the main priority was finding trans-specific funding that aligned with TCHC, and funding that maintained the employment. That was our priority was maintain the employment of the staff before finding funding for the interventions. We did receive funding through Alameda County for our Prep Navigation Grant through 2018. This includes trans women and has added program sustainability. So that's great.

With HIV funding cuts nationally at the federal level, any intervention activities sustainability may come from available private foundations. So this is just an overall problem across the board for transgender-specific programming, is finding interventions that are trans-specific. It's not a regional problem. It's a national problem. So it's something that I think everybody has a responsibility to work on.

These are our resources. This is our staff and our administration and our project directors. Tri-City Health Center, TransVision, and, of course, our technical systems was UCSF Centers of Excellence for Transgender Health. Fast but effective. Thank you for staying with me.

MODERATOR: Thank you so much, Tiffany. And thank you all. Thank you both. Thank you, Josie, as well. And before we open the lines for questions. Really appreciate it if you would take some time and make notes of the link on the screen so that you can give us your feedback following this presentation. And we will also be sending out this link via email to everyone who registered.

Josie, I want to give you an opportunity to go back and talk about the key takeaways to your program, because I noticed that you felt a little rushed and jumped over that slide. So if you want to talk a little bit more about that, I think that would be great.

JOSIE LYNNE PAUL: Well, really, a lot of it is things I talked about. Let's go backwards. Relationship, relationship, relationship, and collaboration being collaboration with partners. But you know, that really is the number one trans women of color living with HIV have a lot of good reasons to have a lot of trust issues with providers. And that we have to build those relationships with providers that serve trans women of color.

And that we really need to look at what is it that Tiffany was pointing out about priorities, that the priorities for trans women of color living with HIV are not HIV. It's all those competing kinds of issues. And so we have to put together the meaningful services, not just what we think they need-- you need to be in care. If that's not what they are thinking is their priority, they're not going to engage with us. And to have that kind of client-centered and trauma-informed kind of approach. Really the big things that I think are what I would call the key takeaways.

MODERATOR: Thank you. We do have two questions in the chat box. The first question. "For both programs, are both programs able to meet the needs of undocumented individuals?"

TIFFANY WOODS: This is Tiffany. I'll take that one first. Yes, absolutely. Out of our Latinas that were engaged, the majority of them were undocumented. And actually, as far as our HIV prevention and our primary care program, I would say most of our Latina clients are undocumented or working on-- and working towards getting some kind of citizenship.

Actually, one of my key Latina staff who works with them has been getting her citizenship. But she was undocumented when I hired her. We get them through a county insurance program. We don't have any problem. We get them through prep. We get them whatever they need. That's not an issue. And Tri-City is known for working with undocumented immigrants of multiple communities across the board in our area.

Secondary, for integrating trans-masculine people, non-binary into-- we integrate them into our interventions. This was a HRSA-specific with the criteria for trans women of color. But we have actually put in for funding through the Elton John Foundation to create these interventions with Elton John funding. And we actually, in the letter we wrote, and in our criteria, we're including trans-masculine and non-binary and HIV-negative trans women in too so that we can-- we think it's a-- we want to make it available for everybody, and not just HIV-positive trans women of color. So we've already been working on the grant process to include them since we're not going to be tied to specific research funding.

And most of our trans-masculine and trans women are coming from low communities of color right now. So that's primarily what we work with. Josie?

JOSIE LYNNE PAUL: So in relation to meeting the needs of undocumented individuals, during the SPNS project, we did not have bilingual staff capacity to really sufficiently meet the needs of undocumented individuals. We've had some staffing changes in the last couple of months. We've had an influx of particularly trans-Latina individuals with needs. And actually, we've had to do a lot of work with local legal agencies, building a network of providers who can provide pro-bono work, because it's beyond the capacity of our very small legal team of one here in Chicago House. But we have been finding an increased ability with actual attention to serving undocumented individuals, that we're actually able to meet more of their needs.

As far as integrating and incorporating trans-masculine and non-binary individuals, we, from the beginning, in our TransSafe drop-in, served all gender identities. So while the SPNS project itself works to engage trans women of color, non-binary individuals, trans-masculine individuals of all races were willing to access the TransSafe space to access legal housing, employment, medical care.

And what we found was that for the trans women of color, by not focusing, you can only come in if you are a specific gender, race, identity, it meant that they were actually more comfortable engaging, not feeling like they were the only population being targeted, and that was part of what removed stigma. So that we actually find that we can easily integrate all genders including trans-masculine and non-binary folks particularly. Again, serving those most marginalized, those are often from communities of color, those individuals.

MODERATOR: Thank you. Tiffany, do you have anything to add to that?

TIFFANY WOODS: I think a lot of trans-specific programs that serve primarily transgender women, not just trans women of color, but trans women, which most HIV prevention and care programs do serve and address because of the high epidemic globally of impacting trans women of color, these programs don't serve trans-masculine and non-binary. We have served trans-guys and non-binary for the last 10 years basically. We don't have any HIV-positive trans-masculine guys, thank goodness. We're not trying to have any. They have access to all of the prevention services.

And 30% to 40% of our primary care services are accessed by trans-masculine guys. We're actually working for a support group right now, starting a support group. We did it successful in February, first ever, half day for trans guys with a support group, put on by a trans-masculine provider from UCSF. So we integrate him into our services, and we've been integrating him into our prevention-specific groups.

So a lot of times the guys are sometimes just moving and not hanging out for the groups, so, you know, we want to make sure that they're included in everything. And I see there's another question around participants, they're not happy with the intervention take place in a medical setting. So I can go ahead and address that while I'm speaking, and then I'll hand that off to Josie.

Our area, or TransVision specific area, is not actually in the medical clinic exam room area. We have a conference room that's all trans-specific. Our whole area is decorated by our clients. It's not clinical at all. We did a lot of research and field stuff that we had to do for the project in the community, we met them, you know, portable laptop.

But yeah, our space isn't clinical, and they loved coming here. And we did have a drop-in satellite site in Hayward that was non-clinical, and they accessed that too. So we haven't had any pushback about being in a non-medical setting. Josie?

JOSIE LYNNE PAUL: So for our programs, we're not based in a medical setting at all. Our TransHealth is actually by a local FQHC, Heartland Alliance Health, that comes into our drop-in space. Instead of us being in their medical setting, they're in our social service setting.

And we found that actually to be very successful not being in a medical setting. That when individuals that were engaging would come in, they're not necessarily wanting to talk about medical things until they find out maybe that we might be able to provide hormones through our medical provider partnership. But that's not what they're looking for. So it is actually a benefit not being in a medical setting.

TIFFANY WOODS: That's a great question. Thank you, Jason.

MODERATOR: Yeah, thank you, Anthony, Ray, and Jason for those questions. Someone asked about the availability of the slides. Yes, the slides, audio and the slides will be available at the Target Center. And we ask that you allow about three to four weeks before they are available to be uploaded. But you will have access to the presentation later on. So those are all our questions from the chat box. And if there are no other questions from the phone lines, I thank everyone for your time and your participation. Thanks to our presenters. And I'm going to remind you, hopefully, you took note of our link so that you can give us your feedback, but you will receive an email reminding you to do so.

The next presentation in this series is scheduled for August the 15th, also at 2:00 PM Eastern time, and that will feature two homeless initiative demonstration models. So we thank you all so much for your participation. If you have any additional questions after the webinar today, please don't hesitate to contact SPNS at HRSA.gov. So I want to thank our presenters. I want to thank our participants, and wish everyone a great afternoon.