



Advancing Innovation to End the HIV Epidemic

2019 Ryan White HIV/AIDS
Program Highlights



U.S. Department of Health and Human Services
Health Resources and Services Administration
HIV/AIDS Bureau

September 2019



HRSA
Ryan White & Global HIV/AIDS Programs

The publication was produced for the U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau under contract number HSH250201800026G.

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Suggested citation: U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau. *2019 Ryan White HIV/AIDS Program Highlights: Advancing Innovation to End the HIV Epidemic*. 2019. Rockville, Maryland: Author.

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Foreword

2019 Ryan White HIV/AIDS Program Highlights: Advancing Innovation to End the HIV Epidemic

For 29 years, the Health Resources and Services Administration's (HRSA) Ryan White HIV/AIDS Program (RWHAP) has played a vital role in responding to the HIV epidemic. Named for Ryan White, a young man who was diagnosed with AIDS in 1984 and gained national attention for his efforts to attend school and educate the public about HIV/AIDS, the RWHAP was authorized by Congress in 1990 through the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act.

Today, the RWHAP provides a comprehensive system of HIV primary medical care, essential support services, and medication for low-income people with HIV who are uninsured and underserved. More than half of people diagnosed with HIV in the United States receive services through RWHAP each year. That means more than half a million people receive RWHAP services as a result of this groundbreaking legislation. Without the services and support of HRSA's RWHAP providers, many of our nation's most vulnerable individuals—including people with HIV who are from racial/ethnic minority populations, youth, older adults, men who have sex with men, transgender individuals, and women—would not receive HIV care and life-extending medication.

Ending the HIV epidemic is a comprehensive effort by organizations at the federal, state, and local levels of government across the nation, including the Administration's new effort, *Ending the HIV Epidemic: A Plan for America*. HRSA's RWHAP funding to states, cities/counties, and local community-based organizations has enabled RWHAP recipients and providers to adopt innovative patient-focused models of care. This ensures that people with HIV receive the care they need without fear of stigma or discrimination, are engaged and remain in care and on medication to ultimately reach viral suppression. The providers of HRSA's RWHAP have long been leaders in helping to end the HIV epidemic by implementing effective data-driven systems and models of care and ensuring that people with HIV reap the benefits of scientific advancements, such as daily antiretroviral therapy (ART). RWHAP clients who take HIV medication daily as prescribed and reach and maintain an undetectable viral load have effectively no risk of sexually transmitting HIV to their partners and can lead longer, healthier lives. Because of these efforts, the percentage of RWHAP clients who are virally suppressed has been increasing. In 2010, 69.5 percent of RWHAP clients were virally

suppressed; in 2017, 85.9 percent of clients had reached viral suppression, greatly exceeding the national average of 59.8 percent.

Building on the successes of the program, the RWHAP will continue to have a major role in achieving HRSA's goals to end the HIV epidemic in the United States by leveraging innovative practices and program models of care that—

- Decrease new HIV infections.
- Reduce HIV-related health disparities.
- Improve access to HIV care and treatment without stigma and discrimination and improve health outcomes.
- Achieve a more coordinated national response to the HIV epidemic.

Recipients of HRSA's RWHAP have much to be proud of while continuing the fight to end the HIV epidemic. This biennial report, *Advancing Innovation to End the HIV Epidemic*, highlights the accomplishments of HRSA's RWHAP and features five recipients selected by HRSA. These recipients have implemented successful strategies and models of care—including practice transformation, public-private partnerships, rapid entry to HIV care and delivery of ART, the use of telehealth/telemedicine, and a jurisdictional approach to providing treatment and care. These and other recipients of HRSA's RWHAP provide inspiration for advancing innovation to end the HIV epidemic in this country.

In the sections that follow, program highlights from HRSA's RWHAP are presented, along with a summary of innovative approaches used by recipients and their success stories.

2018 National Ryan White Conference on HIV Care and Treatment Highlights

Approximately 4,000 HIV health care providers, HRSA's Ryan White HIV/AIDS Program recipients and subrecipients, partners, people with HIV, other stakeholders, and members of the general public gathered for the 2018 National Ryan White Conference on HIV Care & Treatment. The biennial event, hosted by the HRSA's HIV/AIDS Bureau (HAB), was held December 9–14, 2018, at the National Harbor in Oxon Hill, Maryland. The National Ryan White Conference's theme was "Catalyzing Success: Advancing Innovation. Leveraging Data. Ending the HIV Epidemic." The National Ryan White Conference's primary goals were to learn and share best-practice models and strategies that reduce new HIV infections; expand access to high-quality, life-extending HIV care and

treatment without stigma or discrimination; reduce HIV-related health disparities; and improve treatment outcomes.

Six conference session tracks served as the foundation for four plenary sessions, 240 presentations, and nearly 200 poster sessions:

- Increasing Access, Engagement, and Retention in HIV Care and Treatment
- Data Utilization
- Leveraging Innovative Practices to Improve Outcomes and Address Emerging Priorities
- Clinical Quality Management and Quality Improvement
- RWHAP Planning and Resource Allocation: Collaborative Partnerships and Community Engagement
- RWHAP Fiscal and Grant Management Boot Camp

Many of the presentations demonstrated how recipients of HRSA's RWHAP are working within their communities to catalyze innovative strategies and models of care to improve and integrate engagement, services, and treatment for people with HIV across the HIV care continuum. The continued implementation of these effective models and strategies supports the goal of HRSA's RWHAP to end the HIV epidemic. Visit [TargetHIV](#) for a recap of the conference, as well as the presentation slides.

Ryan White HIV/AIDS Program Annual Client-Level Data Report, 2017

HRSA's *Ryan White HIV/AIDS Program Annual Client-Level Data Report, 2017* presents program data about all clients served by the RWHAP during calendar years 2013 through 2017. The report provides an in-depth look at demographics and socioeconomic factors among RWHAP clients, such as age, race/ethnicity, transmission risk category, federal poverty level, health care coverage, and housing status. Client-level data allow HRSA to assess and support the progress that RWHAP recipients are making to improve HIV care, treatment, and health outcomes, such as viral suppression, among people with HIV.

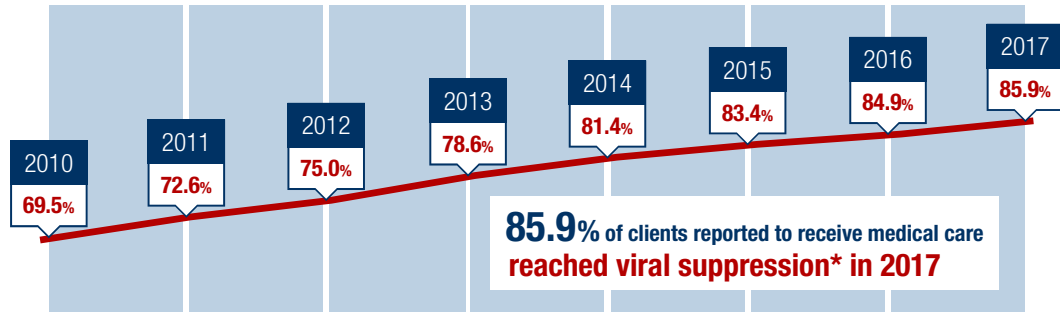
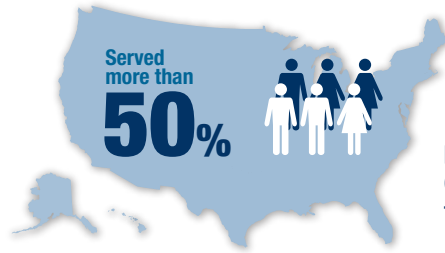
Highlights of the 2017 Report

The **BY THE NUMBERS** infographic on the following page presents selected highlights of the 2017 report. In particular, the 85.9 percent of RWHAP clients receiving HIV medical care who reached viral suppression reflects the ongoing commitment by recipients of HRSA's RWHAP to provide high-quality comprehensive services to their clients.

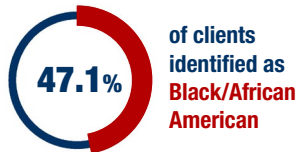
HRSA'S RYAN WHITE HIV/AIDS PROGRAM

BY THE NUMBERS: 2017

Served **534,903**
clients in 2017



73.6% of clients were racial/ethnic minorities**



45.2% of clients were aged 50 years and older



62.8% of clients were living at or below 100% of the Federal Poverty Level

*Viral suppression is based on data for people with HIV who had at least one outpatient ambulatory health services visit and at least one viral load test during the measurement year and whose most recent viral load test result was less than 200 copies/mL.

**Clients self-identified as 26.7% White and less than 2% each American Indian/Alaska Native, Asian, Native Hawaiian/Pacific Islander, and persons of multiple races. Hispanics/Latinos can be of any race.

Data sourced from 2017 Ryan White HIV/AIDS Program Annual Client-Level Data Report.



National HIV/AIDS Strategy for the United States: Updated to 2020

The *National HIV/AIDS Strategy for the United States (NHAS)*, which has served as the nation's roadmap in the fight against HIV, was first released on July 13, 2010, and later updated in July 2015 as the *National HIV/AIDS Strategy for the United States: Updated to 2020 (NHAS 2020)*. The current National HIV/AIDS Strategy expires in 2020.

NHAS 2020 identifies priorities and strategic action steps tied to measurable outcomes to guide the national response to the HIV epidemic. The plan reflects the work accomplished, lessons learned, and scientific developments since publication of the original *NHAS*. *NHAS 2020* outlines four goals for a coordinated national response to HIV:

- ▶ Reduce the number of people who become infected with HIV.
- ▶ Increase access to care and improve health outcomes for people with HIV.
- ▶ Reduce HIV-related health disparities.
- ▶ Achieve a more coordinated national response to the HIV epidemic.

NHAS 2020 highlights several populations for enhancing efforts toward improved health outcomes. These populations include women; transgender individuals; gay, bisexual, and other men who have sex with men (MSM); blacks/African Americans; Hispanics/Latinos; youth; young black/African American MSM; young black/African American women; and people who inject drugs. *NHAS 2020* also includes revised steps and recommended actions, quantitative indicators to better monitor progress, and integration of objectives and recommendations from other federal initiatives.

HRSA supports the *NHAS 2020* as its work cuts across many HRSA programs—from the Ryan White HIV/AIDS Program to the Health Center Program to the National Health Service Corps. HRSA initiatives that respond to each of the four *NHAS 2020* goals are highlighted on the [HRSA website](#).¹

Ending the HIV Epidemic: A Plan for America

During the 2019 State of the Union address, the Administration announced the new [Ending the HIV Epidemic: A Plan for America](#), which will be a 10-year initiative beginning in fiscal year (FY) 2020 to achieve the important goal of reducing new HIV infections to fewer than 3,000 per year by 2030. Reducing new infections to this level essentially means that HIV transmissions would be rare and meet the definition of ending the epidemic. The initiative will focus

efforts in 48 counties; Washington, D.C.; San Juan, Puerto Rico; and seven states with substantial rural HIV burden.

The initiative will leverage scientific advances in HIV prevention, diagnosis, treatment, and care by coordinating the highly successful federal government programs, resources, and infrastructure of HRSA, the Centers for Disease Control and Prevention (CDC), National Institutes of Health, Substance Abuse and Mental Health Services Administration, and Indian Health Service. The U.S. Department of Health and Human Services' Office of the Assistant Secretary for Health is coordinating this cross-agency Plan.

The efforts will focus on four key strategies that together can end the HIV epidemic in the United States:

- **Diagnose** all people with HIV as early as possible.
- **Treat** people with HIV rapidly and effectively to reach sustained viral suppression.
- **Prevent** new HIV transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs).
- **Respond** quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.

As part of the Plan, HHS will provide the hardest hit areas around the country with additional expertise, technology, and resources to address the HIV epidemic in their communities. Through the HRSA's RWHAP and the HRSA-funded Health Center Program, the agency will play a leading role in helping to diagnose, treat, prevent, and respond to efforts to end the HIV epidemic. HRSA will work with RWHAP recipients to expand evidence-based interventions that increase engagement and retention in care, reduce stigma, and improve viral suppression among people with HIV. For additional information about HRSA's role in the Ending the HIV Epidemic initiative, visit www.hrsa.gov/ending-hiv-epidemic. 📄



Carmen ("Cyndi") Diaz, Infectious Diseases Medical Assistant

Summary of Innovative Approaches

Summary of Innovative Approaches Used by Featured Recipients to Help End the HIV Epidemic

The five HRSA RWHAP recipients featured in this report have implemented innovative programs, initiatives, approaches, and models of care to improve the health outcomes of people with HIV and to support ending the HIV epidemic. The five recipients and the HRSA RWHAP Part funding they received are as follows:

- Philadelphia Department of Public Health (PDPH), Philadelphia, Pennsylvania (Part A)
- DC Department of Health (DC Health), Washington, D.C. (Parts A and B)
- West Virginia University Positive Health Clinic (WVUPHC), Morgantown, West Virginia (Part C)
- The MetroHealth System, Cleveland, Ohio (Part F)
- Southeast AIDS Education and Training Center (SE AETC), Nashville, Tennessee (Part F)

Although they have different approaches, all of the recipients focus on providing high-quality services across the HIV care continuum to link, engage, and retain people with HIV in care and, ultimately, help them reach and maintain viral suppression. Several common approaches used by recipients in their fight to end the HIV epidemic include collaborating with jurisdictional partners and providers, engaging with members of the HIV community, effectively collecting data, and conducting training to ensure that providers have the knowledge and tools to manage their patients' HIV care and reduce barriers to care, such as stigma.

The PDPH uses Part A funds to support clinics and other partner organizations that provide core HIV medical and support services to people with HIV in Philadelphia. Additionally, the PDPH has been using a jurisdictional approach to reduce health disparities related to hepatitis C virus (HCV) coinfection among people with HIV. Through its *C Ya!* project, the PDPH is identifying systems-level opportunities to enhance its capacity for HCV screening, care, and treatment; providing targeted HCV treatment and prevention interventions for local high-risk populations; and providing training for local HIV care providers. A unique component of the *C Ya!* project is the integration of HIV and HCV

data systems, including HRSA's CAREWare, to enable the PDPH to target activities and measure progress toward ending HCV.

In Washington, D.C., DC Health receives funding from both Parts A and B of HRSA's RWHAP. DC Health has been collaborating with partners across the Eligible Metropolitan Area (EMA) to provide core services to support people with HIV. DC Health worked with partners to develop the *90/90/90/50 Plan: Ending the HIV Epidemic in the District of Columbia by 2020*. The plan name reflects its four goals: 90 percent of D.C. residents with HIV will know their status; 90 percent of persons diagnosed with HIV will be in treatment; 90 percent of persons in treatment will reach viral suppression; and the District will see a 50 percent decrease in new HIV cases by 2020. To meet the plan's goals, DC Health engages with people with HIV, health care providers, and community partners to prevent HIV by improving access to PrEP and increasing access to HIV care and ART through its Red Carpet Entry and Rapid ART programs and its medication treatment adherence initiatives.

The WVUPHC uses Part C funds to bring state-of-the-art, comprehensive HIV medical care and support services to 33 counties in the north-central and northeastern regions of West Virginia. The WVUPHC implemented a telehealth initiative to train health care professionals in rural, underserved areas to provide well-informed, high-quality HIV care to help people with HIV reach viral suppression. The WVUPHC uses a patient case model in which every member of the care team shares his or her knowledge of a particular patient—from treatment and


medical status to barriers that the patient may encounter in accessing care. The information is shared in patient care conferences, during which staff learn from one another as they discuss strategies to enhance their patients' HIV care and fully meet each patient's needs.

MetroHealth, the public health system of Cuyahoga County, Ohio—which includes Cleveland—receives Part F funding from HRSA's RWHAP Special Projects of National Significance (SPNS) Program. MetroHealth's project

The WVUPHC uses a patient case model in which every member of the care team shares his or her knowledge of a particular patient.

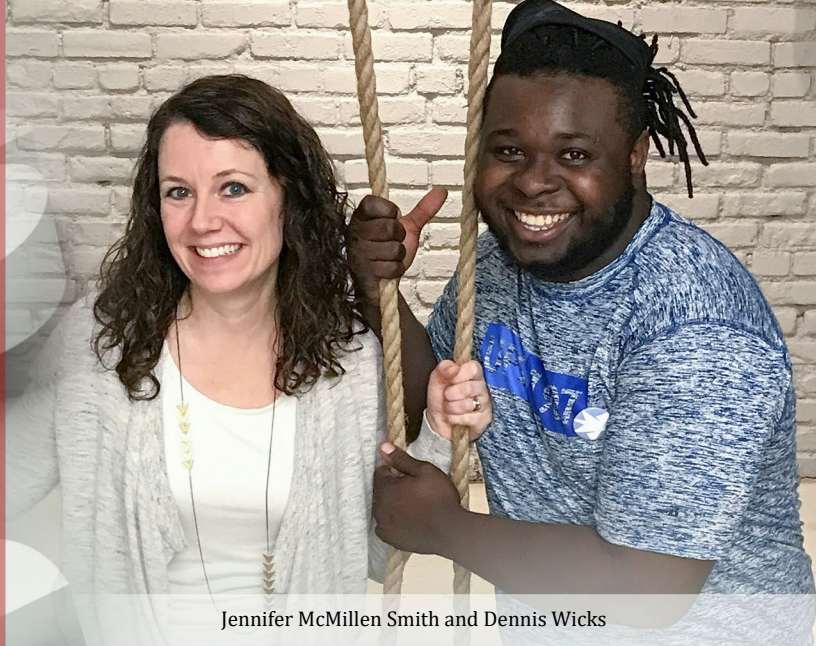
employs mobile applications and social media technologies to identify, link, and retain underserved youth and young adults (aged 13–34 years) in HIV care and help them reach viral suppression. MetroHealth introduced the Positive Peers website and app to engage youth with HIV, not only to provide information and self-management tools but also to encourage peer-to-peer support. The website features blogs and success stories written by young people with HIV. The app is reserved for newly diagnosed young people and those who are not optimally engaged in care and features innovative social networking opportunities.

The SE AETC, located at Vanderbilt University in Nashville, Tennessee, receives Part F funding from HRSA's RWHAP. The SE AETC provides a wide range of innovative training and education interventions for health professionals across the region, with the goals of increasing the HIV care workforce and building provider capacity to serve people with HIV across the full HIV care continuum. SE AETC's Practice Transformation Project offers a series of online courses that focus on the first 30 days of HIV care. SE AETC-trained providers and coaches work with staff at clinics in their state to implement HIV care strategies adapted to the unique needs of the individual clinics. Expansion of the Practice Transformation Project focuses on improving HIV opt-out testing and referral to care, offering PrEP to patients at risk, routinely collecting sexual history information during visits, and creating a stigma-free clinical setting.

The sections that follow offer a detailed overview of the innovative programs, initiatives, approaches, and models of care that each recipient uses to improve the health outcomes of people with HIV and to support ending the HIV epidemic. 



Ana Lapp



Jennifer McMillen Smith and Dennis Wicks

Recipient Success Stories to
Help End the HIV Epidemic

Success Stories



Arif Sarwari, Jeanette Southerly, and Anne Behr

Ana Lapp, Nurse Care Coordinator and Data Manager;
Jennifer McMillen Smith, Project Director, and Dennis Wicks,
participant; Dr. Arif R. Sarwari, Parts C and D Medical Director
and Chair of the Department of Medicine at WVUPHC, and
RNs Jeanette Southerly, Resource Coordinator, and Anne Behr



Sheila Thomas, RWHAP client

Working Together to Eliminate Hepatitis C in People with HIV: Philadelphia Department of Public Health (Part A)

The Philadelphia Department of Public Health receives HRSA RWHAP Part A funding for EMAs most severely affected by the HIV epidemic. The PDPH uses Part A funds to support clinics and other partner organizations providing core HIV medical and support services to people with HIV. Dr. Kathleen Brady, Medical Director of PDPH's AIDS Activities Coordinating Office (AACO), estimates that approximately 75 percent of the 19,199 people with HIV in the Philadelphia area receive care through RWHAP-supported programs.

Populations served by PDPH's RWHAP are primarily people from racial or ethnic minority backgrounds. According to Dr. Brady, approximately 58 percent of people with HIV in the Philadelphia EMA are black/African American, approximately 15 percent are Hispanic/Latino, and most of the remaining 22 percent are white/Caucasian. The PDPH is working with each of the 25 RWHAP-funded medical providers to identify and reduce HIV-related disparities by race, gender, age, and health care coverage status. The PDPH continuously examines systemwide causes of HIV disparities.

Jurisdictional Approach: Saying “C Ya!” to Hepatitis C in People with HIV

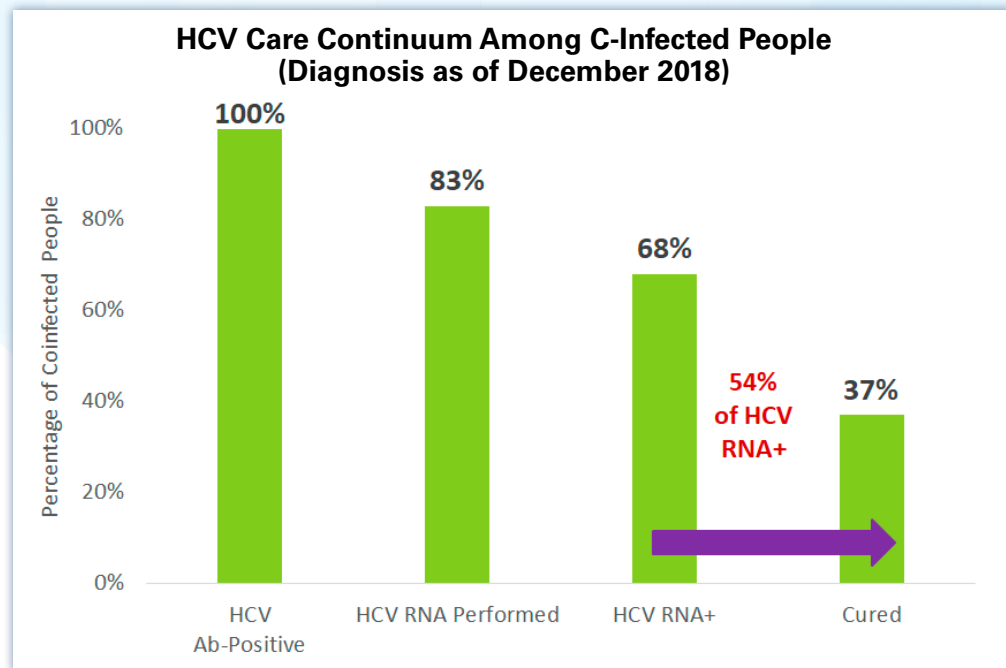
Since 2016, the PDPH has been working to reduce disparities related to HCV coinfection among people with HIV. The PDPH was one of three RWHAP Part A jurisdictions to receive RWHAP Part F funding for the SPNS *Jurisdictional Approach to Curing Hepatitis C Among HIV/HCV Co-infected People of Color* from 2016 through 2019. The SPNS project in Philadelphia, called *C Ya!*, supports the development, implementation, and evaluation of comprehensive approaches to screening, care, and treatment of people of color who are co-infected with HIV and HCV. More than 45,000 people who live in Philadelphia are estimated to have HCV, and more than 3,000 also are people with HIV. Among co-infected individuals, approximately 57 percent are non-Hispanic blacks, 70 percent are men, and 66 percent are aged 45–64 years. Approximately 56 percent reported past or present injection drug use.²

The goals of the *C Ya!* project are to—

- Identify systems-level opportunities to increase capacity for HCV screening, care, and treatment.
- Increase the number of HIV/HCV co-infected people who are diagnosed, treated, and cured of HCV.
- Eliminate HCV among people with HIV.

The PDPH views *C Ya!* as a micro-elimination project that breaks down HCV elimination goals into smaller ones for individual populations, allowing targeted treatment and prevention interventions to be delivered more quickly and efficiently.³ Danica Kuncio, PDPH’s Viral Hepatitis Program Manager, explained that micro-elimination is easier than trying to end HCV coinfection at the population level because this approach “zooms in on those high-risk individuals rather than talking about 15,000 people or 30,000 people or 60,000 people.” Prompt delivery of the curative HCV treatment to people with HIV is critical because HCV progresses faster in people with HIV, and the effects of HCV in this population are more serious. To ensure that people co-infected with HCV receive treatment, the PDPH created an HCV care continuum, similar to care models for people with HIV, and integrated HIV and HCV data

systems. “We’ve been able to develop a care continuum for hepatitis C, which is fairly unique among jurisdictions throughout the country,” Ms. Kuncio explained. The integrated HIV and HCV data systems allow the PDPH to better identify patients with HCV, facilitate confirmatory testing, and ensure that they receive HCV treatment.



Because the PDPH had previously worked with the Program Collaboration and Service Integration initiative of the CDC to improve coordination across PDPH’s infectious disease program areas—sexually transmitted disease (STD), HIV, hepatitis, and tuberculosis (TB)—the PDPH was able to “hit the ground running” with the *C Ya!* project, according to Ms. Kuncio. Alexandra Shirreffs, PDPH’s *C Ya!* Project Coordinator, said that *C Ya!* was a “nice way to continue building internal collaboration.” She explained that *C Ya!* increased HIV/HCV care integration, and “it’s been a huge success in moving health department programs closer together and breaking down the silos between us.”



Alexandra Shirreffs, *C Ya!* Project Coordinator

C Ya! also builds on PDPH's existing community partnerships. Philadelphia's hepatitis care stakeholders have been engaged since 2012 through the Hep C Allies of Philadelphia (HepCAP) coalition. HepCAP is housed at the Health Federation of Philadelphia, an organization that supports a network of Community Health Centers and is an important *C Ya!* partner for the project's training and capacity-building activities.

MidAtlantic AIDS Education and Training Center Partnership

As the Philadelphia Performance Site of the MidAtlantic AIDS Education and Training Center (MA AETC), the Health Federation of Philadelphia Education and Training Center provides HIV education, consultation, technical assistance, and resources to health care professionals in eastern Pennsylvania. Health Federation staff coordinate training, capacity building, and program evaluation activities for HIV clinics and health centers in the greater Philadelphia region. According to Debra D'Alessandro, MA AETC's Regional Partner Coordinator and Health Federation's Director of Public Health Training and Technical Assistance, "There's been a really long collaborative relationship between the Philadelphia AETC and [the PDPH], and we have mutual goals" to ensure that local providers have the tools to provide high-quality care to help people with HIV manage HIV and comorbidities.

The MA AETC has leveraged longstanding relationships with both the PDPH and local HIV care providers, "to bring [*C Ya!*] right to the providers," according to Susan Thompson, MA AETC Training Director. "For example, we did a needs assessment where we visited every provider to see what they were doing. That was very easy to do because they knew who we were." Ms. Shirreffs explained that including health department staff in site visits showed providers that the city's public health leadership sees HCV as a priority. "Sitting with clinic staff face-to-face helped get buy-in for *C Ya!*'s goals on a site-specific level," she added. For example, at one site visit, the HIV Program Manager overseeing an HIV program embedded in a larger Federally Qualified Health

"For example, we did a needs assessment where we visited every provider to see what they were doing. That was very easy to do because they knew who we were."



City of Philadelphia

Centers (FQHC) system invited the *C Ya!* team to meet with the FQHC director. As a result, the site staff began training their clinicians to treat HCV, a service that ultimately will improve HCV care not only for people with HIV but also for people mono-infected with HCV in the general FQHC population.

The MA AETC training models, which use peer-to-peer learning, fit well with *C Ya!*'s approach of leveraging existing services and partnerships to encourage HCV integration. "We have really wonderful HIV clinicians who are very experienced in hepatitis C, and we recruited them as faculty for training. They're also very much trusted in the Ryan White [HIV/AIDS Program] community," said Ms. Thompson. These experts used the *HCV Provider Competencies and Curriculum for HCV Screening, Care, and Treatment* to teach other providers about HCV care for people with HIV. These trainings are vitally important to ensure that providers are up to date on HCV treatment knowledge and are able to share the latest recommendations for HCV care with their patients.

Training at clinics specializing in hepatitis C infection involved "intensive clinical knowledge, and then trainees get to observe clinicians actually implementing what they saw in their lectures," explained Ms. Thompson. Following the training, calls with experts were scheduled two to three times each month to allow clinicians to discuss specific questions and concerns.



Susan Thompson, MA AETC Training Director

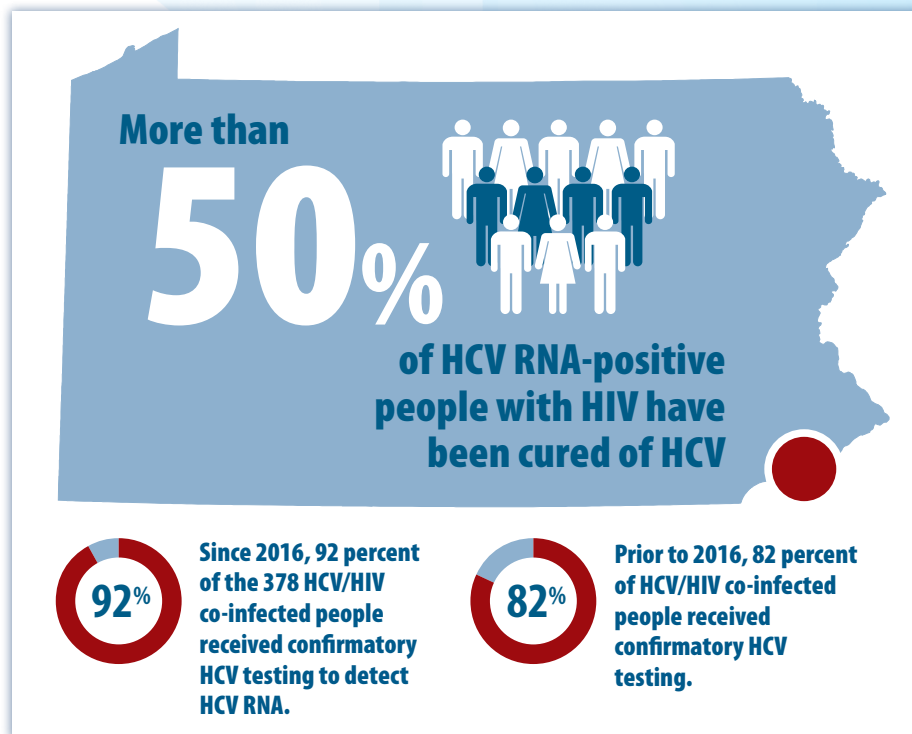
In addition to delivering training, the MA AETC helped to identify the training and capacity-building needs of participating clinics. As of March 2019, 50 clinicians had received the didactic HIV/HCV training, and 27 had completed the clinical observation training. Multiple clinics also are asking for expert advice on HCV care for people with HIV. When

C Ya! started, 16 out of 23 RWHAP adult medical care sites were able to treat HCV in people with HIV. By the end of *C Ya!*, nearly every RWHAP site in the Philadelphia EMA will be able to offer the full spectrum of HCV care.

Re-engaging Co-Infected People in Care. According to PDPH data from January 2019, of the approximately 1,000 co-infected people with HIV who still needed HCV treatment, 61 percent were out of HIV care and 36 percent had been out of HIV care for a year or longer. *C Ya!* worked closely with PDPH’s HIV Data-to-Care team to cross-train their staff on HCV and drug user health, modify a protocol to incorporate HCV into the data-to-care processes, match HIV lost-to-care patient lists with HCV data, and flag co-infected patients for the HIV clinic teams. These efforts improved the likelihood that HCV is addressed when lost-to-care patients are identified and agree to return to HIV care. In addition, the program helps patients overcome barriers to care, such as stigma associated with both HIV and HCV, which are exacerbated by behavioral health issues; mental or substance use disorders, or both; homelessness and housing instability; a history of incarceration; and poverty. If people with HIV also have challenges accessing care, such as finding time for medical visits around a work schedule or getting to a clinic in a different neighborhood, regular engagement in HIV and HCV care may be difficult to prioritize. Supports offered through RWHAP—including case management, housing services, and medical transportation—help patients overcome these barriers. *C Ya!* initially worked with the Data-to-Care team to implement HCV at its five pilot facilities in Philadelphia; as this project expands to more RWHAP care sites, it will continue to incorporate HCV as a priority for lost-to-care people with HIV.

Key Successes and Lessons Learned Toward Ending the HIV Epidemic and HCV Co-Infections

C Ya! has improved the capacity to address HCV within the Philadelphia EMA, which has, in turn, improved the health outcomes of people with HIV who also have HCV. From September 2016 through December 2018, PDPH data showed improvement in HCV screening, diagnosis, and treatment outcomes. For example, 92 percent of the 378 HCV/HIV co-infected people identified by *C Ya!* since 2016 received confirmatory HCV testing to detect HCV RNA. This percentage is substantially greater than the percentage of HCV/HIV co-infected people identified by the PDPH who received confirmatory HCV testing prior to 2016 (82 percent). From 2016 through December 2018, the PDPH observed a 48 percent increase in the number of HCV RNA-positive people with HIV who were cured of HCV. Of the initial 2,160 RNA-positive people with HIV from the *C Ya!* baseline cohort, 1,120—more than 50 percent—have been cured of HCV.



Using Data to Guide Action. The PDPH needed strong, integrated HIV and HCV data systems to accomplish *C Ya!*'s monitoring and evaluation goals. Although RWHAP's CAREWare system and the CDC's Enhanced HIV/AIDS

Reporting System (eHARS) have allowed clinics to track HIV care for nearly two decades, these systems were not designed to monitor HCV care. With SPNS funding, the PDPH integrated HIV and HCV data systems, including the Hepatitis Registry, eHARS, and CAREWare, a strategy that could be replicated in other RWHAP jurisdictions. In addition, the *C Ya!* project collected both quantitative and qualitative data to track how many people with HIV were co-infected, assess gaps in services, target project activities, and evaluate the project's impact. According to Ms. Shirreffs, the "ability to use data to target activities and measure progress toward HCV elimination allowed us to apply our limited resources strategically and sustainably. ... Data [are] really the foundation of this project and our work."

Continual Community Feedback and Ongoing Training. The PDPH collects qualitative data through a variety of activities, including informational interviews, focus groups, practice surveys, and community meetings. The qualitative data complement surveillance data by describing best practices and barriers that influence HCV care-continuum outcomes. Efforts to engage with and obtain input from community partners helped *C Ya!* identify providers who could benefit from education and respond with the most up-to-date information. With support from HepCAP, *C Ya!* keeps local HIV providers up to date on HCV policy changes and encourages treatment expansion in HIV settings.

In addition, focus group findings show that frontline staff "didn't see HCV as a priority," according to Amy Hueber, PDPH Hepatitis C Community Outreach Specialist. "We also learned that medical case managers were not talking to their clients about HCV. They knew they were being tested within the Ryan White CARE system, but no education was being provided."

Consumers also lacked knowledge.

"People didn't know about treatment. They also thought that the old treatment was still [the only one] available, and they thought that if they were actively using drugs, they wouldn't be able to be treated," Ms. Hueber added. To

"We also learned that medical case managers were not talking to their clients about HCV. They knew they were being tested within the Ryan White CARE system, but no education was being provided."

address this issue, the PDPH educated more than 400 case managers and frontline staff on HCV and available treatments and disseminated hundreds of hepatitis-related educational materials at health fairs and other community events. The PDPH also used focus group feedback to create a handout comparing the old and new HCV treatments. After the MA AETC shared the handout with the National Resource Coordinating center, it was adapted into a pamphlet entitled *Hepatitis C: Getting Cured Is Easier than Ever* for national dissemination. Partly as a result of these efforts, Pennsylvania now has a grade of A- for HCV treatment access in the National Viral Hepatitis Roundtable's *State of Hep C's Medicaid Access Report Card*.

Although the SPNS initiative will end in September 2019 and more work remains to achieve HCV micro-elimination, Coleman Terrell, AACO Director, believes that project accomplishments will be sustained through “all of these hepatitis awareness measures we’ve embedded in our training



Coleman Terrell, AACO Director

for providers and for consumers, in our engagement program. ... I think we’ve placed things so that the structural changes can continue.” Project champions within health care systems throughout the Philadelphia metro area also will help to sustain the effects of *C Ya!*. Ms. Shirreffs also sees opportunities among the challenges that remain. “The people we serve don’t live in a silo, and learning more about the complexity of their lives has reminded our team to consider the many intersecting factors that impact people’s health and access to care. For the most complex patients, we’re going to have to think beyond their HIV or HCV to engage them. As big a challenge as that is, there’s also something exciting in the creativity that will be required to transform the system to meet the needs of the people who need these services the most.” 🙌



Staff at National Ryan White Conference on HIV Care and Treatment

Ending the HIV Epidemic in the District of Columbia Department of Health (Parts A and B)

The HIV/AIDS, Hepatitis, STD, and TB Administration (HAHSTA) of the District of Columbia Department of Health (DC Health) receives funding for HRSA's RWHAP Parts A and B. DC Health administers the RWHAP Part A grant in the D.C. EMA and uses these funds to provide core medical and support services for residents with HIV. DC Health's Commission on Health and HIV (COHAH), composed of representatives who work in HIV prevention or care across the EMA, serves as a Part A planning council and advisory body. As such, the COHAH sets priorities and allocates resources. DC Health engages with partners and regional health departments to plan and establish HIV-related service priorities to support people with HIV in Washington, D.C., and parts of Maryland, Virginia, and West Virginia.

DC Health uses RWHAP Part B funds to provide a wide range of integrated HIV care and support services, such as the Part B AIDS Drug Assistance Program (ADAP); medical case management, including treatment adherence services; mental health services; and outpatient substance use disorder treatment.

According to Ms. Clover Barnes, HAHSTA's Chief, Care and Treatment Division, "We're the only Part A EMA that crosses four jurisdictions—District of Columbia, Maryland, Virginia, and West Virginia—so it really allows us to look at how the HIV epidemic moves across our very fluid borders and to really try to make the biggest and best impact we can."

As of now, approximately 13,000 people in D.C. live with HIV. The number of new HIV diagnoses in D.C. remains high—approximately 370 people in 2017. Ms. Barnes stated, “The majority of our new HIV cases have been among

“I don’t think we would be able to make any headway on our epidemic if we didn’t have HRSA support.”

younger people, 35 and under, black/African American and Latino men who have sex with men, and black/African American women.” Almost half of all people with HIV in D.C. receive HRSA’s RWHAP services. In 2018, 11,537 individuals accessed RWHAP-

funded services in the D.C. EMA, including 6,718 individuals who received RWHAP services in D.C. Ms. Barnes stated, “I don’t think we would be able to make any headway on our epidemic if we didn’t have HRSA support.”

To address the HIV epidemic and recent scientific advances in treatments for people with HIV, DC Health and partners developed the *90/90/90/50 Plan: Ending the HIV Epidemic in the District of Columbia by 2020*.⁴ The Plan and several of its elements are highlighted in the pages that follow.

90/90/90/50 Plan: Ending the HIV Epidemic in the District of Columbia by 2020

A major priority of DC Health has been planning and implementing the *90/90/90/50 Plan*. This four-year plan—to support Washington, D.C., Mayor Muriel Bowser’s vision to end the HIV epidemic—was created through a public-private collaboration with DC Health, the DC Appleseed Center for Law and Justice, and the Washington AIDS Partnership. The Plan’s four goals are as follow: 90 percent of D.C. residents living with HIV will know their status, 90 percent of persons diagnosed with HIV will be in treatment, 90 percent of persons in treatment will achieve viral suppression, and the District will see a 50 percent decrease in new HIV cases by 2020. The Plan provides steps and strategies—including the innovative demonstration or pilot projects described below—to meet the goals, as well as a call to action for D.C. residents, health care providers, advocates, and community members to educate themselves about HIV, reduce stigma, and support effective care and prevention strategies.

Increasing Access to Treatment Through the Red Carpet Entry Program and Rapid Antiretroviral Therapy Demonstration Project



Lena Lago, Care and Treatment Division, Deputy Chief

To meet the Plan’s goal of getting 90 percent of HIV-positive D.C. residents into treatment, DC Health is reinvigorating its Red Carpet Entry (RCE) program. RCE began approximately 10 years ago as a way to help newly diagnosed people with HIV in D.C. connect with an HIV provider. According to Ms. Lena Lago, Deputy Chief for the Care and

Treatment Division, HAHSTA, “At the time, one out of four newly diagnosed residents with HIV waited three months or more before seeing a provider.” To shorten this time, DC Health set up a process by which testing sites could call RWHAP providers and request an RCE appointment. This neutral term was designed to reduce stigma for those newly diagnosed clients who were still coming to terms with an HIV diagnosis. Although the original requirement was to link clients into care with an RCE provider within 72 hours, the linkage to care window was closer to 48 hours. Ms. Barnes explained, “We’re able to offer a warm handoff and know that the client will have an appointment with the medical case manager, as well as the actual provider he or she will see for their care moving forward. We make sure the initial evaluation includes a mental health screening to assess a client’s readiness for care and ART treatment, because it can be overwhelming when you’re first diagnosed with HIV.” To reinvigorate RCE, DC Health plans to update materials and hold a webinar or in-person meeting to introduce new providers to this successful program.

DC Health also is launching a Rapid ART program whereby all newly diagnosed individuals are seen quickly by providers who evaluate them and get them started on ART within seven days of diagnosis, so the individual can achieve viral suppression within 60 days of starting ART. According to

Ms. Lago, “We are piloting Rapid ART along with a 30-day ART starter pack at our DC Health and Wellness Center, which is HAHSTA’s STD clinic. We’ve learned from literature reviews and from other jurisdictions that have implemented Rapid ART that clients gain a sense of empowerment when they are actually handed the medication after diagnosis and before they leave the clinic.” Ms. Lago also stated, “Along with our community partners, we are solidifying the program parameters and data we are going to collect around the initiative, specifically establishing our baseline and our targets, and using this information to implement the program.”

HRSA HAB recognizes the importance of the rapid initiation of ART. In the past, people with HIV receiving care through RWHAP could not begin treatment without first meeting certain eligibility criteria. HRSA HAB recently [updated the criteria](#) to allow rapid initiation of HIV care before eligibility is documented.⁵

Although RCE and Rapid ART are separate programs, they are closely connected. “You get [clients] in the door, you get them on ART, and you get them suppressed,” Ms. Lago stated.

Improving Medication Treatment Adherence

To help meet the goal of treatment toward viral suppression for 90 percent of D.C. residents living with HIV, DC Health created an online portal for case managers to enroll clients in the RWHAP ADAP. Ms. Barnes stated, “We used to have a more antiquated system before we implemented our own new system. Now we have control over the system, and we can enroll and disenroll clients within 24 hours, which is amazing since it took about three weeks when I first started working here about five years ago.” DC Health works with pharmacies and pharmacy benefits managers to increase client access to prescriptions and improve medication treatment adherence. According to Ms. Barnes, “Through our ADAP, clinical pharmacists are monitoring client medication treatment regimens, such as ART, as well as refill times, and reaching out to people who haven’t picked up their refills on time



Open House with staff (LtR) Tom Ogungbemi, Quality Improvement Coach Lead, Justin Britanik, Quality Management Specialist, and Lena Lago, Care and Treatment Division, Deputy Chief

to find out what the barriers are. They are also helping to resolve issues, such as changing difficult-to-swallow pills to a liquid and working with providers and clients to lessen medication side effects. DC Health also has an initiative to monitor the medication regimens and viral loads of youth and youth of color to help ensure that they reach viral suppression. Staff engage with youth to understand the barriers keeping them from taking medications in a consistent manner.” Ms. Barnes also stated, “We’ve hired a Spanish-speaking ADAP support staff member to work with young Latinos, and she has made tremendous headway in getting to know where they are in care, getting them enrolled in our medication therapy management program—which helps them manage their medication—and just really trying to make sure they are getting the best care possible.”

DC Health also has created an app to enable clients to check the status of their ADAP enrollment, as well as their medication refills. Another way that DC Health is helping clients stay in care is through a new pilot program with rideshare companies, such as Uber via its Uber Health program, to assess whether providing transportation to appointments helps clients reengage in care and get the medications they need.

Preventing New HIV Infections with Pre-Exposure Prophylaxis

To meet the goal of a 50 percent reduction in new HIV infections, as well as the goal of 90 percent of D.C. residents with HIV knowing their status, DC Health started programs to educate D.C. residents about HIV risk and improve access to PrEP to prevent HIV. One strategy is to use the ADAP infrastructure to provide PrEP, including starter packs. Ms. Barnes explained, “We don’t pay for PrEP with RWHAP funds, but we use the infrastructure of the ADAP so clients can get qualified for the medication; then they go to a pharmacy and pick up their PrEP the way they would if they were picking up ART.”

Developing an Integrated HIV Prevention and Care Plan Through Regional Collaboration

The development of the *90/90/90/50 Plan* coincided with new federal planning requirements that jurisdictions must follow to align with the goals of the National HIV/AIDS Strategy. In 2015, HRSA and the CDC announced that they would offer jurisdictions the opportunity to combine two required, but separate, plans—the HIV Prevention Cooperative Agreement for a Jurisdictional HIV Prevention Plan (from CDC) and the Ryan White CARE Program for a Comprehensive Care Plan (from HRSA)—into one integrated plan to address HIV prevention, care, and treatment. To do this, the existing RWHAP Planning Council and the HIV Prevention Planning Group—both of which include government agencies, health departments, care providers, community representatives, and people with HIV—formed a joint regional working group to prepare the *Integrated HIV Prevention and Care Plan*.

This Integrated Plan covers HIV activities related to federal funding throughout the entire EMA, including D.C., five counties in suburban Maryland, 11 counties and six cities in Northern Virginia, and two counties in West Virginia. The *90/90/90/50 Plan* informed the Integrated Plan’s development, and the *90/90/90/50* goals are mirrored in the Integrated Plan. Ms. Barnes stated, “We took our *90/90/90/50 Plan* and made sure it aligned with our Integrated Plan, since the two are different but connected documents. We didn’t want

to be working toward different goals, so all the goals and activities align.” Leah Varga, Ph.D., HAHSTA’s HIV Services Planner, added, “Even though D.C. has most of the HIV burden, we made sure we created a plan that speaks to the needs of our communities—including rural ones in Virginia, Maryland, and West Virginia—since borders here are very fluid. People don’t pay attention to borders, even if we do as bureaucrats. There are plenty of people with HIV who live in either Maryland or Virginia, for example, who work in D.C. and go out with friends in another part of the metropolitan area, and vice versa.” As such, the Integrated Plan is more detailed than the *90/90/90/50 Plan* and reflects regional realities. Like the *90/90/90/50 Plan*, the Integrated Plan provides specific details for establishing a portable regional health care system for RWHAP clients across the EMA. This regional system would enable people with HIV to select service providers who meet their needs, regardless of where they live or work. To reduce barriers to services and increase treatment adherence, the system will allow clients to seek RWHAP-funded providers anywhere in the region if none are available nearby.

“We took our *90/90/90/50 Plan* and made sure it aligned with our *Integrated Plan*.”

Key Successes and Lessons Learned Toward Ending the HIV Epidemic

To successfully implement the *90/90/90/50 Plan*, the Integrated Plan, and new programs and initiatives, DC Health engages with the provider community to increase understanding of their systems and processes. Ms. Barnes stated, “You can have all the ideas you want, but if it doesn’t work for their system, or they can’t engage with you in implementation, you’re never going to get anywhere. I think making sure you have open communication and providers at the table to help you develop strategies to implement programs [is one] of the key tenets to be successful. Provider turnover is one of our biggest challenges. When a case manager or program coordinator leaves, for example, it always creates a void at that specific organization, and then we have to engage with a new person all over again.”

Partnerships also are key to successful efforts, including the development of both the *90/90/90/50 Plan* and the Integrated Plan. Dr. Varga explained that developing the Integrated Plan was a time-challenging, but successful, regional collaboration that “got stronger as we moved forward. ... Keeping the community and other partners engaged and making sure they are part of the process is integral for developing a responsive regional plan.”

DC Health monitors progress on health outcomes, and both DC Health and the DC Appleseed Center for Law and Justice monitor the *90/90/90/50 Plan* in an effort to end the HIV epidemic. Ms. Lago stated, “Many of the *90/90/90/50 Plan* goals and activities are intentionally ambitious—it takes time to implement processes and changes to programs and delivery systems.” DC Health has reported progress though, especially among RWHAP clients.

“You can have all the ideas you want, but if it doesn’t work for their system ... you’re never going to get anywhere.”

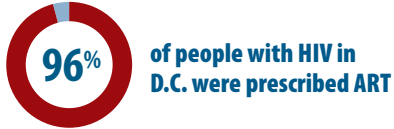
“Clients who receive RWHAP services always have better outcomes than our clients who don’t access RWHAP services,” Ms. Barnes stated. “I think that’s something we can really be proud of as a health department; but then I also see that’s where we can

improve with providers who are not connected to RWHAP.” The infographic on next page shows the health outcomes of people with HIV in D.C.⁶

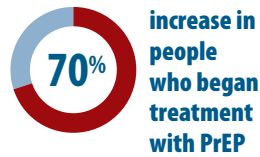
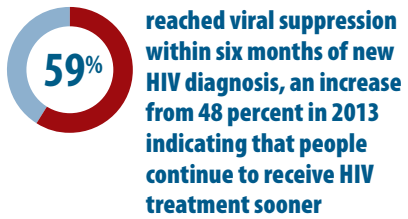
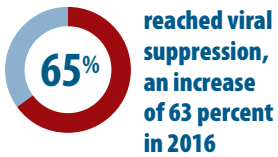
To further efforts to end the HIV epidemic, DC Health’s plans include expanding HIV services and education to youth because this population currently represents 41 percent of new HIV diagnoses in DC. With its own funds, DC Health will promote and make PrEP available to adolescents, along with financial assistance; work with school-based health centers and community partners to make sexual health services more available; enhance education campaigns; and provide easier access to partner treatment of sexually transmitted diseases. Other efforts include launching a new PrEP Drug Assistance Program to provide financial assistance to people with insurance coverage gaps and a post-exposure prophylaxis (PEP) initiative to make PEP available 24 hours a day/seven days a week to people who potentially were exposed to HIV. 📌



Among RWHAP clients:



Among all people with HIV in D.C. :





Physicians Jessica Johnson and Nasira Roidad

Expanding HIV Services in West Virginia Through Telehealth: West Virginia University Positive Health Clinic (Part C)

HRSA's RWHAP Part C recipient West Virginia University Positive Health Clinic (WVUPHC) uses RWHAP funds to bring state-of-the-art, comprehensive HIV medical care and support services to 33 counties in north-central and northeastern West Virginia—a mountainous region in Appalachia—and regions of adjacent states. WVUPHC serves a largely rural, impoverished, and medically underserved area. Approximately 66 percent of WVUPHC patients are non-Hispanic whites, and the majority are men who have sex with men. Patients also include individuals who were infected with HIV through heterosexual contact and injection drug use.

In addition to five infectious disease physicians, the WVUPHC staff includes two psychiatrists, a nurse clinician, a nurse educator, three medical assistants, a program director and associate director, and a grant specialist. WVUPHC also contracts with two RWHAP Part B case managers, an American Academy of HIV Medicine–certified pharmacist, a mental health counselor, and a financial counselor. With its diverse group of providers, WVUPHC can offer a broad range of services to its patients. These services include primary medical care; medication-adherence counseling; mental health services; patient education on HIV, smoking cessation, and cardiovascular disease and diabetes risk reduction; and assistance transitioning from pediatric to adult HIV care. WVUPHC provides referrals to other services, such as oral health care and

substance use disorder treatment. The clinic also receives RWHAP Part D funding, which allows WVUPHC to provide primary and specialty medical care to women, infants, children, and youth with HIV in medically underserved communities.

In addition to the services offered at the main WVUPHC clinic in Morgantown, West Virginia, the program includes a satellite clinic in Wheeling, West Virginia, and supervision of care for people with HIV at the Shenandoah Community Health Center, part of the Shenandoah Valley Medical System, in Martinsburg, West Virginia.

Using Telehealth to Improve Patient Care



Tabatha Coombs, WVUPHC Associate Director, and Kathy Houser

Telehealth is an important tool in patient care, particularly in rural areas where HIV services are not readily accessible for many patients and where infectious disease specialists are in short supply. The telehealth initiative helps train health professionals to provide the most appropriate care for their patients

with HIV, with the ultimate goal of reaching viral suppression for all patients. WVUPHC's initial foray into the use of technology for patient care was the adoption of electronic medical records (EMRs). WVUPHC uses EMR software that includes MyChart, a patient portal that gives patients online access to their medical records and allows them to communicate directly with their health care team. Arif R. Sarwari, M.D., M.Sc., M.B.A., Parts C and D Medical Director and Chair of the Department of Medicine at WVUPHC, explained, "Instead of having to respond to a phone message and talk to an answering machine, you, literally—at your convenience at either end—are able to directly address questions, whether they are about a lab test or about a prescription or about a side effect. I found that an extremely useful way to directly communicate with our patients." As a result of the RWHAP Part C capacity-building grant that funded this effort, WVUPHC has been able to decrease the number of in-person clinic visits for stable patients and make more appointment times available to those who need more frequent visits.

WVUPHC's Case-Based Learning Model

Dr. Sarwari described WVUPHC's telehealth support of the Shenandoah Community Health Center, explaining that, although the center has never had an infectious disease physician onsite, it has become, by default, the HIV care provider in the eastern panhandle of West Virginia. Shenandoah Center staff members were eager to partner with an infectious disease specialist at the university level so they could learn from the experts and provide knowledgeable, high-quality care to their patients with HIV. That partnership led to monthly patient-care videoconferences between WVUPHC and the Shenandoah Center. Dr. Sarwari explained, "The model we are using

"The model we are using is essentially a patient case-based learning model, and, in the process of presenting patients, each and every member of the team learns about what was done, why it is being done, and which regimen was chosen."

is essentially a patient case-based learning model, and, in the process of presenting patients, each and every member of the team learns about what was done, why it is being done, and which regimen was chosen." As part of the learning process, WVUPHC staff address specific questions from the Shenandoah Center staff and provide information on new developments in the field as they occur. In addition, WVUPHC staff offer person-to-person consultations

and trainings based on the individual clinic's needs. The case-based model is central to WVUPHC's approach to RWHAP Part C and is used at the Morgantown clinic on a weekly basis.

The patient-case model is key to successfully caring for people with HIV, as Dr. Sarwari explained. Jeanette Southerly, B.S.N., RN, ACRN, Resource Coordinator with the West Virginia regional partner of the RWHAP Part F MidAtlantic AETC, added that committed staff are important to providing effective care. She stated, "We've been very fortunate in that the groups and the people we've worked with have all been very passionate; they've been very eager to jump in and do whatever's needed to make the best patient care possible."



WVUPHC staff at a patient care meeting

Dr. Sarwari agreed the Shenandoah Center displayed that commitment to caring for an underserved population by reaching out to WVU for support, resulting in a successful telehealth partnership. Dr. Sarwari said, “Without an infectious disease [ID] doctor, the Shenandoah Valley Medical System can provide care to an HIV patient today that is equivalent to a university setting in Morgantown with six ID physicians, just by virtue of the knowledge they have gained over the years taking care of these patients.”

Innovating Patient Care

Aside from the telehealth effort with the Shenandoah Community Health Center, Dr. Sarwari highlighted several other WVUPHC’s Part C program initiatives that are critical to meeting the unique needs of their patient population. Among them are the weekly meetings at the Morgantown clinic attended by all patient caregivers, including nursing staff, physicians, pharmacists, social workers, and case managers to discuss patient care progress and challenges.

Another unique element of the Part C program is the quarterly WVUPHC team trip to the Wheeling clinic (a 90-minute drive) to tend to patients in that region who have challenges traveling to the clinic in Morgantown.

The HIV Care Continuum

Dr. Sarwari said that WVUHPC's Part C program goal is zero HIV transmission in the areas it serves. To accomplish that goal, he explained, "Each and every patient diagnosed as HIV-positive needs to be linked to care, kept in care, started on antiretrovirals, and ... [ultimately, to become] undetectable in terms of viral load." WVUHPC staff quickly learned that the biggest break in this process is the linkage to care. WVUPHC partnered with the state of West Virginia and its early intervention services staff to start a rapid testing program administered by WVU. Rapid testing uses either an oral swab or a blood sample from a fingerstick with results available within minutes. This program allows the health care providers to identify new cases and bring people into care quickly. As a result, the linkage to care is increasing to nearly 100 percent, according to Dr. Sarwari.

Ms. Southerly said that retention in care "is higher than in other places because of the ongoing communication between patients and the clinic staff, who keep the patients coming back to the clinic." In addition to high retention levels, approximately 94 percent of WVU clinic patients and 100 percent of the Martinsburg clinic patients are receiving antiretroviral therapy. Of these patients, 91 percent have undetectable viral loads.



WVUPHC staff Jennifer Barchetti, Michelle Lott, Anne Behr, Tabatha Coombs, Kathy Houser, Megan Rohan

Key Successes and Lessons Learned Toward Ending the HIV Epidemic

WVU's success in effectively caring for and treating people with HIV in its own clinics and in the Shenandoah Center hinges on communication and education—whether in person, through EMRs, or through telehealth. Dr. Sarwari emphasized the importance of patient care conferences and sharing information among all health care providers, which allow staff to address barriers that patients may encounter in maintaining their HIV care regime. “As a physician, it was very humbling to realize that, honestly, you’re not the most important piece of that wheel. You may write the most appropriate prescription; it doesn’t matter if the patient doesn’t have a way of getting it,” Dr. Sarwari said. Other members of the care team also are crucial to providing comprehensive care to people with HIV by ensuring that other patient needs, such as access to transportation, are met.

Dr. Sarwari explained that the funds WVU receives from the RWHAP are critical in supporting these efforts. In a standard infectious disease clinic, Dr. Sarwari said, “There’s little opportunity to try to do things differently. HRSA funding allows us to work toward bigger goals like zero HIV transmission within West Virginia. ... I think HRSA funding has basically allowed the vision, the mission to be broader.” By striving for zero HIV transmission through an integrated care approach and using telehealth to provide the care and treatment people with HIV need to help them reach viral suppression, WVU is contributing to the goal of ending the HIV epidemic in the United States. 🤝

“As a physician, it was very humbling to realize that, honestly, you’re not the most important piece of that wheel. You may write the most appropriate prescription; it doesn’t matter if the patient doesn’t have a way of getting it.”



Positive Peers app feature

Using Social Media to Improve Engagement, Retention, and Health Outcomes: MetroHealth (Part F)

The MetroHealth System, the public health system of Cuyahoga County, Ohio, receives HRSA's Ryan White HIV/AIDS Program (RWHAP) Part F funds for a SPNS initiative that uses social media technologies to identify underserved youth and young adults (aged 13–34 years) and link them to and retain them in HIV care. MetroHealth provides HIV services to approximately 1,700 clients, approximately 30 percent of whom are youth and young adults, at its main facility in Cleveland and at four satellite clinics in the county. Among the full client cohort, approximately 65 percent are black/African American, 10 to 15 percent are Hispanic/Latino, and the remainder are non-Hispanic white. MetroHealth also receives RWHAP Part A and Part B funding.

Ann K. Avery, M.D., an infectious disease physician and Associate Professor at Case Western Reserve University Medical School, is the Principal Investigator for the RWHAP's SPNS initiative. Dr. Avery said that MetroHealth serves a population that has a great need for HIV services. "Many of our patients have experienced trauma, repeated lifetime trauma, substance use and misuse, mental illness. Our young adults are often sexual minorities, as well as racial or ethnic minorities, and have had great challenges. And I see them rise up to the challenge and actually use HIV as a turning point in their life."

Engaging Young People with HIV

Dr. Avery said that clients aged 18 to 29 years have the lowest viral suppression rates among all of MetroHealth’s clients with HIV—approximately 60 to 70 percent of them have reached viral suppression, compared with 80 percent among the full client cohort. The primary goals of the RWHAP SPNS initiative are to improve client engagement in continuous coordinated care among young people with HIV and help them reach viral suppression. Jennifer McMillen Smith, LISW-S, Project Director and social worker at MetroHealth, identified supplemental goals: “We also are really hoping to decrease feelings of stigma and isolation among our patients and increase their management of their health,” she said.

To help accomplish these goals, MetroHealth developed an innovative website, positivepeers.org, and an app to engage younger people with HIV. This innovation sprang from support groups that Ms. Smith led. At the end of each meeting, she would encourage people to exchange phone numbers so they could text or call one another. She noticed, however, that the young people in the group were more interested in connecting through their Facebook accounts. Ms. Smith concluded, “If that’s where they are, that’s where we need to be.”

MetroHealth then partnered with Blue Star Design, a local design, marketing, and web development firm, to create a private Facebook page for clients. When RWHAP Part F funding became available, MetroHealth took advantage of the opportunity to expand its social media outreach. Ms. Smith convened



Mary Step, Project Evaluator, and Jennifer McMillen Smith, Project Director

a group of young people with HIV to talk about what sort of social media efforts they would like to see. Ms. Smith recalled the group’s consensus: “You know our Facebook group? We want something like that that is just for us that is not connected in any way to some other larger social media platform.” MetroHealth again partnered with

Blue Star and their colleagues at Blackbird, a technology developer, to create the website and app specifically for its young clients.

Positive Peers Website and App

The Positive Peers website is available to the public and includes health information and resources. The app is limited to young people who have received a recent diagnosis of HIV or those who have not achieved viral suppression in the past two years and, therefore, are not engaged optimally in care. App participants also include health ambassadors, or individuals doing well in their treatment, who interact with other users and serve as role models. Dr. Avery said that the website and app offer three key features: “health management tools, health information, and a social connectedness platform where the patients can either post on a community board, like a Facebook-style board, or direct-message other users.”

Health Management Tools. Health management tools in the app include a medication reminder that users can program for specific times. Users also

“The website and app offer health management tools, health information, and a social connectedness platform where the patients can either post on a community board, like a Facebook-style board, or direct-message other users.”

can add information about upcoming medical appointments, support groups, or other reminders. Another feature allows users to record their daily exercise, medication usage, and other healthy behaviors, as well as their CD4 count and viral load. This information translates to a weekly personalized health score that gives a quick glimpse of how well that individual is doing. MetroHealth is working to revise the health

management aspect of the app to capture more information about what individuals are doing to improve their health and wellness.

Health Information. The health information found on the public-facing website includes approximately 260 blog posts on a wide array of topics important to young adults with HIV, such as how to tell their partner that they have HIV, advice on dealing with grief, myths and facts about PrEP, how to



Ann Avery, infectious disease physician and principal investigator for RWHAP's SPNS, Joshua Kratz, Clinical Research Coordinator, and Jennifer McMillen Smith, Project Director

safely conceive a baby, and tips on job interviewing. MetroHealth is working on adding voiceovers, referred to as “The Tea,” so that a user who does not want to read a full blog post can hear a brief summary of its contents. In 2018, *Medical News Today* recognized the Positive Peers blog as one of the 10 best blogs related to HIV and AIDS.

Many “Tales of Triumph”—brief stories about young people with HIV—also populate the website. Other tales are available only through the app. Dr. Avery explained that the decision to post on the website or only in the app is up to the individual telling the story. Health information on the website also includes a list of Cleveland-area resources that address many areas of concern to people with HIV, such as mental health issues, substance use and misuse, legal services, housing, case management providers, and MetroHealth HIV physicians.

Social Connections. Individuals can post and reply on a community forum or communicate privately with other forum members. Initially, the app was designed to provide anonymity; each user chose an avatar, but no identifiable information was included. “It seemed to stifle the community conversation. ... People felt weird not knowing whom they were talking to, and so we’ve been allowing users to put more of themselves out there,” explained Dr. Avery. Some users, however, prefer to remain relatively anonymous. Ms. Smith added, “The way we’ve handled that is ... allowing everything to be customizable. You can choose an avatar still, or you can upload a picture. And that picture might be of

your face or of your dog; it doesn't matter." Each user can choose how much identifying information to include.

Ms. Smith said that the peer-to-peer social connectedness aspect of the app makes it unique. When the development of the app began in 2015, an AmeriCorp member researched available apps about HIV for MetroHealth and found nothing that offered a social connection. Since that time, other apps with social connectedness have been developed, but most of them

focus on connecting a client to a care-team member. Dr. Avery pointed out that the Positive Peers app is designed specifically for users to interact with one another. "The goal is that it becomes more of an organic process to get people with HIV connected to each other," she explained. MetroHealth continues to

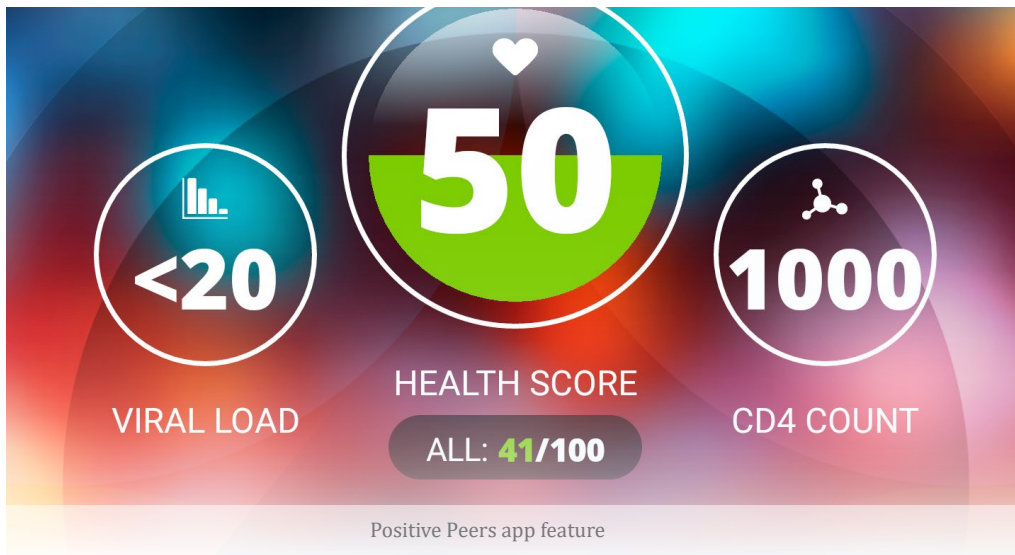
"We know all kinds of things about HIV—except for the lived experience of being a young person with HIV ... so we go to the real experts."

solicit feedback from users as the app evolves. Ms. Smith added, "We know all kinds of things about HIV—except for the lived experience of being a young person with HIV ... so we go to the real experts."

Evaluating the App

One aspect of evaluation is analyzing information gleaned from audio computer-assisted self-interview technology, in which app users listen to recorded survey questions through headphones and enter responses directly into the computer. The questions touch on such subjects as engagement in care, drug use, stigma, mental health, empowerment, and sexual health communication. Interviews are conducted at baseline and after six, 12, and 18 months of app use.

Back-end data include the number of times that users logged in; what pages they visited; how long they spent on each page; the number of posts, replies, and private messages they sent; and what version of the app they have. Data are collected on each user every month. MetroHealth is examining trends in app activity among different subgroups of users, such as those with a new diagnosis, those who have been living with HIV for an extended period of



time, and those who are engaged suboptimally in care. Other data track the use among different demographic groups, such as those who are younger than age 25 and those who are 25 years or older. MetroHealth is in the process of analyzing all of the data and other information it collects to evaluate the success of the app and to improve the user experience.

The User Experience

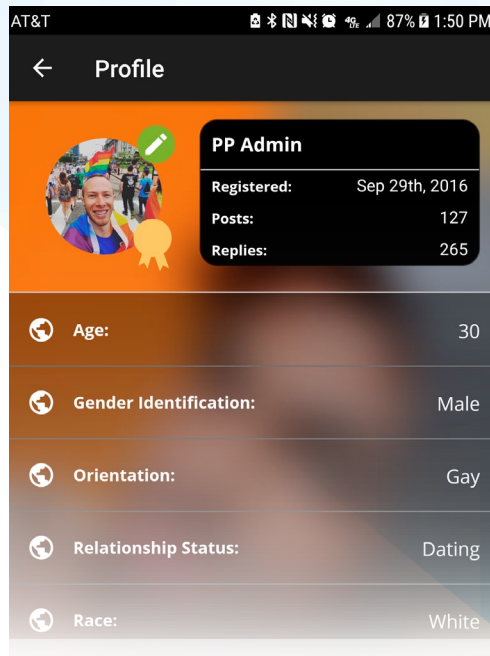
Ms. Smith explained that the app has three types of users. “We have broad users who are clicking on all the different things in the app; we have people who are community forum users; ... then we have users who primarily use the private-messaging feature.” Feedback received from the advisory group of young people, as well as qualitative interviews, has reflected this pattern of use. “Different people use it for different things, and that affords them different benefits,” said Ms. Smith. Dr. Avery added that a woman who had not used the app in months reported that she liked just knowing it is available. “The fact that it is there and she knows she has a community behind her was empowering to this woman,” she said.

Key Successes and Lessons Learned Toward Ending the HIV Epidemic

In addition to gathering data through the app, MetroHealth collects information on users’ medical outcomes through office visits and laboratory

results. Among frequent users of the app, MetroHealth found a small but significant increase in viral suppression from baseline to six months of use—a concrete measure of the app’s success. Additionally, MetroHealth found that 32 percent of people enrolled in the app continued to use it for more than 90 days, whereas MetroHealth’s social media experts report that health apps, in general, have a retention rate of approximately 27 percent. Ms. Smith also said that the content from Positive Peers’ social media platforms is accessed beyond the Cleveland area. “When we’re having national organizations

retweet our stuff or share our articles online, on Facebook, that’s really exciting.”



Positive Peers app feature

Dr. Avery and Ms. Smith agreed that the key to developing effective social media technologies like the app is to listen to the people who will be using it. “If you don’t build something that they’re going to use, it’s pointless, so you have to start where your patients are,” explained Ms. Smith. Another take-away from MetroHealth’s experience with the Positive Peers website and app is the importance of partnering with experts. In addition to working with Blue Star Design on the

web and app design, MetroHealth worked with Blackbird Digital, which wrote the code and made the app’s features functional. Dr. Avery said that support from RWHAP was “absolutely essential” in developing the app.

“I think ... that innovation is the key to ending the epidemic,” Dr. Avery said. “If we want to end the epidemic, we need to really home in on pockets of individuals and recognize that there is definitely not a ‘one size fits all’—and so we need 10 or 20 different sizes.” Ms. Smith agreed that flexibility and creativity are important in meeting the medical, social, and spiritual needs of various populations of people with HIV. 🧡



Participants in the SEPTEP Keeping the Momentum Training, April 2019

Transforming HIV Care Through Provider Training and Education: The Southeast AIDS Education and Training Center (Part F)

The Southeast (SE) AIDS Education and Training Center (AETC) is funded by HRSA's Ryan White RWHAP Part F AETC Program and offers specialized clinical education and training on HIV transmission, care, treatment, and prevention, as well as technical and capacity-building assistance to physicians, physician assistants, nurses, dentists, pharmacists, social service workers, and other HIV-care providers in the southeastern United States. The Regional SE AETC is located at Vanderbilt University Medical Center (VUMC), with partner AETCs selected in each of the eight states served by the SE AETC: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee. The South overall has a high incidence of HIV diagnosis. In 2017, 46 percent of all adults and adolescents with HIV lived in the South, and 52 percent of new HIV diagnoses were in the South. Georgia, Louisiana, and Florida are particularly affected by the HIV epidemic, with rates of diagnosis at more than 20 per 100,000 people in 2017.

According to Stephen Raffanti, M.D., M.P.H, SE AETC Principal Investigator, approximately one-half of the populations served by RWHAP in the SE AETC service area are racial/ethnic minorities (black/African American and Hispanic/Latino), except in Kentucky, where populations served are mostly non-Hispanic white individuals. As in other parts of the United States, HIV

diagnoses are higher among black/African American populations than other racial/ethnic groups.⁷ The region, however, is experiencing an increase in new HIV infections among young college men who have sex with men (MSM). “We have a fairly new epidemic that we’re seeing here, as well as in other parts of the country, where college-age MSM are presenting as new patients, so they’re getting infected sometime in their college career. That’s really a more commonly represented group than it [was] 10 or 15 years ago,” explained Dr. Raffanti.

Many clients struggle with substance use—opioid misuse has become an epidemic in many parts of the SE region. An epidemic of HIV/HCV coinfection possibly is related to the opioid epidemic, particularly in Tennessee and

Kentucky, where rates of opioid use are highest.⁸ “The opioid epidemic—the misuse disorder epidemic—is probably going to lend itself to transmission of HIV, as well as hepatitis B [in addition to HCV], as people shift from ingesting opioids to injecting opioids,” said Dr. Raffanti. Many clients also are dealing with mental health diagnoses, which, Dr. Raffanti explained, are “overlaid

“The opioid epidemic—the misuse disorder epidemic—is probably going to lend itself to transmission of HIV, as well as hepatitis B [in addition to HCV], as people shift from ingesting opioids to injecting opioids.”

with a lot of structural institutional violence and issues of poverty.” The SE AETC recently joined forces with a psychiatrist who specializes in addiction medicine to develop training resources and opportunities that will allow providers to better serve patients struggling with substance misuse and other mental health issues.

To ensure optimal HIV care for clients, SE AETC partner sites perform training and program evaluation for HIV care providers across their state and also coordinate statewide events, presentations, and full-day conferences. The center staff also provide approximately 10,000 hours each year of “preceptorships,” which are mentored, hands-on clinical training programs for



Jennifer Burdge, SE AETC Program Director

clinicians. The SE AETC also conducts an interprofessional education (IPE) program that trains teams composed of medical, nurse practitioner, pharmacy, and social work students by allowing them to care for patients at HIV clinics under the guidance of a mentor. The preceptorships and the IPE program help the SE AETC

achieve its primary goal of increasing the HIV care workforce. According to Ms. Jennifer Burdge, Program Director for the SE AETC, the IPE program has allowed students to learn how to “provide care as a team and ... to appreciate the different levels and expertise of their colleagues, and that’s really helped to grow the workforce.” Many IPE participants have gone on to work at HIV clinics. The SE AETC also provides various training modules tailored to the roles, knowledge level, and time availability of the trainee. For example, a case-management training curriculum focuses on HIV education of most value to case managers and social workers.

The SE AETC also provides regular, ongoing training activities, such as a webcast on a different HIV-related topic each Wednesday and videoconferenced “case conferences” every Friday that allow any clinician to call in and receive advice on the care of patients with HIV. The Center also offers regular online learning courses and treatment toolkits on such topics as HIV/HCV coinfection. An innovative aspect of these courses is the ability to view them in segments, which has proven to be extremely successful with rural providers. The SE AETC also has developed a special training program to help providers combat the stigma associated with HIV, because, as Ms. Burdge said, “In the Southeast, ... we’re still fighting HIV stigma.” The program is geared toward helping busy providers reduce stigma among all staff working at their clinics, because “every person in a clinic needs to be part of the welcoming process to make someone feel comfortable ... and to not feel stigmatized.”

SE AETC Practice Transformation Project

The [Practice Transformation Project](#) is an innovative intervention that is critical to building provider capacity to care for HIV patients across the care continuum. The Practice Transformation Project began in 2015 and has been completed by 12 clinics across the states served by the SE AETC. The Project ended in June 2019, with some clinics becoming part of the SE AETC's Champions Academy and training other health centers and some continuing to build their capacity to provide HIV care.

The Practice Transformation Project's online curriculum includes nine courses in English and two in Spanish, with a focus on the first 30 days of HIV care. Another highly attended course was entitled "How to Deliver a Positive Test Result." Ms. Burdge explained that some of the clinics do not provide HIV testing because the staff members do not want to deliver a positive test result. The courses are delivered online as videos interspersed with activities, questions, and short knowledge tests. Each segment is about 10 minutes long, which allows clinical staff to stop after completing a segment and return to the training program later. The SE AETC offers continuing medical

education, nursing contact hours, and pharmacy and social work credit for completing these courses.

Some important goals of the Practice Transformation Project are to decrease stigma, improve sexual history-taking processes, increase opt-out HIV testing, and implement procedures for

“Practice transformation ... looks very different from clinic to clinic based on whatever they need. ... We do have this sort of agility to try out different things.”

prescribing PrEP. Once these goals are accomplished, the SE AETC will focus on helping clinicians develop skills for treating uncomplicated HIV patients. A critical component of the Practice Transformation Project is the ongoing evaluation and monitoring of progress toward the Project's goals. Researchers at the University of Alabama at Birmingham supported the evaluation by developing surveys to assess clinic needs and analyzing data collected from the clinics. The SE AETC uses the evaluation data to adapt practice transformation to the specific clinics. Program Manager Ms. Clare Boldts said, "Practice transformation ... looks very different from clinic to clinic based



Sierra Harris, SEPTTEP Associate Program Manager

on whatever they need. ... We do have this sort of agility to try out different things.” Regional coordinators and coaches travel to the Practice Transformation Project clinics to discuss clinic goals as determined by the project survey and strategies for achieving those goals over the next four years. Project coaches from state-level AETCs then work with the clinic champion in their state to implement the strategies.

SE Practice Transformation Expansion Project

Another 16 clinics—all certified, patient-centered medical homes—were involved in a nine-month [SE Practice Transformation Expansion Project \(SEPTTEP\)](#) to improve HIV opt-out testing and referral to care, offer PrEP to patients at risk, integrate sexual history-taking into visits, and create a stigma-free clinical setting through the practice of culture change. According to Ms. Burdge, the lessons learned from the main Practice Transformation Project involving 13 clinics were applied to SEPTTEP. For example, the SE AETC staff were concerned that the Practice Transformation training provided by the coaches and champions at state partner organizations was inconsistent for specific topics, such as PrEP. To improve consistency, SEPTTEP training and support activities all were implemented by the SE AETC central office, rather than by state partner organizations. The SE AETC also evaluated the impact of SEPTTEP using the same trainers and consistent training practices across clinics and communicated with the health centers via group and individual calls on a monthly basis. In addition, multiple staff members from the health centers participating in SEPTTEP attended a two-day orientation in Nashville, Tennessee. At this training, participants received a binder containing

resources, including protocols that they could adapt and implement at their clinics, as well as summaries of survey findings for their clinic. All binder materials also are available online. This initial orientation, along with monthly “culture change” calls, process communities of practice, onsite training, and access to SE AETC staff for specific advice and assistance, helped the clinical staff learn how to overcome resistance and make HIV testing and PrEP prescribing an integral part of primary care at their clinics.

Key Successes and Lessons Learned Toward Ending the HIV Epidemic

The Practice Transformation Program has produced many successes. No-show rates have decreased, and HIV testing rates have increased across the region since the Practice Transformation Program was implemented. In addition, 10 participating clinics have implemented PrEP programs, adding 1,046 new PrEP patients with the help of SEPTTEP. Many of these clinics have progressed from merely testing and referral to providing direct HIV care. Some clinics even are providing HIV home care for patients who must drive long distances to see an HIV care provider. In addition, five clinics that had not qualified for RWHAP funding previously now are eligible, and some of the clinics that already had qualified for RWHAP funding now are eligible to receive additional funds. The SEPTTEP also was highly successful. All 16 clinics involved in SEPTTEP have increased HIV testing since the project began, and seven clinics have implemented opt-out testing. Approximately 22,272 additional HIV tests have been performed compared to the previous year, providing new HIV diagnoses to 228 individuals.

SE AETC staff have overcome several challenges in implementing the Practice Transformation and SEPTTEP projects and, in the process, have learned important lessons in serving people with HIV. One important challenge was changing the culture at certain clinics to better accommodate people with HIV. Dr. Raffanti said, “The program won’t work in a clinic that doesn’t have a committed champion and can’t pull the rest of the clinic along.” Although an open-minded and motivated clinician/champion is important, this individual only can achieve the Project goals when all members of the clinic—from the front desk staff to the administration and clinicians—adopt cultural changes and are committed to destigmatizing HIV.



Idia Thurston, Assistant Professor and speaker at a recent training workshop

Ms. Burdge said that culture change often requires relationship building to ensure that administrators are on board and time is allotted for implementing new SE AETC programs. A key ingredient for success is the availability of SE AETC staff to discuss problems with clinic staff and help them develop

solutions. This availability of expertise is especially important for clinics in rural areas, where providers might not have anyone to consult in their area, and for providers in underfunded clinics in general, where staff turnover is high. Training all clinic staff was important for managing high staff turnover, because, as Ms. Burdge explained, “When that nurse practitioner or that physician leaves for a different position and another person comes in, the staff around them can train them pretty quickly because their process is really cemented and secure.”


In implementing the Practice Transformation Project, clinical staff struggled with using the EMR systems to monitor clinic performance in achieving Project goals. The SE AETC team spent the first six months of the four-year Project working with the participating clinics to help them access and analyze their EMR data and complete surveys. Some clinics had to update or purchase EMR systems to collect the data required for the Project. As a result of the SE AETC’s work with the clinics, five clinics added a dedicated data manager, and four gained the capability to generate reminders and track no-show rates to improve patient retention.

Partnerships have been critical to overcoming these obstacles to implementing Practice Transformation. For example, the Peabody College of Education and Human Development at Vanderbilt University has been vital in implementing effective training strategies that rely on adult learning principles. Dr. Raffanti explained that a key reason for the success of many SE AETC projects was that “from the initial part of this program, we started to focus on how to be better trainers and how to better use the resources that are available, because it is very easy to develop a resource and not know if it’s used and not know if it has impact. And we’ve sort of stayed true to the

From September 2015 to June 2018, the SE AETC provided 6,272 training opportunities for 12,610 physicians, 16,916 nurses, 16,330 social workers, 6,313 pharmacists, and 8,263 community health workers. These providers are critical to helping people with HIV achieve HIV viral suppression.⁹

idea that we would do the best we could to train our trainers and do the best we could to evaluate the impact of our training, and that has filtered down.”

Regular SE AETC activities also have generated many successes outside of the Practice Transformation and SEPTTEP Projects. For example, a four-course Cultural Humility Curriculum and a 10-course Medical Case Management (MCM) 101 curriculum developed by the SE AETC have been well received. The MCM courses became a required part of the on-boarding process for Florida Department of Health case managers. Four other states within and outside the SE AETC service area also are requiring the SE AETC MCM curriculum in case manager training. Among the regular SE AETC activities, the Webcast Wednesday program was an important success. Nearly 500 participants—both within and outside the SE region—register for these opportunities each week. Another innovative and successful SE AETC project involved implementing HIV testing at student health centers at historically black colleges and universities across the Southeast. As a result of this project, some student health centers now are dispersing PrEP and decreasing the stigma around HIV testing on campus.

The successes, challenges, and lessons learned from SE AETC activities will help the Center staff continue to improve and expand HIV testing and care. Dr. Raffanti stressed the importance of continuing current HIV interventions and building on the improvements in treatment and prevention since the earliest days of the epidemic, emphasizing that “we have the means to end the epidemic, both with PrEP and with screening and testing and keeping people undetectable.” Ms. Burdge added that “we wouldn’t be able to do this without the support from HRSA’s RWHAP.”

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