January HAB You Heard Webinar
January 26, 2021
2:00-3:00 PM ET

>> AMY: Hi, everyone. Welcome back to the HIV/AIDS Bureau Have You Heard webinar for January 26. We are glad to have you. A few items for housekeeping purposes.

The call is being recorded and will be shared following the webinar. You will notice at the bottom of your screen there is a CC for closed captioning box. If you are an attendee that requires close the captioning, click on the box to bring up the captioning on your computer. And we will also have a Q&A pod during the webinar. There will not be any live Q&As. If you should require technical question, you can use that pod to send a question to our technical expert.

Now I would like to turn over the webinar to Dr. Laura Cheever, the associate administrator of the HIV/AIDS Bureau.

>> LAURA: Thank you very much. And you were hearing from Amy Schachner who helped organize this. Thank you, Amy. Welcome to the Health Resources & Services Administration first Have You Heard webinar for 2021. Monthly update from the HIV/AIDS Bureau.

I'm Laura Cheever, the associate administrator. I'm joined by Heather Hauck and Dr. Susan Robilotto and April Smith, senior advisor for the office of program support. We are glad you can join us for the afternoon webinar. Next slide. We are excited to have you joining us for the first official Zoom webinar.

We again have a very full agenda for you today including an update on COVID-19 vaccines and the HIV AIDS program. And important update on CARE act funding and no cost extension and look at the most recent COVID-19 data report highlighting data through November of 2020.

As well as how to prepare for virtual comprehensive site visits. We will also share HIV/AIDS Bureau updates including recognizing HAB housing and homelessness month which the bureau observes each

January. And we have two recipient spotlight presentations today. Joining us with the rye -- and the Ryan white program part C recipient Cincinnati health network and Caracole who will highlight how they direct the challenges of homelessness, mental illness and addiction in Cincinnati. Next slide. Before we begin with the COVID-19 update this afternoon, I would like to share a few reflections.

It certainly has been a tumultuous start to 2021?

DC and we want to acknowledge as federal employees we swear an oath to the constitution of the United States. And we recognize our significant roles as public servants. As federal employees, we will continue to focus on our mission to serve the public especially in our work to provide leadership and resources to ensure access to and retention in high quality integrated care and services for vulnerable people with HIV and their families. Last week, we experienced a transition to a new administration.

And while at HRSA we are still awaiting the new priorities from the administration, we know that there is much work to be done and we look forward in working together to end the HIV epidemic.

Next slide. Turning to our COVID-19 updates today. We will begin by sharing information on COVID-19 vaccinations and the Ryan white program recipients. Next slide. HAB understands that the COVID-19 public health emergency has been stressful for all of us.

However, there is some really great news and that is that the COVID-19 rollout has started, and vaccinations are becoming available in the communities. Vaccination is the next critical phase in an important tool in stopping COVID-19. In December of 2020, the FDA gave emergency use authorization for two different COVID-19 vaccines. Both have been shown to be safe and at least 94% effective in prevention of severe disease. When the COVID-19 vaccine becomes available in your community we strongly encourage you to get your COVID-19 vaccine. Last week I received my first dose of COVID-19 vaccine as part of my role as a provider seeing patients at Johns Hopkins. Next slide.

All Ryan white recipients and subrecipients have a critical role in addressing COVID-19 vaccine hesitancy in distributing information about local access to vaccines. Many clients are reluctant to receive the vaccinations because they have questions in the vaccine development and safety in the appropriateness of receiving a vaccine given the HIV diagnosis. Every single one of my patients eligible for vaccine in the community has wanted to hear directly from me that I thought it was a good idea. We know that Ryan White HIV program healthcare team members are trusted source of information and we encourage you to please develop plans for addressing clients' needs related to vaccine education and how to access the vaccine.

Next slide. As you may have seen, HRSA HAB has released a new program letter and frequently asked questions related to COVID-19 vaccination on January 15 to provide additional clarification around the role of the Ryan White HIV program recipient in supporting clients and providers through the COVID-19 vaccination process.

The new FAQs address COVID-19 vaccine costs, hesitancy and use of funds. In addition, the letter encourages Ryan White recipients to address access to vaccine and vaccine hesitancy. You can account less the letter on the program letter web page.

In addition, access to FAQs can be found on the COVID-19 FAQ web page on the HAB website.

I would now like to turn the meeting over to Heather Hauck, the deputy associate administrator to provide important updates on the FY 2020 CARES act funding.

>> HEATHER: Thank you. The HIV/AIDS Bureau encourages to continue to draw down the funding in a timely matter. The period of performance for the FY 20 CARES act is 12 months and ends on March 31, 2021. This year in two months. Next slide.

Over the past several months we have received questions from several Ryan White HIV program recipients about the ability to request a no cost extension and clarification around carryover requests. In response, HAB toss developed two new FAQs to provide FQ 2020

CARES Act funded recipient's information and guidance on the process. On the topic of carryover, a Ryan White program recipient can request a no cost extension of up to 12 months for the 2020 CARES Act award through the EHB prior approval module. The recipient should submit the following with their request. A statement about why the extension is needed.

The duration of the extension not to exceed 12 months. Project objectives the recipient plans to complete and a detailed budget page. A budget justification for the unobligated funds, the recipient anticipates will remain at the end of the current budget period. Next slide.

On the question of carryover, if HRSA approves a Ryan White HIV/AIDS Bureau program recipient request, the recipient will not submit a carryover request it is a these are one year award.

A no cast extension is requested and approved the 2020 CARES Act will remain available for use during that extension period. Next slide. Based on the update you could be wondering how this impacts reporting on the COVID-19 data report -- data report or the CDR as we call it.

If you do receive a no-cost extension. The answer is yes. You will be reporting. Recipients and subrecipients should continue reporting the CDR monthly as applicable. Recipient providers should complete a CDR every month for the duration of the FQ 2020 CARES Act award period including the period covered by a no-cost extension.

Subrecipient providers and second level providers should complete the CDR each month during their contract period.

It is important to note that if subrecipients and second level providers used all FY 20 to CARES Act funding in a single month they would still complete a CDR each month until their contract ends. Please continue to follow the CDR reporting guidance provided through the data technical assistance providers. Next slide.

So next we want to actually show an update on the COVID data report known as the CDR. In the fall we shared a CDR update through

August. Today we will look at the CDR updated over the last quarter. I will turn it over to Antigone Dempsey, the director of HAB division of policy and data.

>> ANTIGONE: Thank you again and I want to begin with thanking everyone for submitting the monthly CDR COVID-19 data reports. These data are incredibly important for us to be able to monitor our activities related to the CARES Act funding and you will see that providers have been using CARES funding to implement and expand services to prevent, prepare for and respond to COVID-19 and we have the data to be able to show that. Baltimore Ravens so also wanted to just note that we are aware -- also just wanted to note that we are aware that many recipients have requested and received extensions on CDR reporting in order to establish contracts or set up reporting. Note that there is missing data. This is preliminary data and we do anticipate that these numbers that I'm going to show will change as more providers start to submit data covering these reporting periods. Next slide.

So this is our telehealth capacity. And for these Slides I'm going to be talking about the first reporting period and looking at that reporting period to a reporting period in November. We just received our data for December on January 15. So that data is not included in these. But that is just sort of the layout of the data reports that we are share. So we started in the first reporting period with about 68% of our Ryan White providers reported having in I telehealth pass I and that has gone -- capacity and that has gone up to 8% 4%. You see here some of the common telehealth services reported but you all. Testings.

We see that providers expanding and implementing COVID-19 testing. The providers increased from 29% as of March 31 to 48% in November 30.

So that results in about close to 9,000 Ryan White eligible clients and household members who received COVID-19 testing in November.

So next slide. So this slide is showing the folks that you are all serving who have been newly identified with COVID-19.

So as you can see here, what we are showing is the number of people per month who are newly identified as having COVID-19. Those are the blue bars, and you can see starting from the January to March reporting period going all the way through to November. Then the red bar is adding all of those numbers up to show that we are -- have served a little over 15,000 eligible client who have been identified with COVID-19.

And again, these data are preliminary. That is a note on all of the slides. The next slide.

The next slide is looking at the types of services that have been provided over this past reporting periods and you can see that the number of clients and also household members receiving services for each month on the slide. One thing I want to point out there is most likely duplication here because the same people may be receiving services in multiple months so make sure to note that. There will be duplication across the month.

These are preliminary but you can kind of see the curve that I think sort of goes along with the number of people testing positive as well. The correlations there. So next slide.

And again I just want to highlight the services that are being received by our clients related to the COVID CARES Act funding. I don't think any of these are a surprise but outpatient ambulatory health services. Medical case management. Today bank, home delivered meals. AIDS drug assistance program treatments and then also health education, risk reduction and case management.

So now I would like to turn it over to Dr. Susan Robilotto the director for HAB's division of HIV AIDS pro.

>> SUSAN: Thank you. Given the importance of the Ryan White program recipients in the local, state and national COVID-19 response effort as well as guidance from the CDC, HRSA HAB has postponed onsite visits since the beginning of the pandemic. However, as an alternative to in-person site visits in the public health emergency, HRSA

HAB is continuing to move forward for plans with in-person site visits and will transition if and when it is safe to do so. Next slide, please.

We understand the virtual site visit is a different experience than on-site visits and HAB has received several questions from recipients who have concerns about what to expect when it is your turn to participate in a virtual site visit.

We wanted to take a few minutes today to provide some information about what is involved in the virtual site visit experience and how you can prepare to participate. As a division director for the Ryan White HIV/AIDS program part B, several have already taken part in virtual site visits. The breakdown over the last 11 months and how many HAB is preparing for the FY 2021 year since mar of 2020, there have been four and two are in progress. Next slide, please.

Recipients preparing it is important to note while there are minor adjustments, all components of the comprehensive site visit are included in a virtual site visit. They are conducted using Microsoft Teams. The Ryan White HIV/AIDS program officers will work with the recipients and MSCG consultants to ensure there is IT support for the recipient and provides support throughout the virtual site visit to address any technical glitches that may arise. MSCG will train the recipient staff prior to the site visit to everyone is comfortable with the technology. The sessions range in time from two to four hours and spread out through the week. In a few minutes, one of today's recipient spotlight presentations will feature a part B recipient who will share their first-hand experience with the virtual site visit process.

I now will turn it back over to Heather Hauck. Heather?

>> HEATHER: Thank you, Susan. We would now like to turn to important HIV/AIDS Bureau updates. April Stubbs-Smith will share an important observance for HAB, housing and homelessness month. April?

>> APRIL: Thank you, Heather. Just getting my video together. Thank you. I'm about to serve as the senior sponsor to HAB's homeless and housing work group. Each January the bureau honors the

significant work of many of our Ryan White program recipients who serve the unique needs of people experiencing homelessness.

The HIV AIDS bureau sevens a critical role in the intersection between HIV care and treatment and housing. There is a large and growing body of research that indicates that stable housing has a direct and powerful effect on HIV incidence, outcomes, and on health disparities. In fact, and this is powerful, housing is a more significant predicter of healthcare access and HIV outcomes than individual characteristics. Behavioral health issues, and access to other services.

And finally, housing is a proven and cost-effective intervention that can improve HIV healthcare outcomes.

Next slide. Here is a look at our 2019 Ryan White HIV/AIDS program client level data by housing status. In viral suppression. Shortly we will hear from the Ryan White HIV/AIDS program recipients in Cincinnati who will highlight the incredible work they are doing to seven people with HIV experiencing homelessness in their community. For the next update I would like to turn it back over to Antigone Dempsey.

>> ANTIGONE: Great.

Thank you, April. So we also wanted to let you all know that we just recently put out our AIDS education and training data report and that is online.

And we just want to thank all of our program recipients and the performance sites for work on that.

It is available at the link here or go to the HRSA HAB website and find it there. Next slide.

We also wanted to let you all know that we are so in my division we have the clinical and quality branch led my Marlene and one of the things that branch is doing that we are developing resource for clinical quality management staff across the Ryan White recipients and subrecipients through a list serv to connection people and answer questions around clinical quality management work. And you can see the e-mail address if you have questions about that. I will now turn back over to Susan Robilotto.

>> SUSAN: Thanks. As I high heighted earlier, several recipients have already had the opportunity to experience a virtual comprehensive site visit. I'm excited to introduce the first recipient spotlight presentation. Tara Thomas from the Ryan White HIV/AIDS program recipient at the Maine Department of Health and Human Services. The data and quality specialist for the Maine part B program for the last 12 years and has more than 20 years of experience working in HIV services. Thank you for joining us today, Tara.

>> TARA: Thank you. Next slide. Hold on one second. I minimized the wrong thing because, of course, technical issues. All right.

So if you drive into Maine you will see a big blue sign that reads welcome to Maine the way life should be. I included this slide in our overview to let the site visit team see a little bit of what they were missing in person. Next slide. Maine is geographically bigger than the five other New England states combined but our population is only 1.3 million. We have about 1700 people living with diagnosed HIV in the state. And about 1100 of them are enrolled in the part B program.

Our formula award for FY '20 is 1.74 million. And the total budget including part B supplemental funds, rebates and state general funds is $5 million. The program sits in the Maine CDC, our state health department. Next slide.

Our first case of COVID-19 was diagnosed March 12 in the first 10 months we had over 31,000 cases and over 450 death.

S. In the last week it increased to 281.7 from 232.7 and another 6500 cases and 108 deaths. Next slide.

Our part B program has a really small staff. My position is half funded by our formula grant and half through state general fund.

I'm responsible for all of our policy and compliance work and since I had participated in the previous two in-person site visits I took charge of all of the site visit preparation. During the 2016 site visit we provided documents for and interviews with all of our staff. This time we were asked to only provide documents for staff funded directly

about the Xo7 grant and they interviewed two out of three already participate. We also had a number of long-term vacancies.

Critical positions since the 2016 visit so I made a chart that I included in the program overview because I thought that that was really important context. Next slide.

We had relationships with the three contractors more than a decade and they all participated in fast federal site visits and are familiar with the structure. Only the subrecipient was required to participate to that made is easier to schedule and manage. Next slide. The service portfolio is probably smaller than most states. Most people living with HIV are eligible for targeted case management through Medicaid so funds that would have been spent on case management are directed to food housing and dental assistance instead. Most of the resources go into the ADAP. Last year it was 86% of our direct costs. Next slide. Our 2011 site visit was before the current model for comprehensive site visits was put in place. It was only the project officer and branch chief who attended. 2016 was hard on us because we had a brand new program manager. We had a federal site visit and had to develop our first integrated plan. So we asked that our next site visit be a year early so it wouldn't be on the five-year cycle as the integrated plan. Little did we know how 2020 was going to work out. We were asked to pilot a site visit. I contacted the state IT to get the most secure platform and they recommended Microsoft teams and one drive. Next slide.

After that, I e-mailed all of the different play involved. We had two people from audit and three fiscal staff. HR needed to provide Documents but didn't need to participate in the site visit itself.

We partially fund four case managers so between them, their supervisor, the fiscal person, the Executive Director and their QM person we had eight people from the subrecipient who needed to be involve just ahead, that was the most logistically challenging. I asked them to coordinate the consumer meeting. They wanted a conference call without a video option. During the previous visit they provided a conference room in the office and the meeting was well attended by

clients. This time there were only a handful who participated on the call. We had a practice session in teams. Two weeks before the site visit, we had a conference call with the full site review team and our staff to go over the agenda and Document list.

I was surprised to find out that the reviewers were already going through the documents in the one drive, so I made sure that they were aware that I was still compiling documents right up until the day before the site visit began. Next slide. I created a site visit folder in my personal one drive and granted full access to the site review team and our staff involved in the site visit and created subfolders for client records and fiscal records. This led to upload directly without granting access to everything else in the folder and the same true for the fiscal staff. We do centralized eligibility and have a statewide network, so I provide the documents from our files and exported the case notes for all of the case management clients select the for review. They were still using paper records, so they had to figure out outcome to digitize and get them uploaded but they didn't report any issues getting it done.

I started out by creating folders based on the categories on the document list so admin, fiscal, ADAP and CQM. I ended up just giving folders broad names based on the contents. Next slide. Teams didn't have an option for breakout rooms when we had the site visit, so I created individual meetings for each block. It was a lot of invites to manage but it worked out well because it is easier to partition who needed to attend each meeting. I sent the invites from teams and that made it challenging because some of didn't have teams already. If I sent the insides from outlook it wouldn't have been a -- invites from outlook it wouldn't have been a problem. Teams lets you create multiple meetings at the same time and not attend. It doesn't have the same host issues that other platforms like Zoom has. The program manager has administrate eastbound and fiscal duties. I have administrative and CQM and we both have ADAP related duties so that made it challenging to divide staff up for con current meetings but that was a problem in the previous in-person site visit, too. The final agenda

and Document list were delayed for the last site visit as we lats this one. If felt like more of a time crunch because we were short staffed. I didn't think computers did the blue screen of death anymore until mine did it coming back from lunch on the first day. That was the only major technology issue. Teams didn't have the large gallery view available so we couldn't always see stun unless they were speaking during the entrance and exit meetings which had more attendees than the other meetings did. If we had to include the admin contractors and or staff it would have been that many more Teams meetings to schedule and coordinate. We had much less participation in this consumer meeting than the live one during our previous in-person site visit. Next slide.

We were able to make last minute changes to the agenda when people had extra time. We didn't have any major issues with team. Everyone made it to the meetings without any issues because the site review team had access to the documents well in advance there were fewer requests for documents during the site visit than they were in the last one in person. Having the virtual site visit allow 9 people working at home or different offices to participate without having to take time to travel. The acting branch chief and Dr. Susan Robilotto were able to participate because of that. During the last in-person visit the branch Keefe participated by phone for part of the exit conference but that was it. Everyone was flexible. Overall I thought it went really well and I really wouldn't mind doing future site visits virtually.

>> APRIL: Thank you, Tara. I'm April Stubbs-Smith, I have the pleasure of serve is at the senior sponsor of the HAB's homelessness and housing work group. The next recipient spotlight is Ms. Kate Bennett and Susan McIlvain from Cincinnati health network and Carolyn Yorio from caracole. Kate has been the CEO of the Cincinnati health network since 2003 with oversight of all health service programs, the healthcare for the homeless and local Ryan White part C program and dedicated more than 35 years advocating for equal housing rights. Susan is with the network that provides primary healthcare to people experiencing homelessness and individuals living

with HIV AIDS and leads a multidisciplinary team that delivers primary and specialized care and mental health services for people underserved and at risk. Susan has more than 15 years' experience as a psychotherapist treating trauma-related disorders. And Carolyn Yorio, started at Caracole. The Cincinnati AIDS service organization as a medical case manager in 2013.

She moved to Caracole's housing department in 2019. The housing department serves 250 households every year with the range of short-term services and permanent supportive housing options.

Thank you for being here today, Kate, Carolyn and Susan. Next slide. Kati hi, everybody. My name is Kate Bennett. Thank you very much. And I want.

>> KATE: Hi, my name is Kate Bennett. Thank you very much. I want to take a minute and introduce you if I can to the Cincinnati health network so you can know a little bit about us before two employees, one from Caracole and one from the network each give you their own take on homelessness and HIV and care for people who are experiencing homelessness.

The health network was formed about 35 years ago. At the time we were a partner group of five different community health centers in the Cincinnati area. We evolved over the years with adding a healthcare for the homeless only program in 1988. And in 1990, a Ryan White part C program. As an FQHC we are patient centered. We are funded exclusively to provide healthcare, comprehensive, integrated care for people who are experiencing homelessness. Just so put in perspective what we are talking about even nationally, the latest statistics that well over a half a million people experiencing homelessness on any given night throughout the year.

One-third of those are unsheltered. They are living on streets, in parks, in subways, in woods, in camps, tents on sidewalks, a variety of different housing options exist in addition to that. So in the source of one year, 1.4 million people will experience homelessness. Homelessness itself is too transient. It's -- we don't always have in the

care that we provide people the benefit of longevity. Some people are homeless for a few weeks. Others for many years.

And some people cycle in and out of homelessness. We know that all of the same medical conditions exist in the homeless population as are in the general public. But let's keep in mind folks have no place to heal, let alone a place to be sick.

The face of the HIV virus has changed dramatically in some areas of the country and particularly in our area. The opioid epidemic has really impacted homeless population significantly. The number of -- has increased the number of people who are homeless. And also the number of people at risk for contracting the virus.

And so when someone is newly diagnosed with HIV, and they are also experiencing homelessness, it can be a life changing condition for them. It is really stressful to just have that diagnosis. And then add on top of that, that they have no place to live. They have no space. And they have no resources for their basic survival.

At the Cincinnati health network as I said, we are patient centered. We are striving to become a complete trauma informed care facility. We do believe that it is our responsibility to show up and meet the clients where they're at.

And that the integration of care is really what makes a difference that we have a seamless continuum of care and people can enter in that care at any point. Whether it's for food, a place to live. And we believe in a housing first model.

And that we are there for the patients that we serve. And that it truly does take a village. I would like to move this on to Susan McIlvain. And she is going to talk to you about trauma informed care and mental health and behavioral health services.

>> My name is Susan McIlvain. I want to talk about what the network has been doing to break down the barriers to receiving care and I want to go back to something that April said earlier in her presentation which was absolutely spot on to what we are talking about today and that was when she mentioned that housing status is

the most significant predicter of a person's ability to access healthcare, to have HIV outcomes be in a positive way. To access behavioral health and other services.

With that in mind, that is how we as our work sort of so the dawn and thought about ways we would overcome barriers to services in our community and within the Cincinnati health network and our partner agencies. We know that homelessness obviously is the number one predicter in terms of getting people in door and being able to serve them. And addiction, the opioid crisis prior to COVID was rampant, particularly in the Cincinnati area. We are in a tristate area that we have a great deal of traffic in terms of drug trafficking and opiate issues.

Mental illness and trauma exposure. Sort of looking at the amount of patients that we have in our clinic who have been exposed to trauma with was staggering, particularly in the HIV clinic and really wanting to kind of address how do we address that.

And then just the overall limited access to care based on eligible requirements, the hoops that people have to jump many through to be connected to services. All barriers that we put in different buckets and really wanted to kind of talk about and put a plan in place on how we were going to help overcome these barriers to care. Next slide, please.

So, what we wanted to do is first and foremost we wanted to increase the population that we were reaching so we wanted to create a registry that looked at the patients we had seen in the past and make contact with them and ensure that they were not lost to follow-up through a registry that we have developed.

We also reached out to our partner organizations to enhance and increase the collaborative efforts and you will hear from one of our partners from Caracole from Carolyn Yorio, my colleague. And also a multidirectional communication. A multidirectional access channel as well. Reaching, using the services whether in-house in the primary care clinic or behavioral health services or through our referrals where we have warm hand-offs for housing referrals, for addiction referrals, for legal counseling if such the case for reacclimation after incarceration. A

myriad of things that people might need, we have developed those collaborations with partner organizations. And we are able to make warm hand-offs and assist in making sure that the loop is closed in terms of getting our patients referred. Next slide, please.

So, back to what I talked about earlier. The trauma informed care approach really when we sort of assess our agency and educated our staff and started to sort of implement that with our patients, really demanded that we open up multipoint access into our clinic or into our network system. And what I mean by that is we no longer just start with a patient for primary care. Patients can come to us, they can be referred to us by caracole, the housel arm. Referred to us by the HIV specialty clinic for behavioral healthcare needs for primary care needs. And they can come from just self-referred. Just come to the clinic because they need to talk to someone. They need to talk about housing, they need to talk to someone to get advice on legal issues.

So making our primary care -- our FQHC a home for contact with people that are safe, that will help you get the services you need. That is the message that we wanted to get out there.

We also took a deep dive in terms of expanding our mental healthcare services. So we were offering counseling before but what we have done now is we really have a detailed assessment process. We offer evidence-based psychotherapies that include trauma-focused treatments.

We have approximately 900 behavioral health patients in our clinic. And approximately 30 to 40% of the patients that we know of because not everyone will talk about it, but that we know of that have endorsed a trauma, either with their primary care or their behavioral healthcare provider. So trauma is a very big component in prohibiting people from engaging in or asking for services or even thinking they might need service is.

>> S. What we know about trauma and post-traumatic stress is avoidance is a powerful motivator for people to avoid the symptoms in the hopes that they can keep them at bay, or they will go away. By

expanding the mental healthcare offerings by hiring behavioral healthcare providers that are trained and able to provide these services has been really a wonderful thing.

Also, we have our docs certified to offer medication assisted treatment, so we provide that for patients who have addiction issues and we have also as I mentioned before, built a client registry of our patients but also done a behavioral health ridge chemistry that helps improve patient and provider treatment and outcomes because we constantly manage that registry, and we are able to reach out to patients, so no one is lost to follow-up.

On the next slide, I also wanted to share before I turn this over to Carolyn, I just wanted to share a really anecdotal story that is void of statistics, but I thought this might help kind of put into perspective what our approach has meant in the lives of our patients.

I will just share with you a case study of a gentleman who is a 37-year-old male who has a history of significant incarceration in his life and opiate addiction. He is receiving that.

He has post-traumatic stress from a childhood sexual trauma. He is homeless. He has HIV and he is not currently taking his medications when we met him.

And he also lost custody of his two boys.

And his main goal at the outset when we first met him was to get custody of his children back. That was his main goal. However, that was interfering with that is he was not able to do that because he didn't have stable housing.

So we helped him sort of check off the boxes. We helped him get a stable housing. We helped him with legal aid to help get his children back. We helped him get a GED because he was incarcerated and wasn't able to finish his education. He got a GED, and he is now compliant with his HIV treatment and medications and his viral load is suppressed and he is getting treatment for the post-traumatic stress disorder and his scores are coming down and he is getting better. In addition to just being an FQHC, we have helped this gentleman granted

he was very motivated, it was the right time, but through our collaborative agencies and our work within our agency we were able to help this gentleman get back on his feet and attain the one thing he wanted most which was to be reunited with his kids. So we are really proud of what we are doing and right now I'm going to turn over to my colleague Carolyn Yorio to talk about how Caracole impacts people that are homeless. Thank you.

>> Thanks for the opportunity to present. The stigma or cost or other factors relating to being HIV positive can be contributing factors to homelessness and homelessness can be a contributing factor to highest risk sexual and drug abuse behaviors that increase the HIV transmission or engagement in care, and it is really factors that hurt one another and so in order to address it we address them together in providing housing supports in conjunction with HIV support. Next slide, please.

So our model is to pair medical case managers and who are dedicated to HIV as their primary focus of intervention and housing specialists whose job is to maintain stable housing and we take these two really -- these two teams of professionals and equip them with three interventions. One is the idea of housing first that we provide housing without prerequisites to be a stable foundation. We provide harm reduction so if there is drug use or sex work involved, we try to reduce the harm associated with those behaviors to keep people as healthy as possible in the life stage they are in. And then also motivational interview. Recognizing the client as their own expert in their care.

Helping them to identify interventions that work for them and explore both the pros and cons of those changes so that they can make plans they can stick to.

Our teams are committed to coordinating with the partners including the Cincinnati health network and other medical and substance use providers to provide services that support clients on you will all fronts and the dignity and respect needed to maintain housing

instability and address HIV and AIDS. I want to point out as a final note, HIV and homelessness disproportionately impact the LGBQ community and Black community. COVID is disproportionately impact is the exact same groups.

This is a unique time where HIV and homelessness and COVID is a real threat to people living in the communities who are LBTQ and or our members of the African American or Black community. And so thank you for all of the work that you are all doing, and I want to end with a call to action to serving those groups well during this difficult time.

Thanks.

>> LAURA: Great First, I want to thank you all for those great presentations Tara, Kate, Carol and Susan. We appreciate the work you are doing in Maine and Cincinnati to support the needs of patients, clients and providers. I also want to take a moment before we end to remind you of several key resources being updated to support the work of the Ryan White HIV/AIDS program recipients. We continue to update the HAB COVID-19 frequently asked questions web page as new information becomes available. We encourage you to continue to visit the HIV/AIDS Bureau website noted there on that link. And we encourage you to visit several other web pages for critical information on the COVID-19 pandemic as it continues to evolve. This I want to especially note the CDC COVID-19 vaccination website which has a lot of great resources.

Next slide. And that concludes today's HAB you heard webinar. The recording for the event will be post on the HAB COVID-19 web page. The next HAB you heard webinar will take place on February 24 from 2:00 to 3:00 p.m. Mark your calendars and be on the lookout for the save your date. I want to remind you as you continue to care for your families, your patients and communities, please take time for your own self-care and consider getting a COVID-19 vaccine when it is available in your community.

Last slide. Thank you again for the vital work you do in your communities during this challenging time. And thanks for participating on today's webinar. Have a great week!

>> AMY: That concludes today's webinar. You may disconnect.