# October HAB You Heard Webinar
# October 27, 2020
# 2:00-3:00 PM ET

Coordinator: Welcome and thank you all for standing by. At this time I would like to inform all participants that your lines will be on a listen-only mode for the duration of today's presentation. Today's call is also being recorded. If anyone has any objections you may disconnect at this time. And I would now like to turn the call over to Dr. Laura Cheever. Thank you. You may begin.

Dr. Laura Cheever: Thank you so much. And good afternoon and welcome to the Health Resources and Services Administration's HAB You Heard, our monthly update from the HIV/AIDS Bureau.

I'm Laura Cheever, the Associate Administrator in the HIV/AIDS Bureau, the HAB in HAB You Heard. And I'm joined today by Antigone Dempsey, the Director of HAB's Division of Policy and Data; Heather Hauck, HAB's Deputy Associate Administrator; Lieutenant Commander (Emeka Egwim), Senior Policy Analyst in HAB's Division of Policy and Data; Dr. Susan Robilotto, Director of HAB's Division of State HIV/AIDS Program; and Captain Mahyar Mofidi, Director of HAB's Division of Community HIV/AIDS Programs.

We're so glad you could join us for this afternoon's webinar. Next slide. We once again have a full agenda for you today, including a look at our most recent COVID-19 data report through August of 2020; an update on the Provider Relief Fund; a look at HAB's telehealth best practices technical assistance; a discussion of the FY 2020 CARES Act draw down; and the importance of maintaining flu vaccine delivery to Ryan White clients. We'll

also share HIV/AIDS Bureau updates including highlights of several new resources.

In addition, we're excited to have two presentations today. Joining us is the Ryan White Part B recipient in Iowa who will be highlighting the COVID-19 impact on mental health and how they're utilizing trauma informed practices to meet the needs of both clients and staff. And the Ryan White Part C recipient, Vivent Health in Milwaukee, Wisconsin, who will discuss telehealth. Next slide.

As we begin, I would really like to thank all of you for the work that you do every day that - in the trying response to this unprecedented COVID-19 public health emergency. We are really humbled here by your continued commitment to providing HIV care and treatment in your communities and to people with HIV including the most vulnerable populations across the country.

I definitely can understand and see your dedication, especially to those of you serving on the front lines during the COVID-19 pandemic. And we are reminded why we continue to do this work each and every day. So really a very sincere thank you. Next slide.

Next, we are officially into fall here at HAB and we wanted to share a number of COVID-19 updates with you as we continue to navigate this public health emergency. Earlier this summer, we shared an update on the COVID data report known here as the CDR.

Today we'll have some new information to share with you. And with that, I'm going to turn it over to Antigone Dempsey, the Director of HAB's Division of

Policy and Data, who will provide an update on CDR and highlight our '20 - our January through August data. Antigone?

Antigone Dempsey: Thanks, Dr. Cheever. So next slide. So to begin with, I just want to echo Dr. Cheever to thank you all - all of our Ryan White program recipients, subrecipients and providers, who have been diligently working to submit the new COVID-19 data report or CDR every month.

We understand this is a - has been a really difficult time to implement new activities and to manage this new data reporting system. We want to let you know that these data are incredibly important for HAB's efforts to monitor activities related the CARES Act funding.

And as we'll show you over the next few slides, we have seen that providers have been able to use the CARES Act funding to implement and expand services to prevent, prepare for and respond, to COVID-19. Next slide.

So to begin with, a little background for you - so this summary includes data from the first as well as the most recent COVID data report. So January 20 through March 31 and then August 1 to August 31. Data for the September month were submitted on October 15 and thank you all for your hard work in getting that in, and are not included in this presentation.

HAB is reviewing the data now and we will include it in a future presentation. HAB is aware that many recipients requested and received extensions on the CDR reporting in order to establish contracts and set up reporting. So to that we just really want to note that this is preliminary data and we anticipate that the numbers presented here will change as more providers submit data covering these reporting periods. Next slide.

Next slide. Okay, great. Thanks. So from this slide you can see that providers are expanding telehealth services. Among the providers who submitted a CDR for the January to March timeframe, we had 69 reported that they were providing any telehealth - they had any telehealth capacity.

And then among providers who submitted a CDR for August, the August reported period, 82% reported any telehealth capacity. And you can see up here on the slide, the most common telehealth services reported by those with any telehealth capacity, are listed here. And I think they make a lot of sense I'm sure, to many of you.

And it's important to highlight some of the services that are particularly relevant for responding to COVID, such as emergency financial assistance, medical transportation, food bank and home delivered meals. And we've seen a number of presentations previously on these webinars about these topics. Next slide.

So providers are expanding and implementing COVID-19 testing. The percentage of provider sites conducting any COVID-19 testing increased from 30% as of March 31st, to 47% in August. Due to the expanded capacity for testing providers are testing larger numbers of Ryan White eligible clients and their household members.

More than 8800 people were tested in August. Providers have served almost 10,000 Ryan White eligible clients who have COVID-19. Both of these are preliminary figures as we talked about earlier. As we know that there is - this is an undercount of the number of clients because many providers are still working to submit their data once their contracts are finalized. Next slide.

So providers served over 75,000 Ryan White eligible clients and immediate household members in August using CARES Act funding, to prepare and prevent and respond to COVID-19. And this - what you see here on the slide, are the most common services that were accessed during that time period. Next slide.

So as we shared earlier this summer, in a presentation this summer, we know that there have been questions about the CDR and we've been receiving those as well throughout. So we wanted to make sure to share a reminder about the CDR resources that are available on the Target HIV Web site, including a set of questions and answers and a replay of our main CDR technical assistance webinar.

In addition, we encourage you to access the CDR instruction manual. And next, I would like to turn it over to Heather Hauck, who will provide an update on the Provider Relief Fund. Heather?

Heather Hauck: Great. Thanks, Antigone. So today I'm happy to share information about a new phase of the Provider Relief Fund which is now open for applications. Providers are encouraged to apply for this latest round of Provider Relief Fund support. Applications will be considered regardless of whether your organization was previously eligible for, applied for, received, accepted, or rejected prior PRF payments.

For this newest phase funding will be allocated to providers based on assessed financial losses and changes in operating expenses caused by COVID-19. It's important to note that applications are due by 11:59 pm Eastern Standard Time on November 6th. You can find more information about this phase 3 general distribution of the PRF on the Provider Relief Fund Web page.

And now I'd like to turn it over to Lieutenant Commander Emeka Egwim, Policy Analyst in HAB's Division of Policy and Data who will provide an update on HAB's best practices telehealth technical assistance efforts.

Lieutenant Commander Emeka Egwim: Thank you, Heather. I'm happy to share a brief overview of the HIV/AIDS Bureau's efforts around telehealth in light of the changes brought about by the COVID-19 pandemic.

As many of you are well aware, the advancement of technologies over the year have presented opportunities to enhance how healthcare is delivered. And as Antigone just highlighted, the implementation of telehealth technologies and care delivery models, is continuing to expand among Ryan White program recipients. And the COVID-19 public health emergency has catalyzed advances in this space.

We recognize that many of you are Ryan White program recipients, have made significant changes to rethink how you deliver care in order to continue to provide quality care to the communities you serve including Ryan White program clients. Next slide.

The Bureau has put together a HAB telehealth workgroup to develop technical assistance, material on telehealth best practices for recipients and stakeholders. As part of the workgroup's efforts, we are looking to identify key features and approaches that you have augmented and continue to use to provide quality comprehensive HIV care and treatment during a pandemic.

We will also highlight lessons learned and successful strategies that could be applied post-pandemic, as well as challenges and opportunities as efforts continue to move forward. Next slide. As part of this initiative, we will be

looking to you to share success stories and lessons learned that may be replicable more broadly across the Ryan White program.

We have already started working with our project officers and program leadership, to identify a number of recipients from the Ryan White program Parts A, B and C, that have been dynamic with telehealth. In addition, if you have a best practice around telehealth that you're willing to share, we invite you to contact us using the email address listed here. Next slide.

We are hoping to learn about successful models on a number of topics which include linkage to and retention in care; technological considerations; informed consent; cross state practice and care delivery; workflow and procedure manuals; as well as documentation and billing.

We look forward to highlighting some best practices and innovative models of care over the coming months. So thank you for your continued telehealth efforts. And I will now turn it over to Dr. Laura Cheever. Dr. Cheever?

Dr. Laura Cheever: Thank you, Emeka and thanks for taking the lead on that workgroup. Next, we're going to turn our discussion to influenza vaccines. During the COVID-19 pandemic we understand that it is more critical than ever to protect Ryan White HIV/AIDS Program clients, patients and communities, from influenza.

As Ryan White providers we can really play a critical role to ensure that clients maintain adherence with the recommended vaccines, and particularly with Ryan White under outpatient ambulatory health services, and with CARE Act funds they can both be used to support the provision of routine immunizations including flu shots and other immunizations necessary to

prevent medical visits, hospitalizations and other strains on the healthcare system.

More information about allowable use of funding is available at the HRSA HAB Policy Clarification Notice 1602. Next slide. The CDC recent interim guidance for immunization services during the COVID-19 pandemic can help Ryan White healthcare providers plan of safe vaccination administration during the COVID-19 pandemic.

The advisory committee on immunization practices recently updated recommendations for prevention and control of seasonal flu vaccination for the 2021 influenzas season, recommending influenza vaccine for persons greater than or equal to six months. Next slide.

I also wanted to provide a brief reminder about the FY 2020 CARES Act funding and the importance of drawing down funds. HAB encourages FY 2020 CARES Act funded Ryan White program recipients to continue to draw down funding in a timely manner.

During upcoming monitor calls your project officer will highlight this topic during your discussion. And we encourage you to use this opportunity to share any technical issues or other challenges related to FY 2020 CARES Act funding and drawing it down with our project officer and division leadership. Next slide.

I also thought it was very important to highlight today something that's important to us in the HIV/AIDS Bureau and to me particularly as a provider. We know that many of our Ryan White HIV/AIDS Program recipients and providers continuing to provide services on the frontlines and provide care for

some of the most vulnerable populations during the pandemic, it can sometimes be very difficult and challenging to do that work.

And we realize that this work over time, is taking as significant toll on our own providers' mental health as we move through this time. I'm really aware that this new normal is challenging to a personal sense of wellbeing and it continue to be a huge challenge as providers are caring for their families, their patients and their communities.

So I want to encourage all of you to continue to focus on taking care of yourself. We are aware that the workforce shortages, exhaustion and burnout due to COVID related stressors continues to be significant challenges for providers and Ryan White program recipients, and particularly as we're seeing this uptick as we head into the fall.

One resource I can recommend is the (NAFTAD)'s trauma informed approaches toolkit. The toolkit assists health departments, specifically Ryan White HIV/AIDS Program Part B and (ADAP) programs, AIDS service organizations and HIV clinics, to take actions to become trauma informed.

And in just a few minutes we're going to hear from one of our Ryan White Part B recipients who is going to highlight the work they are doing to implement trauma informed practices in tehri current work setting. I'd now like to turn this back to HAB's Deputy Director Heather Hauck, for the HAB Bureau update.

Heather Hauck: Thank you, Dr. Cheever. So to start, I want to begin with our recent wrap up press release of the FY 2020 Ryan White HIV/AIDS Program grant awards. So earlier this month HRSA announced approximately $2.24 billion in Ryan

White HIV/AIDS Program grants, awarded to cities, counties, states and local community based organizations and clinics for FY 2020.

This also builds on the FY 2020 Coronavirus Aid Relief and Economic Security or CARES Act awards made in April and the ending the HIV Epidemic Initiative Awards made in February, reflecting a total FY 2020 investment of approximately $2.39 billion.

As you can see on the slide, it breaks out the total funding by program part. And as always, you can find the list of all funded FY 2020 Ryan White HIV/AIDS Program recipients on our hub Web site under the About the Ryan White HIV/AIDS Program landing page. Next slide.

We also wanted to share with you a new Ending the HIV Epidemic jurisdictional directory that is now available. This directory was developed by (NASTAD) which is a HRSA funded Ryan White HIV/AIDS Program Parts A and B systems coordination provider for EHE and is a CDC National Technical Assistance Partner for EHE Technical Assistance as well.

The directory provides a list of local and state points of contact for EHE efforts and is intended to facilitate community participation for local engagement activities, EHE Web sites, EHE jurisdictional plans and social media for the EHE phase one jurisdictions.

(NASTAD) plans to add more points of contact as they become available. And we wanted to thank the community members and the people with HIV who shared that this was a need with us, at HRSA HAB. And we really help that this will facilitate more dialog and collaborations to meet the goals of the Ending the HIV Epidemic. I will now turn it back over to Antigone Dempsey.

Antigone Dempsey: Thank you, Heather. So we're excited to share two new reference guides on optimizing care for people aging with HIV. Last month the HIV/AIDS Bureau released these resources to assist healthcare professionals as their aging populations grow and also our data is showing this as well.

The first is called Incorporating New Elements of Care. This reference guide identifies commonly occurring healthcare and social needs of people who are aging with HIV and highlight the screening and assessments for these needs and is a starting point for healthcare teams as they build and expand their knowledge in practice of serving people who are aging with HIV.

And the second one is called Putting Together the Best Healthcare Team. And it discusses how all members of the healthcare team can contribute to the care of people who are aging with HIV. So the two guides can be found on the HIV or HAB Web site on the clinical care guidelines and resources landing page. And the link is also in the slide there.

Now I will turn it over to the HAB Division Director, Susan Robilotto. Susan?

Dr. Susan Robilotto: Thanks, Antigone. So recently HRSA's HIV/AIDS Bureau released the 2018 Ryan White HIV/AIDS Program AIDS Drug Assistance Program, so ADAP, Annual Client Level Data Report.

The report is the second publication of the national ADAP client level data submitted through the ADAP data report or ADR system. The publication provides an in-depth look at service utilization, demographics and socioeconomic factors among clients served by ADAP.

In 2018 the Ryan White HIV/AIDS Program ADAP served approximately 285,000 people with HIV. The report is now available on the HAB Web site under the data section.

Now I will turn it over to the Director of the Division of Community HIV/AIDS Program, Captain Mahyar Mofidi. Mahyar?

Captain Mahyar Mofidi: Yes. Thank you so much, Susan. I am happy to share some additional new resources that support Ryan White providers to improve health outcomes through integration. These include oral health and community health worker integration resources. Next slide, please.

First, to address the importance of oral health and reduced oral health disparities for people with HIV, HRSA's HIV/AIDS Bureau identified best practices and strategies implemented by Ryan White Part C and D recipients, to integrate oral health and primary care services, as part of this effort of the integration of oral health and primary care technical assistance toolkit, which is available on Target HIV.

Additionally, a series of really great webinars supporting the toolkit and oral health integration are also available on Target HIV. These include primary care providers assessing oral disease risks and providing basic services and connecting clients to oral health services. Next slide, please.

We're also excited to share several new resources to (unintelligible) community health worker integration. Community health workers are important members of the primary healthcare workforce in helping link and retain clients in HIV care.

And as many of you know, community health workers carry out this role as frontline workers who are trusted members of the community and have been shown to improve access to care and health outcomes, particularly among populations at high risk for health inequities.

A community health worker implementation guide is available for download on TargetHIV. This comprehensive resource covers all aspects of implementation including hiring, training, integration to care teams, supervision and professional development.

In addition, a community health worker curriculum is also available on Target HIV. This resource provides 80 hours of interactive training for community health workers including 64 hours on national community health worker core competencies.

And with that, I would like to turn it back over to Dr. Susan Robilotto. Susan?

Dr. Susan Robilotto: Thank you, Mahyar. As the Director of the Division of State HIV/AIDS Programs I'm excited to introduce our first presenter for our recipient spotlight presentation. First we'll hear from the Ryan White HIV/AIDS Program Part B recipient in Iowa.

Holly Hanson is the Iowa Ryan White Program Manager at the Iowa Department of Public Health. And has implemented a trauma informed approach throughout the Iowa Part B program. Today she's going to tell us about how they have utilized these principles during the COVID-19 pandemic. Thanks for joining us today, Holly.

Holly Hanson: Hi. Thank you for having me. Go ahead and move onto the next slide. So I don't have long so I'm going to kind of breeze through this a little bit. So what we're going to talk about today is what we mean by a trauma informed response.

I'm going to assume that you have a basic understanding of the impact that trauma and chronic stress has on our clients or patients, any subrecipients. And then one of the things that we're really kind of highlighting today is the impact it has on ourselves as well.

We're going to take a look at what the six key principles of trauma informed care are and the ten domains that they should be applied to when you're implementing a trauma informed care system. And then as was mentioned, we're going to move into how we in Iowa, have used these principles, responding to the events of 2020.

We're going to largely focus on three of the domains, which we're going to go over all ten of them here in just a second. Namely, workforce wellness; service delivery and capacity; and then addressing cultural, historical, racial, and gender-based inequities. Next slide, please.

So this is what many of you might know as referred to the four Rs. I've added a fifth R there to talk a little bit about what a trauma informed approach is. So briefly, it's realizing the widespread impacts that trauma has, recognizes the signs and symptoms of trauma in clients, families, staff and ourselves; and then responding to those.

Learning how to address those signs and symptoms of trauma; integrating that knowledge into your policies, procedures and practices. And then resisting to actively resist traumatization. A lot of the things that we do for our clients if

we're not careful, can retraumatize them. And we want to really be careful not to do that.

And then the fifth R that I've added is really kind of making sure that we promote a strength-based approach and building resiliency, promoting resiliency to actively kind of put in these protective factors so folks can bounce back from stress and traumatic events better than they might have otherwise. Next slide, please.

So there are six key principles in a trauma informed care model and you can see them there. Safety would refer to anything physical, emotional or psychological; trustworthy and transparency - one example of this is regular communication and that's one of the things I'm going to talk about here in a minute.

Peer support - one of the biggest things in a trauma informed care organization is the importance of relationships. So whether that's peer or not relationships is one of the most important things that you can do. Build those and be a part of those. Next is collaboration and neutrality. This is like all of the best of the things that you can think of with teamwork; really doing things together and having respect for one another and working well on a team.

Empowerment, voice and choice - one example that I thought up for this is thinking about the Denver Principals, nothing for us without us. So really, you know, community planning group is another great way to engage with empowerment, voice, and choice. Other planning groups. Ending the epidemic - we think about bringing in more community to help us end the epidemic.

And then cultural, historical, and gender issues -we really need to make sure that we're taking those into account in all of these domains. Next slide, please. So these are the ten domains that I referenced earlier and I'll just let you take a quick look at those. Again, I'm going to focus a little bit more today on workforce wellness.

Kind of a theme today that was mentioned earlier. We really need to take care of ourselves to continue to be able to do the best we can for our patients and clients, and creating wellness within the workplace is a huge part of that.

We're also going to talk a little bit about service delivery and capacity. And then we'll touch on addressing cultural, historical, racial and gender-based health inequities. And before we move to the next slide I just want to kind of help you think this through. So for each of those ten domains remember we want to apply each of those six principles.

So when you're thinking about how do I become a trauma informed organization, it really is looking at each of those ten domains and are all of those six key principles alive and well in each of those domains? So let's go ahead and go onto the next slide.

And bring it back to how did we respond since March. in a trauma informed way. Well the first slide here is really talking about communication. And I put in there clear is (kind). People really need to get communication in many different ways to really ensure that they're understanding.

So I have listed there that we have Monday Messages. That's an email that goes out every Monday with relevant information that folks - that our subrecipients need to have to do their jobs well. We have monthly monitoring calls. So these are not only part of our monitoring programs, but also a good

way to check in with people to stay really connected with all of our subrecipients.

Back up to the first bullet there - when the - when COVID first hit, we and everybody, you know, we weren't really on lockdown but we all were told to kind of go start working from home at the health department. And many of our agencies did as well.

We really spent the first week very intensely reaching out to all of our subrecipients and getting a sense from them on what they needed from us and what support they needed to be able to continue to do their jobs. And that was very appreciated by them.

The second bullet there is something I wanted to touch on that we did as a bureau internally, as well as to our subrecipients. The management team within the bureau, created a letter to send out to bureau staff and all of our subrecipients, really acknowledging the intensity and the feelings that many of us and many of our colleagues and staff, were having in response to George Floyd's death and the ensuing social unrest.

And I think that was very important. And then that last bullet there is it did lead to an implementation of what we're embarking on an 18 month bureau wide racial equity challenge. And I have a slide a little bit later I'll tell you about that. Next slide.

So one of the most important things that you can do to have a trauma informed organization, is building relationships; maintaining relationships. When we first transitioned to being all, you know, working from home and being all online, we really did a better job in learning how to use chat rooms;

learning how to use different kinds of platforms whether it be Zoom or Google Meets and stuff like that.

It was a little bit to get used to and I'm sure you can all identify. But really ensuring that that was a priority to stay in touch with people and to check in with others as we move forward into the pandemic and the increased social unrest and everything else. So agencies have reported doing the same and finding that very, very useful.

They're staying connected with clients through the use of FaceTiming, they were hand delivering necessities away from the street and that's really been helpful for folks. So relationships, relationships, relationships. Why don't we go to the next slide, please?

So we really wanted to do something in response to all of the increased social unrest. We had done some work around racial equity in the past and we were pretty much - pretty prime to move that work forward. And so in our research we came across the 21-day racial equity challenge that was originally developed by Dr. Eddie Moore, Jr and Debby Irving, and has been adapted by many organizations across the country.

The challenge is designed to create dedicated time and space to build more effective social justice habits, particularly those dealing with issues of race, power and privilege. So the YWCA in Cleveland adaptation was so popular in 2019 that they did another one in 2020.

So we're essentially using their curriculum and dragging - instead of days, we're doing it over weeks and having bureau wide conversations. And it has really helped people to feel challenged as well as a sense of safety and

openness in our bureau, to be able to talk about the issues that are going on right now.

And certainly there is a tie in to COVID-19 of course, with increased COVID cases with people of color. Next slide. And this is really just ensuring subrecipient agencies knew we supported their decisions to work in office or remotely based on their individual agency needs.

Most agencies teleworked but a few have partial or all staff in the office, which oftentimes created its own stressors. And we were, you know, cognizant of that and doing what we could do to help with that. And then as it indicates there, you know, we kind of just pivoted to be able to accept applications via fax instead of email - or sorry, email instead of fax.

Another really great thing was that all of our subrecipients already have that technology to be able to just go straight to working from home and being able to contact their clients and get the paperwork done all online. And that really goes to show how critical it is to really build a strong foundation in your programs for times like these. Next slide.

And this really is - I think probably most of you did this but we did the self-attestation income and residency at six months, and annual reviews which it think most people did. And then HRSA really was helpful in saying yes, that we can do that.

So that was very, very reassuring for all of our subrecipients. We've had an interesting situations where they are - kind of feel like we should be getting back to the old way but we are like nothing's changed yet so just keep on using these greater flexibility for now. Let's move onto the next slide.

So let's talk a little bit about the impact of mental health, and it really is as we mentioned earlier, kind of the theme for today in that we really do need to recognize the impact that this new normal or new temporary normal is having on not only your clients and patients, but staff and yourself. And we certainly have heard that here in Iowa.

Agencies are reporting that clients are feeling anxious, depressed and powerless and, you know, increased symptoms of PTSD or post traumatic stress disorder at times, compounded by social distancing; creating feelings of isolation, fear and loneliness.

Luckily, we have a system of behavioral health consultants located at many of our larger Part C clients that Ryan White Part B supports. And so we were - leaned heavily on those folks. We also had a webinar where we talked about self-care and taking care of yourself during this time.

And it really, really is one of the best things that we can do to help our clients. Why don't we go to the next slide, please? And this is a slide really kind of taking the time to think about promoting workforce wellness. That little sticky in the middle there says I pledge - I can't even see it. I pledge to secure my mask first. And that really is alluding to, you know, when you're on an airplane and they tell you to put your oxygen mask on before you go and help somebody else.

It's - you know, you can't help others if you're not well. And so we've really been promoting it not only with ourselves, our contractors and our clients - well what I mean is, but definitely ourselves. You know, like we cannot have a workforce that's not well in this time.

And so as I mentioned, we did our presentation on - the Department of Health has Wellness Wednesdays so there's been a lot of good ideas for folks to implement. You can see a little wheel there that self-care can be really different for everybody. And so really taking the time to think about what can you do to take care of yourself?

We've implemented a buddy system so we're really checking in on each other. It's not a formal buddy system but we are - I've been monitoring to make sure, everybody's checking in with somebody. We have attempt virtual happy hours. We've had some states in person small get-together. One example is the Ryan White National Conference.

We went over to somebody's house where we could sit and watch it outside. And I know I'm running a little slow on time here so why don't we go to the next slide and I'm going to skip that one and go to the last slide. And just really kind of wrap up with essentially we were able to really focus on taking care of all of the folks involved, whether that be clients, patients, staff.

Because we have spent so much time really building up capacity within - building that infrastructure at the state health department as well as all of our subrecipients. So for one of the examples that I've mentioned already was to ensure that everybody had the appropriate computers to be able to work from home when the need - when the need arose.

And I think we'll go to the next slide. And I think that can wrap it up for me. And thank you so much for the opportunity for sharing ever-so-briefly on what we've been doing in Iowa.

Captain Mahyar Mofidi: Thank you, Holly for that great and important presentation. Next, we will hear from Debra Endean and Dr. Leslie Cockerham from the Ryan

White Part C Recipient Vivent Health in Wisconsin, as they reflect on their response to the COVID-19.

Debra is the Executive Vice President and Chief Operating Officer and responsible for the delivery of integrated health and social services across Vivent Health, ensuring optimal outcomes for patients and clients.

And Dr. Leslie Cockerham is an infectious disease physician and the Vice President of Medical Affairs at Vivent Health where she oversees clinical care and the quality department. She's also an Assistant Professor of Medicine in the Department of Infectious Disease as the Medical College of Wisconsin in Milwaukee, Wisconsin.

Thank you so much for joining us today Debra and Leslie.

Debra Endean: Thank you so much. If I could ask you to advance one more slide. Thank you. We very much appreciate this opportunity to talk with you today and tell you just a little bit about Vivent Health's response early on to the COVID-19 pandemic. If I could have the next slide, please.

I just want to share a little bit about Vivent Health. We are a national organization that offers prevention care and treatment with the goal of ending the AIDS epidemic. We are located in four states and have 15 different clinical locations.

Our budget is about $150 million and we have about 425 employees or as we call them here, champions. Last year we served about 10,000 patients and clients and we're especially proud of the fact that greater than 95% of patients who've been in care with us for at least six months, achieved viral suppression. Next slide, please.

One reason for that kind of outcome is our integrated care model, the Vivent Health HIV Medical Home. In this model, both health services that you see listed there on the left and social services as listed on the right, are brought together in an integrated way in order to achieve the best possible outcomes for our patients and clients.

An independent study by the Center for Health Systems Research and Analysis, has shown that our patients are 50% less likely to be in the hospital or unnecessarily use the emergency room. And in addition, this model is estimated to save the state of Wisconsin Medicaid program about $12 million every year. Next slide, please.

I put these graphs in just to kind of give you a quick snapshot of what the early profile of the COVID pandemic looks like in the four states where we operate - Colorado, Texas, Missouri and Wisconsin. And it was this kind of rapid growth in newly recorded cases that led us to really rapidly transform our service delivery model early on in the pandemic. Could I have the next slide?

The goals of the service delivery transformation were really twofold. One, we wanted to shift mostly to remote work early on and at the same time, we wanted to assure continued access to our patients and clients for all essential services. We also wanted to be mindful of the fact that the stress to he pandemic and the isolation it caused, were going to create additional needs for our patients and clients that we wanted to be attuned to.

At the same time as Dr. Cheever mentioned, support for the people delivering those services - our providers and our staff, are really important to keep in mind. And so early on we guaranteed our champions full salary and benefits

with no furloughs or layoffs. And enhanced our communication with staff and support mechanisms available to them. Next slide, please.

We're going to really focus on telehealth in just a moment, but I did want to highlight a couple of the early things that we did again, early on in the pandemic. Food services which were typically patients coming in, clients coming into the facility to pick up their food, we switched to a 75% home delivery model so that people didn't even have to leave their homes to be assured of having the food they needed.

We also offered curbside pickup. The same thing for pharmacy - home delivery of pharmaceuticals. And then weekly calls - so in addition to the typical calls that would be made between providers, case managers and patients and clients, we instituted a program where every client and every patient got a call every week to proactively find out what was going on; what they might need; make sure we connected them to resources; and to help combat some of that isolation that's still with us as we fight the pandemic.

And then finally, we transformed and expanded our telehealth services. And I'm going to transition this now to Dr. Leslie Cockerham, to tell you a little bit more about how we did that in medical and behavioral health. Leslie?

Dr. Leslie Cockerham: Thank you. Next slide, please. So prior to the COVID-19 pandemic we did provide some care via telehealth but it was limited. Vivent health used the telehealth platform to provide psychiatric care to our more rural areas of Wisconsin. We have our largest office in Milwaukee, but we also have three additional clinics and six other offices that provide case management and prevention services throughout Wisconsin.

So in this case, our psychiatric providers were located in their offices in Milwaukee and patients traveled to one of these other Vivent health offices in Greater Wisconsin, to access their care. Next slide.

However, as Debra Endean noted, as part of our initial response to COVID was to shift the majority of our workforce to remote work. However, we were still focused on providing access to care and services. We therefore, quickly implemented telehealth via our (Epic) provider, (OCHIN) at the end of March. And this allowed us to do video visits via Zoom which was integrated within our electronic health record, for patients who had the MyChart app.

And patients are now able to access video visits from their phone, a tablet or a computer, from their own home. We also implemented phone visits for those who were either unable or unwilling for one reason or another, to do video visits.

And this was available for both medical care and behavioral healthcare which includes psychotherapy, psychiatric care and AODA or substance use services. And this really allowed us to use our in office visits for more urgent care needs and getting new patients into care, and yet still maintain access to care for all of our patients.

And our CARES funding really allowed us to do this by supporting the purchase of our hardware which included things like Webcams and laptops, as well as the implementation costs of a new telehealth platform within our electronic health record. Next slide.

Like many though, we soon realized that the pandemic was unfortunately not going away any time soon and we wanted to utilize the opportunities and innovations in service delivery where we could. I think we also like many of

you on the call, began to note that the conditions that put our patients at highest risk for complications of COVID-19 was not usually their HIV, but rather other chronic health conditions such as hypertension, diabetes and obesity.

And therefore, we began to work on expanding our use of telehealth to chronic health management. This then meant that we also expanded telehealth to not just our medical and behavioral health providers but also our other clinical staff like clinical pharmacists and our dietitian. And we used our CARES Act funding for Bluetooth enabled home monitoring devices such as blood pressure machines, glucometers and scales that we could give our patients so that we could implement this.

And this has really allowed for more frequent visits to do check-ins, to do titrations of medications via telehealth and MyChart communication. And we're also finding that this is seeming to break down some of the barriers to healthcare, things like (unintelligible) care or transportation or travel related costs so that people can access us more frequently but again, from the safety and ease of their own home. Next slide.

So what we're currently working on is workflows and guidelines for first, identifying and selecting the patients that are most likely to be able to use these types of devices and are - have a willingness to really work on their chronic health issues.

We're tracking our device distribution. We're doing a bit of staff and patient training so that they're able to use these devices well and know how to get the data back to us. And then we are planning to work on outcome reporting so we can actually see hopefully, the benefits of this work.

So we are working currently on distributing devices to patients and we've given many of them out already. And now scheduling follow up telehealth appointments, again whether that be the video visits, MyChart communication or even phone visits to follow up on these chronic health conditions. And then we'll work on tracking outcomes with them and hope to be able to report more of that someday soon.

So again, thank you for certainly the funding that has allowed us to do this work and for the opportunity to present this.

Dr. Laura Cheever: Great. Next slide. Thank you. One more slide. Okay. So thanks so much for those great presentations, Holly, Debra and Leslie. It was really very inspiring for me to hear about the innovations that you've done with your teams in both Iowa and Milwaukee, Wisconsin, to meet the needs of your clients, cases and providers during this time of COVID. So thank you so much for continuing to provide care to people and for continuing to innovate to meet needs as they arise.

Now I want to take a few moments to remind everyone about several key resources that are continuously being updated to support your work. First, we continue to update our HAB COVID-19 Frequently Asked Questions Web page. It's a searchable FAQ database. So please do return to visit there if you have any specific questions. There are also several other Web pages with critical information that we have listed here as well. Next slide.

So in conclusion, our next HAB You Heard will take place on Thursday, November 19 from 3:30 to 4:30 Eastern Time, so be on the lookout for our next save the date. That'll conclude today's HAB You Heard webinar. The recording for today's event is going to be posted on the HAB COVID Web page.

I also want to remind you to continue to take care of your families, your patients and communities. But also importantly, as we heard over and over again today, to please take some time to take care of yourself. Last slide. We hope that you and your families are staying safe and staying healthy during this troubling time.

Thank you again for your vital work that you do in you communities and for your participation on today's call. Thanks so much.

Coordinator: Thank you. That does conclude today's conference. Thank you all for participating. You may now disconnect.

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