HAB You Heard about the 2019 Ryan White HIV/AIDS Program Data Webinar
December 9, 2020
2:00-3:00 PM ET

Coordinator: Welcome and thank you for standing by. All participants in - are in a listen-only mode for the duration of today's call. As a reminder this call is being recorded. If you have any objections you may disconnect at this time. Now I would like to turn the call over to your host Dr. Laura Cheever. You may begin. Thank you.

Dr. Laura Cheever: Thanks so much. Good afternoon and welcome to this special edition of the Health Resource and Services Administration's HAB You Heard Webinar, our monthly update from the HIV/AIDS Bureau.

Today's Webinar will focus on our new 2019 Ryan White HIV/AIDS Program Services Report annual client level data. I'm Dr. Laura Cheever, the Associate Administrator for HRSA's HIV/AIDS Bureau and I'm so glad you could join us for today's Webinar.

Next slide. The HIV/AIDS Bureau is committed to making our data available and usable for our recipients, subrecipients partners and stakeholders. Today's Web cast will present our data from the sixth annual Ryan White HIV/AIDS program annual client level data report which was released on December 1, 2020.

I'd also like to take a moment to acknowledge the contributions of the Ryan White HIV program recipients and sub recipients whose data contributions made this report possible. It's through the hard work of these providers in the Ryan White community that the Ryan White HIV/AIDS program continues to help people every day.

I'd also like to acknowledge the extraordinary amount of work being done by Ryan White recipients, sub recipients and stakeholders in response to the COVID-19 public health emergency and the incredible efforts made to submit high quality complete RSR data in a timely manner during this time.

Next slide. I'm hearing a lot of background noise if people could mute themselves. So the agenda. Once again we have a full agenda for you today. We'll share a quick overview of the Ryan White HIV/AIDS program and then we'll present an overview of the changes made to the 2019 program client level data report as well as highlights from the report.

In addition we're excited this year to be joined by two Ryan White program recipients who've used their data to enhance clinical quality improvement activities to provide care and treatment for people with HIV. For today's recipient highlight presentations will be joined by the AIDS Project of the Ozarks in Springfield, Missouri and the University of Mississippi Medical Center Adult Special Care Clinic in Jackson, Mississippi. And we'll finish up with some HIV/AIDS Bureau updates and resources.

Next slide. So today I'm joined by Heather Hauck, the HAB Deputy Associate Administrator, Stacy Cohen, Chief of the Evaluation Analysis and Dissemination Branch in HAB's Division of Policy and Data, Shelita Merchant, Chief of DPD's Data Management and Analysis branch and Marlene Matosky, Chief of DPD's Clinical and Quality Branch.

Also joining us today are Lauri Massey with the AIDS Project of the Ozarks and Aubri Hickman from the University of Mississippi Medical Center Adult Special Care Clinic.

Next slide. Let's begin with a quick overview of the Ryan White HIV/AIDS program. Next. This slide I know many of you have seen before but it bears repeating that the vision of the HIV/AIDS Bureau is optimal HIV care and treatment for all. And our mission is to provide both leadership and resources to ensure access to and retention in high quality integrated care and treatment services for vulnerable people with HIV and their family.

It's also important to note that this year we are recognizing the 30th Anniversary of the Ryan White HIV/AIDS program and the impact that you are recipients, sub recipients and stakeholders have made on the lives of people with HIV.

Next. The Ryan White program provides a comprehensive system of care that includes primary care services, medication, essential support services for people with HIV. The program funds cities, counties, states in local communities or stations to provide HIV care and treatment services to more than half 1 million people each year. The program reaches more than 50% of all the people with diagnosed HIV in this country. The program provides an ongoing and important source of access to HIV medication that can enable people with HIV to live long healthy lives.

Next slide. The Ryan White HIV/AIDS program provides a public health approach with integrated medical care and support services. Importantly recipients determine service delivery and funding priorities based on local need and planning processes.

People with HIV are an integral part of that planning process and quality management is a requirement. It's also important to note that the Ryan White program is payor of last resort.

Next slide. As we move to the data portion of the presentation it's important to remember that each member represents a person with HIV or their family member who's received service from your organization. These members represent people not just numbers. I'd like now to turn it over to Stacy Cohen and Shelita Merchant who will walk you through the 2019 Annual Client Level Data Report. Shelita?

Shelita Merchant: Thank you Dr. Cheever. Next slide. Good afternoon. My name is Shelita Merchant and I'm the Chief of the Data Management and Analysis branch in the HIV/AIDS Bureau. I'd like to begin by first sharing with you the changes to this year's RSR Report.

As many of you know HRSA HAB periodically makes updates to the RSR. These updates allow us to better measure the full investment of the Ryan White Program and its impact at the state and local levels. Somewhat recently the CDC HRSA Advisory Committee on HIV Viral Hepatitis and STD Prevention and Treatment also known as CHACHSPT recommended that HRSA HAB expands reporting of RSR clients to include those served using Ryan White program related funding and so that means that clients served with the program income and pharmaceutical rebates.

As a result beginning with the 2019 data reporting cycle recipients and sub recipients now are encouraged to include RSR data on clients receiving services provided through Ryan White program related funding. This new reporting requirement has already begun to be implemented and will be

required of all Ryan White program recipients and sub recipients by the 2021 data year. So that's the data that will be reported in the spring of 2022.

To provide that guidance to the RSR client data I wanted to point out that these reporting changes have contributed to an increased number of clients in the 2019 data. Additionally I also want to remind you that the numbers that you are about to see are limited to people served by the Ryan White programs and do not include all people with HIV in the United States. So this is not CDC surveillance data.

Next slide please. So let's take a look at our 2019 numbers. Next slide. In 2019 the Ryan White program served nearly 560,000 clients the majority of whom are people with HIV. According to CDC's HIV surveillance data the Ryan White program client population accounts for more than half of all people with diagnosed HIV infection in the United States.

Nearly 3/4 specifically 73% of Ryan White program clients in 2019 were from racial and ethnic minority populations, approximately 61% of clients lived at or below the federal poverty level and 47% of clients were age 50 or over. In addition 80% of clients had some form of health care coverage. These sociodemographic characteristics have been relatively consistent since 2010.

Next slide please. This next slide provides some additional context to the Ryan White program client data. The graph shows Ryan White program clients with HIV as a proportion of all people with diagnosed HIV in the United States. According to the published HIV surveillance data from the CDC.

The far left bar on the chart shows that Ryan White programs - the Ryan White program serves approximately 53% of all people with diagnosed HIV

in the US and its territories. But as you can see this proportion varies by population and so there's the example shown here.

So in 2019 the Ryan White program serves 64.6% of youths, 40.3% of MSM, 60.5% of Blacks or African-Americans, 62.3% of Hispanics are Latino and 59.8% of women with diagnosed HIV infection.

Next slide. This next slide shows the distribution of Ryan White clients by age group in 2010 and 2019. We see that the age distribution of Ryan White program clients is shifting. In 2010 there was a relatively normal age distribution among clients. However by 2019 multiple age groups have flattened.

In 2019 the 24 to 34 and 35 to 44 age groups accounted for nearly 20% of Ryan White clients each. The 45 to 54 and 55 to 64 year old age groups accounted for about 25% of clients each.

As you can see people with HIV are aging. From 2010 to 2019 there was a 9 percentage point decrease in clients ages 55 to 54. There was a 10 percentage point increase in the 55 to 64-year-olds in this age group and a 5.6% point increase in 65 and over group. Now I'd like to turn it over to Stacy Cohen. Stacy?

Stacy Cohen: Thank you Shelita. Hi everyone. Again this is Stacy Cohen, the Branch Chief for the Evaluation Analysis and Dissemination Branch in HAB's Division of Policy and Data. Today I will be sharing with you the Ryan White Programs national viral suppression data.

The Ryan White HIV/AIDS program is critical to ensuring that individuals with HIV are linked to and retained in care are able to access treatment and

remain virally suppressed. People with HIV who reach and maintain an undetectable viral load can live close to normal lifespans with improved quality of life. Having an undetectable viral load means that there is effectively no risk of sexually transmitting the virus to an HIV negative partner.

The Ryan White HIV/AIDS program services are crucial for obtaining optimal HIV health outcomes among people with HIV, preventing further transmission of the virus and ultimately ending the HIV epidemic.

The Ryan White HIV/AIDS program has made huge gains in viral suppression among its clients. As you can see in slide in 2019 88.1% of Ryan White HIV/AIDS program clients in medical care reached viral suppression compared to 69.5% in 2010.

Next slide. Here we see state-level viral suppression in 2010 and 2019 where darker red is lower viral suppression. Overall, all states have seen increases in viral suppression, however as you can see some states, particularly those in the southern US continue to have disproportionately lower viral suppression compared with other areas of the county - of the country.

Next slide. So this chart shows viral suppression among key population served by the Ryan White HIV/AIDS program. And I know that there is a lot happening on this slide so you want to take a moment to orient you to it. It shows a side by side comparison of viral suppression for each subpopulation in 2010 indicated by a dark blue bar and in 2019 indicated by a lighter bluish gray blue bar.

For comparison viral suppression for all Ryan White clients overall in 2010 was 69.5% which is indicated by the dark blue bar all the way on the left-hand

side of the chart and the dark blue dotted line that extends across the page. And viral suppression was 88.1% in 2019 indicated by the light blue bar on the far left and its corresponding line across the page.

The increase from 2010 to 2019 overall reflects an 18.6 percentage point increase in viral suppression. And this upward trend in viral suppression occurred across all priority populations. However it is important to note that challenges remain in reaching and maintaining viral suppression for certain populations. Most notably in 2019 the clients of populations with viral suppression lower than the overall percentage of 88.1% were Black or African Americans which is only a slightly lower - is only slightly lower than the Ryan White program average at 85.2% among transgender clients at 83.2%, youth age 13 to 24 years at 79.4% and clients with unstable housing at 74.5%.

As you can see we have made great progress but there remains some gaps and disparities to address. And on the next few slides I'm going to review these gaps a little closer.

Next slide please. So on this slide we highlight viral suppression by age group. I mentioned youth on the previous slide. As you can see here only 79.4% of people aged 13 to 24 were virally suppressed in 2019 which is nearly 10 percentage points lower than the national Ryan White average of 88.1%.

However we have made progress. Viral suppression among youth age 13 to 24 increased by 32.8 percentage points from 2010 to 2019. This increase greatly reduces the gap between this population and the national Ryan White average. I also want to note here that a larger proportion of the youth represented in this graphic has behaviorally acquired HIV versus perinatal HIV.

And when looking at this particular age group of people 13 to 24 years there is not much difference between those transmission categories. But I do want to note that across all age groups people with perinatally acquired HIV have significantly lower viral suppression then people with other HIV transmission categories. So viral suppression amongst people age 13 to 24 years can be found in the report on Table 14B, 15B and 16B.

Next slide. Here we see viral suppression by race and ethnicity. As mentioned previously Black or African Americans continue to have somewhat lower viral suppressions than people of other races and ethnicities. Overall for Blacks or African-Americans we have seen significant gains -- a 21.9 percentage point increase from 2010 to 2019. Importantly however subpopulations of Blacks or African-Americans may not have seen as significant increases.

Viral suppression data are available by race and ethnicity for all priority populations and can be found in the B as in boy table from 11B through 18B in the report.

Next slide. This slide is showing viral suppression among men who have sex with men or MSM who are served by the Ryan White program. On the left side is all ages of MSM and on the right side is specifically among young MSM age 13 to 24.

Focusing on the left side viral suppression increased among Black MSM and Hispanic MSM with increases of 22.2 percentage points and 15.9 percentage points respectively.

Shifting to the right side of the screen you can see notable gains in viral suppression evident among younger MSM. And I discussed previously that viral suppression among all youth overall increased 32.8 percentage points.

Here we see among young MSM in that same age group that there was an increase of 36.3 percentage points in young black MSM and a 36.9% percentage point increase in young Hispanic or Latino MSM. And these increases again contribute greatly toward reducing the disparities between these populations in the national Ryan White average but among young Black MSM in particular more work is needed to close that gap.

Viral suppression of among all ages of MSM can be found in Table 12D as in Dog in the report. And data for young MSM ages 13 to 24 can be found in Table 15B as in Boy in the report.

Next slide. On this slide we're showing viral suppression by gender in 2010 and 2019. And focusing in on viral suppression among transgender clients we see an increase of 21.7 percentage points. This is great progress but transgender clients continue to have viral suppression disparity compared to (sys) gender or non-transgender populations. And viral suppression among transgender clients varies by race ethnicity and age group. More specific transgender viral suppression data can be found in Table 13B in the report.

Next slide. And finally we have - we're looking at housing status here. Viral suppression increased among clients with temporary or unstable housing with increases of 18.5 percentage points among those with temporary housing and 19.7 percentage point increase among those with unstable housing.

Housing stability continues to be a significant factor in reaching viral suppression for people with HIV. As you can see the gap between those with

unstable housing and the national averages for 2010 and 2019 are still significant. In 2010 viral suppression among clients with unstable housing was 14.7 percentage points lower than the national Ryan White average and in 2019 it was 13.6% points lower. This slightly decreased difference from the Ryan White average is promising but there is still very obviously an incredible amount of work to be done here.

You can find more detailed housing related viral suppression data in Table 18C in the report and it's also included in each key population viral suppression table from 11B through 17B.

Next slide. So the 2019 RSR client level data report can be found on the HAB Web site at the link provided here and accompanying slide decks will be available by the end of the year. Other data reports such as the AIDS Drug Assistance Program Client Level Data Report can also be found at this link.

So now I would like to turn it over to Marlene Matosky, the Chief of the Clinical and Quality Branch in HAB's Division of Policy and Data. Marlene?

Marlene Matosky: Thank you Stacy. I'm really excited to join all of you here today and especially excited to introduce our two recipient spotlight presentations.

As the Chief of the Clinical and Quality Branch I oversee in support our Ryan White HIV/AIDS program clinical quality management efforts. And for anybody who knows CQM and has heard us talk about this, you know that data is critical and its role and in its effort to improve the quality of care for people with HIV.

So with that being said I want to introduce our first presenter. Her name is Lauri Massey. Lauri is the Director of Quality Management at the AIDS

Project of the Ozarks where she has worked for the past 17 years. With a thirst for ending the HIV epidemic she believes her Master's Degree in Social Work from the University of Kansas helps her to utilize data, influence systems and lead a compassionate team of associates as they work towards improving health outcomes.

Her commitment to quality management comes from a strong personal commitment to those living with HIV having lost her brother to AIDS in 1992. Thank you, Lauri for joining us here today and take it away.

Lauri Massey: Thank you Marlene. Hi folks. I'm Lauri Massey the Director of Quality Management in Springfield, Missouri. Next slide please.

I hope you're all doing well today and this slide is a map of Missouri and an outline of the 29 counties we serve most of which are rural APO functions under a one-stop shop model of care. We're a Part C recipient and a Part D and B sub recipient.

Next slide please. So why am I here today? I want to talk to you about some of the projects that we've done at AIDS Projects of the Ozarks to help move that needle to the last 10% of those who are not suppressed. And what we know all of us, is that's really hard. We also know that we cannot apply the same interventions that we have applied to other folks that aren't as complicated. And then finally we know we have to be creative.

Next slide please. I would be remiss in my duties if I did not acknowledge the larger collaborative that we have across Missouri. We share data, we share interventions, we share projects tirelessly and we do still from one another sometimes with shame and sometimes without.

Next slide please. In the beginning of 2018 our viral load suppression rates at AIDS Project of the Ozarks fluctuated between 91% and 93%. I'm going to speak to you about three of the interventions we used to move the viral load suppression from 93% in January 2018 to 96% at the end of the year.

Next slide please. So one of the interventions that we use which many of you I think are familiar with is Test and Treat model. In I believe it was December of 2018 our medical director approached our executive director and he had been doing some reading about what was happening on East Coast and West Coast but not in the center of the country. And he asked her if we could start the test and treat model of care and she said yes.

And in three weeks policies were written and there was a media turnaround and we started testing every new positive in our region. Once we tested some of tested positive - I'm sorry in our region then we treated them that day.

The other intervention going to talk to you is a green clinic and the final one is a close cohort from the case management team. Next slide please.

Stolen from KC Care - I'm having trouble seeing the slides on the screen. Okay stolen from KC Care we decided there was no need to reinvent the wheel right? So we stole their Green Clinic concept.

And it - the premises of the Green Clinic is to look at those persistently viremic clients, anybody hard to reach and chronically mentally ill and offer them easy access to HIV services. So we sat down as a team and developed a list of initially 25 clients who could be seen upon being in the building or needing an appointment, could be seen without even having an appointment, could be a walk-in, could be brought in by the case manager. And then we educated our staff about that process.

We flagged folks in our HER. Clients started coming in at any time and the medical staff would see them. And when I talk about medical staff I'm talking about a lab visit, a nurse visit or a medical provider visit. The majority of times it was the medical provider visit.

By the end of 2019, 17 of the 25 of those clients were - had achieved suppression. And I don't have enough time to go into detail about all the specifics of that but certainly would be available to talk about that at a later date.

Next slide please. So the other intervention that we did as a staff was a close cohort within the case management team. And so we're all taught about quality management but we need to start small. And one of the things that we asked the case managers to do was identify one client from their caseload who had persistent viremia (unintelligible).

They initially were like, "Oh no one more thing that we have to do." And then what we did was we told them that anything goes and their eyes perked up and they were like, "Really anything goes?" And we said, "Yes anything goes."

So we split them into groups of four or five. We have bimonthly case management meetings so we offered time during those case management meetings for them to do peer-review case conferencing specific time just to address this. And we asked them obviously to think outside of the box. So are close cohort was quite successful. And what we saw – what we found were 17 out of 23 of those individuals by the end of a nine-month period had become suppressed.

Next slide please. The interventions were complicated and simple all at the same time. The last 10% of our clients are substance misusers chronically mentally ill, maybe a combination of both. Certainly they have trouble believing in themselves. And what - we started slowly with them. Every time we had a contact we would write a handwritten note and say thank you for your time or we might take coffee to them or have lunch with them or just stop by their home and visit with them.

We had one client who was in jail so our case manager drove 45 miles to meet with him every week to talk to him about life, about circumstances about medication adherence. The gentleman got out of jail, started using immediately. Suppression levels or viral loads went sky high again. He went back to jail and we continued visiting in jail for six months and he did choose to take his meds that he has suppressed and 18 months later he suppressed. We're excited about that case.

And in the last case I want to talk to you about is (Eleanor). And only I say (Eleanor) because that's my favorite name. She's a 44-year-old woman been with AIDS Project of the Ozarks more than 17 years that I've been here.

She was never willing to take medications, never willing to follow through with treatment. Our case manager said, "She is my person. I am going to do everything I can to get her suppressed." And what that entails was visiting with her every day.

Our case manager went to her house on the way home from work and visited with her. Three months later she still wasn't even having conversations about medication adherence, treatment adherence. She was just building the relationship.

About four months in the woman allowed our case manager to buy a brush for her and calm her matted hair. So that took weeks to get through.

So I say all this and I want to tell you that she is suppressed and she has been suppressed over six months now. It took over nine months to get her there but she's there. And it takes stepping so outside of the box and looking at our folks individually these last 10% have to have individual service plans in looking outside the box.

Next slide please. So I want to talk to you about what didn't work very well, what kind of worked and what worked really well.

Some of the case managers that didn't the clients didn't achieve suppression, felt as though they weren't as skilled as other case managers which aren't the case. We all know that right?

And then substance misuse really impacted some of our clients reaching suppression. What worked pretty well but not always was that having a Green Clinic and opening the doors to walk-ins really strained our clinic at times but they did it and they were incredible and they're still incredible. And then what worked really well, I don't have it on here but I have to say (Julia Schlueter) and (Karin Criticos) from the state-wide case or quality management team are incredible supports and share data and share projects and they've been amazing.

I think being creative in our thinking, absolutely administrative and fiscal support understand the importance of and being good at building relationships and then individualizing the needs of our folks. All right that's my presentation. Thank you.

Marlene Matosky: Thank you Lauri. I want you to also pass along some real gratitude to all the folks in your clinic who worked tirelessly it sounds like on all of these efforts. And we know that using those tenants of quality improvement really does make a difference in real people's lives so thank you.

For our next presenter were going to have Aubri Hickman from the University of Mississippi's Department of the University of Mississippi Medical Center Adult Special Clinic in Jackson, Mississippi. Aubri is a nurse practitioner and has been with UMMC for nearly four years.

Prior to her work in the clinic she was at the STD HIV Communicable Disease Department with the University - or sorry with the Mississippi Department of Health. I want to thank you for joining us here Aubri and we're really interested in what you have to share with us because it's a very special topic. I want to let folks know that our CDC HRSA Advisory Committee on HIV Viral Hepatitis and STDs has a special workgroup on perinatal infection and they're going to provide us with some recommendations in the new feature.

So with that being said Aubri I want to share with you a gratitude for the work you're doing and for being with us here today. Thank you.

Aubri Hickman: Thank you for having me. Can everybody hear me?

Marlene Matosky: Absolutely.

Aubri Hickman: Okay great. So I am Aubri Hickman. I am the Program Director at the Adult Special Care Clinic in Jackson, Mississippi. And so we actually did a quality intervention that was based around postpartum women living with HIV and

how to actively link and engage and then ultimately retain and suppress those young ladies.

Next slide. Just a little bit about our clinic. We're the largest Ryan White funded clinic in the state of Mississippi. Year to date we've provided outpatient ambulatory health services to over 2100 individuals. We have patients that are located in 65 out of the 82 counties in the state. And our cohort of patients is predominantly African-American Blacks -- 87%. And then 1/3 of our patients cohort is female.

Next slide. Just a little bit about the provider makeup of our clinic. We used to have some part-time physicians. They've all been pulled inpatient with the COVID-19 pandemic. They still offer, you know, expertise and things of that nature, but they don't carry their own caseload anymore.

We do have our medical director who has a fellow, myself, two part-time practitioners that have small practices. One of those actually does hepatitis C and HIV co-infected patients. And then we have four full-time nurse practitioners six case managers that are registered nurses, to LMSWs, one linkage coordinator and one patient navigator. And that is what we have in the clinic.

Next slide. So typically when we start to do quality intervention, you know, and we try to base things around either anecdotal things that we've seen and then we'll go in and do like a literature review or it could be something that we have seen that there's actually a national significance and then we try to, you know, peel back and see if we actually have a local problem because some things that have national significance are not directly relatable to our clinic.

So we realize that there was a national issue with the postpartum women with HIV and how they were not retained in care especially following delivery. So nationally, you know, about 24 to max 63%, you know, 63% of those women are actually lost to care during that first postpartum year. And so as the women that were retained on those numbers, you know, only about 30% to 44% are actually found to be virally suppressed which is not good at all.

So next slide. So then we will - we wanted to know did we actually have an issue in this clinic? We were pretty sure but we did have an issue but we wanted to know like what – how bad was the issue? Did we wind up with the national numbers?

And so what we did is we did a retrospective chart review of all the women who were referred from the perinatal HIV program to adult special care clinic. Just for reference the prenatal program, these women who I refer to multiple sites throughout the state and all we really wanted to know was what about the women that were coming to our clinic, not that we don't care about the other women. We absolutely do but we really can't control the barriers to care for women who are not being transferred here to us.

So we looked at all the young ladies that were referred between 2014 and 2016. We looked to see what different variables race, age of diagnosis, how old were they when they delivered, if their diagnosis was actually received during that specific pregnancy that we were reviewing, did they have a history of mental health or substance abuse disorder? And if they weren't diagnosed during pregnancy were they in care prior to pregnancy or were they just in care while they were pregnant?

Next slide. So when we looked at all the information and we actually published a paper on it so there's a lot more information in the report that we

published. But we looked and so there was 30 women total that referred during that baseline time period and the perinatal program was successful in linking 27 of those women to care. So they would make appointments. You know, if they failed to make that appointment they would remake it they would reach out and with the ultimate goal to be to get those to us so that we could kind of take them from their and engage them and take care of them.

But as you can look and see at six months they linked 27 and by six months we already had lost five of those young ladies. We had no clue where they were. And out of the 22 we retained only 15 of those women were virally suppressed.

So fast forward to the 24-month mark we had lost, you know, nine women and only eight of those women were suppressed. So we realize that on our end we were doing a terrible job, you know, engaging those women.

Next slide. So we went and we did a review of the evidence. We just wanted to see what was the known barriers and facilitators and pretty much all of the information lined up. And it made complete sense as far as, you know, what you would find in the postpartum woman, those barriers to care. They have competing priorities. You know, they have lack of childcare. They don't have transportation. A lot of the women who were receiving perinatal HIV care, they actually would have Medicaid and that provided them with Medicaid transportation.

So as soon as they delivered were not an expansion state. So they would actually have their Medicaid cut off and so they no longer have transportation source. They lack social support. A lot of the young ladies had nobody that actually knew their HIV status, sometimes not even the father of their child. And again they lost insurance coverage.

So some of the other things we looked at we're facilitators to care. Basically the huge piece is that coordination between perinatal and continuity programs.

Health literacy pertaining to moms, some of the – some research reported that a lot of women stated they thought they weren't important during their pregnancy because we do all this work to keep these young ladies suppressed while they are pregnant because we want the end result of not having an HIV-positive baby.

But that really almost makes the women feel as if they're not important at all. So they do exactly what they're supposed to do the majority of the time to keep their babies safe and then nobody really puts any emphasis on how important it is for them to remain virally suppressed and to remain healthy so that they can have a long quality life.

And then of course there's that huge piece of patient and provider relationships. The high risk OB perinatal program operates in the same area as HIV continuity clinic but it's in a different point – it's in a different space. So especially for women who are diagnosed during pregnancy, you know, they are having an appointment made at a location they've never been to before with a provider they have never met and it's hard.

I mean it's hard even when you take the HIV aspect out of it to do those type of things. So that was one of the big focuses that we – one of the things we wanted to focus on the most.

Next slide. So of course just break it down into a PDSA. You know, we wanted to plan for that, formed a team. When anytime you're dealing with

HIV care you absolutely want to have people that are passionate about that specific piece of HIV care.

So there was a few of us that were very, very interested in pregnant women living with HIV and the outcomes there. So we formed a team and we have an AIM statement, you know, what do we want to do and why is it important? We had to really think about the contextual element of our problem because we're a very rural state.

So if you can live in typically Hinds County which, you know, has the state capital of Jackson in it but you may not have any access to public transportation.

So then of course there are other parts of a PDSA are do (studies) act and we're still on the act part. We're reflecting on what we were able to change and trying to formalize and trying to tweak it so that we can get optimal outcomes.

Next one. And this is just some (reverbage) of what I said. You know, we gathered together. We wanted to know what we were trying to do and why we were trying to do it, what was the problem.

Next slide. So some of the major parts of the intervention and these components and they were really very multipronged which is what the literature has suggested would be the best way to go about it. We wanted to make sure these active referrals when women who are already in care become – became pregnant.

So historically when we had a young lady that became pregnant we would refer them to the Part D Perinatal Program and we would close the books on

them. They were going to be pregnant, they're going to be followed by this other program and we didn't have to worry about that patient being with us until after they delivered and they somehow managed to get back to us.

So we really kind of change that. We wanted to make sure that we were part of that referral process that we continued to follow-up with those young ladies that were already in care here prior to try turning over the perinatal programs.

We started to think about even before they were close to delivery what would be those potential barriers to care after they delivered? So once we could identify those barriers we could kind of individualize that case management piece to address what that woman may face.

So some women would have Medicaid prior to pregnancy. So we need to determine where they going to go back to Medicaid coverage or were we looking at, you know, having to prepare for ADAP enrollment and financial assistance through the university? Of course we could enroll in those programs prior to delivery if they had Medicaid but we could go ahead and get all the paperwork ready so that we could swap them over without there being any issues.

One of the things we saw when we did the chart review was there would be women who were previously on ADAP or, you know, on pregnancy Medicaid so they're getting their antiretrovirals with no issue. And then but, you know, when their coverage got cut off all of a sudden they couldn't get their antiretrovirals and so you would see a note in the chart and then nothing else.

You know, they called state and they had a problem getting their medicine. And then, you know, they make sure that - then they show up two years later

very, very sick. So we wanted to make sure that we kind of looked at that in terms of trying to manage it on the front end.

We're very lenient with our young ladies as far as follow-up visits and lab work because, you know, their provider visits may not look like what you essentially would imagine that they would look like. And it's not structured. You know, they can get labs and then, you know, just hop in and check in with me and I'll see you and everything is good to go so with my main focus being if they are virally suppressed that their social needs are met and that they have time to be a mother and, you know, a young woman.

We created an individualized support group for young African-American Black women. And it started with six or seven postpartum women that were kind of the foundation of it all. It expanded. You know, it has about 20 active women at any point in time but it expanded to include a few young women who were perinatally infected themselves, women who had not had children yet but who planned to have children.

And then of course young mothers who had young children. We offered transportation, we feed them. We have several staff members that will stay and watch the children so that they can just have a few hours together to just be themselves and to be with young women that understand exactly what they're going through.

And one of the young women actually named it. It's called Women Like Me, because, you know, I can sympathize, you know, I can emphasize with their situation but I cannot - I can't sympathize with anybody who's not in that situation. They can't either.

So it really helped them and benefited them to be able to be of other young women that were experiencing the same issues.

Next slide. So what is the impact? Next slide. So again we have our baseline information from our chart review. Then we took two years of data from January 1, 2017 to the end of December and we referred 24 women during that two year time period. And as you can see all the way down I think when we did our article we stopped at 18 months because that's as far as we could go out. But for this we actually we were able to go and look at the whole 24 month piece.

And so at the 24 month piece you can see the 21 women are still retained in care and 21 women are virally suppressed. So I mean that's huge as far as the impact that we're going to be able to have for these young ladies and, you know, improve those outcomes long term.

Next slide. So reflect and formalize, I won't go too much into this but, you know, our main goal is to make sure that we are doing exactly what we need to do and changing things. And one of the things with this intervention is it's very specialized each woman. So one woman may have, you know, depression or even postpartum depression. She may have been prior to this. What does she need?

You know, and it's going to be very different than somebody who is married and stable and just maybe needs assistance with the kids when they have a visit or they need transportation so we have to really look. One of the biggest things that we realized with this is it makes a huge impact just to know that these women exist.

So instead of just transferring them out and then, you know, kind of forgetting that they're out there is we just kind of track them and make sure if they miss an appointment I'm going to call you before the end of the day because I need to know like what can I do to get you here, you know, what do you need for me? You know, so it's very individualized.

Next slide. So then this last little bit is continuing the work. We've had nine that were referred in 2019. We (unintelligible) eight, retained eight and seven are virally suppressed at the six and 12 month mark. We are working with the last young lady from that cohort that's not quite suppressed yet. And in 2020 I mean we have ten of the 11 that we linked that are suppressed to either the three or the six month mark so we're excited about it.

I think this may be the final slide. Next slide. Okay that's just some references and then I think that's it.

Heather Hauck: Great. Thank you so much Lauri and Aubri. Those were really interesting and concrete and very useful presentations so we really appreciate you taking the time to be on the Webinar with us today. And we also appreciate all of the critical clinical quality improvement work that you and your teams are doing in Missouri and Mississippi to support the clients that you talked about today.

So now this is Heather Hauck. I'm the Deputy Associate Administrator for the HIV/AIDS Bureau. We are going to turn to some brief HIV/AIDS Bureau updates that we want to make sure that you are aware of.

Next slide. So I wanted to remind you that there is still time to participate in HRSA's World AISS Day Twitter thread account. On December 1 HRSA initiated a Twitter thread that continues through today actually. As part of this Twitter campaign Ryan White HIV/AIDS program recipients stakeholder

organizations and federal partners are encouraged to join in the conversation using the hashtag HRSA Honors WAD for World AIDS Day.

You can check out HRSA's Twitter handle at HRSA Gov consider jumping on HRSA's wagon and posting your own content to HRSA's Twitter thread. That content can focus on your program's goals and accomplishments. It's does not need to relate directly to HRSA Twitter content that day and you're also encouraged to comment, like, and retweet the pulse from the Twitter thread.

Next slide. We also wanted to make sure that you were aware that the Department of Health and Human Services is inviting comments on the Draft National HIV Strategic Plan for 2021 through 2025. HHS is coordinating the development of this plan with federal partners from six of our federal agencies 12 six federal departments and 12 HHS agencies and offices.

The Office of Infectious Disease Policy last week published a request for information in the Federal Register to solicit input on the Draft National HIV Strategic Plan. The draft plan and a link to the RFI are posted at www.hiv.gov. The deadline for comments is December 14 at 5:00 pm Eastern Time and all comments must be submitted electronically to the address that you see on the slide.

Next slide. We also wanted to remind you about several key resources related to today's 2019 Annual Client Level Data Report. These are continuously updated to support the work of our Ryan White HIV/AIDS AIDS program recipients. So you'll see the slide the resources listed on the slide and you can click through those links to find the data report, the reports and tools infographics and recordings.

Next slide. Oh and the other thing that's on when you click through we have slide decks that are related to the 2019 Ryan White HIV/AIDS Program Client Level Data Report so you can actually look at specific populations or specific information that was shared earlier today.

So and we also wanted to make sure to thank you for joining us for today's special edition of the HAB You Heard Webinar. The recording for today's event will be posted on the HAB COVID-19 Web page. Please mark your calendars to join us for our first HAB You Heard Webinar in the new year which will be on January 26 from 2:00 to 3:00 Eastern time. We do hope that you'll be able to join us and we will be sending a save the date out soon.

We also always want to remind you that as you continue to care for your families, your patients and communities please do take time for your own self-care. And then last, we hope that you and your families have a safe and healthy holiday season and best wishes for the new year.

We look forward to talking to you again in 2021 and thank you again for the vital work you do in your communities during this challenging time and thank you for your participation in today's call. Today's Webinar is now concluded.

Coordinator: All participants, this concludes today's conference. You may disconnect at this time. Thank you.

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