HAB You Heard Webinar
June 24, 2020
3:00-4:00 PM ET

Coordinator: (Unintelligible). At this time all participants are in a listen-only mode. During the question and answer session, you may press star 1 on your phone if you would like to ask a question. Today's conference is being recorded. If you have any objections, you may disconnect at this time. Now I would like to turn the meeting over to Dr. Laura Cheever. Thank you. You may begin.

Dr. Cheever: Thank you. And good afternoon and welcome to the Health Resources and Services Administration HAB You Heard webinar formerly known as the All Grantee Recipient webinar. I'm Laura Cheever, the Associate Administrator for the HIV/AIDS Bureau. That's the HAB in HAB you heard.

And I'm joined today by Jim Macrae, Associate Administrator of HRSA's Bureau of Primary Health Care, Heather Hauck, Deputy Associate Administrator of HAB and Chrissy Abrahms-Woodland, who was recently named as a permanent director of HAB's Division of Metropolitan HIV/AIDS programs.

We're so glad that you could join us today for today's webinar. Next slide.

We once again have a full agenda for you today, including sharing some thoughts on the recent events around social justice in the United States, highlighting the importance of National HIV Testing Day, providing a few HAB updates, including updates on the 2020 National Ryan White Conference,

a discussion of frequently asked questions and key resources.

In addition, we're excited to have two presentations today, the Ryan White Part A program recipients in the New York EMA and the Indianapolis TGA and a special announcement.

Next slide. To begin today, I did want to take a few minutes to share what has been really been in my heart and mind this past month. Like many of you, we at HRSA have been feeling tremendous heartbreak over the events of the past few weeks that began with the tragic death of George Floyd in Minneapolis.

This horrible situation really reminds and reaffirms to us the persistence of injustice in our society and the continuing need to stand firm against bias, prejudice and inequality. Many of us work in HIV because it's our deep commitment and our calling to work towards greater equity.

The Ryan White HIV/AIDS program began 30 years ago with the goal of improving health and therefore the lives of vulnerable people with HIV/AIDS and their families. Today we continue on that mission and are committed to addressing health disparities in underserved communities and in ensuring access to and retention in high quality, integrated care and treatment services for people with HIV.

We hope we can draw on our collective feelings of grief and outrage over the recent events to recommit ourselves to the mission of the Ryan White program and to continue to embrace the culture of inclusion, equity and respect for all.

I would like to thank each one of you on today's call for all that you are continuing to do during this trying time in response to this unprecedented public health emergency that is COVID-19 and particularly among people with

HIV in the nation's most vulnerable populations.

Thank you for your dedication and commitment as we work towards responding to the COVID-19 pandemic and continuing to move forward with the important work advancing the Ryan White HIV program and the mission of ending the HIV epidemic in America. I'm extremely proud of the work that you are all doing for the people who need it the most.

Next slide. Focusing now on reaching people with HIV who need it the most, this weekend marks an important awareness day for the health resources and services administration, National HIV Testing Day which takes place on June 27.

Next slide. This year's testing day theme is Knowing, which highlights the importance of knowing your HIV status, knowing where you can get tested and knowing how you can connect to care and treatment services if you test positive.

Approximately 1.2 million people in the U.S. have HIV, but one in seven are unaware they have it according to the Centers for Disease Control and Prevention. This testing day we recognize that there is also an unprecedented opportunity in America to end the HIV epidemic through the administration's Ending the HIV Epidemic, a Plan for America or EHE initiative.

This is a 10 year plan which began in fiscal year 2020 to achieve the goal of reducing new HIV infections to less than 3,000 per year in 2030. Through both HRSA's Ryan White HIV/AIDS' program and HRSA's health center program, the agency continues to play a leading role in helping to diagnose, treat, prevent and respond to end the HIV epidemic.

Today I'm very excited that we have a critical player in that here at HRSA and that is HRSA's Bureau of Primary Health Care Associate Administrator Jim Macrae. Jim?

Jim Macrae: Thanks, Laura. And good afternoon to everybody who is participating in today's webinar. I'm really pleased to be a part of this webinar. And it's really because health centers are and will continue to play an important role in ending the HIV epidemic.

And they do that by screening patients that are at risk and encouraging HIV testing. And as many of you know, there are many Ryan White HIV program recipients and sub-recipients that are actually duly funded through the health center program.

We also know that while the COVID-19 public health emergency has made it much more difficult to access traditional places where HIV testing is currently provided, including health centers of Ryan White Program recipient locations, HIV screening continues to be an essential resource and source of care to reduce HIV infections and to improve health outcomes for people living with HIV.

Recently the CDC published guidance about HIV self-testing programs using an FDA approved home test as a way to supplement ongoing HIV prevention efforts.

In alignment with this guidance, health centers may purchase and provide HIV self-test kits to health center patients as a key element of providing primary health care services to their patients. In fact, I think it was two weeks ago we put out a bulletin that highlighted this option for our health centers.

Health centers that do choose to make HIV self-tests available to their patients, however, should also ensure that systems are in place to provide the full range of enabling services to support care to those populations. These services include patient education, case management and care coordination.

For those patients who report positive HIV self-test results, the health center should provide information and health education regarding follow-up confirmatory testing as well as linkage to treatment and care according to HIV care guidelines. Health centers must also follow appropriate state and local health department HIV surveillance program reporting requirements.

Finally if health centers opt to disseminate HIV self-test kits as part of their HIV prevention activity, they should also incorporate these activities into their uniform data system reporting as appropriate.

We recognize that self-testing for HIV can be an effective supplemental resource and tool for HIV prevention. And it can be a real source for improved health during the current COVID-19 public health emergency.

So on behalf of the health center program, I want to thank you for your commitment to continuing to provide care to people living with HIV and for those in whom we can prevent the disease.

So thank you so much for all of your efforts and all of your work and we look forward to the continuing partnership with the Ryan White Program through the health center program. Back to you, Laura.

Dr. Cheever: Great. Thank you so much, Jim, for joining us today and for really setting all the resources of the health center program behind the work of ending the HIV epidemic. And we really do appreciate our continued partnership there.

Next, we want to share several HIV/AIDS Bureau updates. I'm going to turn the first one over to Heather Hauck.

Heather Hauck: Great. Thank you, Laura. Next slide, please. To begin we wanted to provide an update on our recent organizational changes within the Bureau, which are intended to meet the goals of the ending the HIV epidemic initiative.

So as HAB continues to work on implementing the EHE initiative, we reviewed HAB's organizational structure to identify opportunities to optimally and efficiently meet the goals of the EHE initiative.

So on June 7, we actually had a reorganization within HAB that impacted three divisions and offices within HAB. The first was that the Office of HIV Training and Capacity Development, or what we called OTCD, Division of Domestic Programs, was disbanded.

The functions of the Division of the Domestic Programs within OTCD transferred to the Office of Program Support and the Division of Policy and Data and I'll explain the two units that moved to OPS and DPD.

So the integration of the AIDS Education and Training Center Program is within the Office of Program Support. And the Special Projects of National Significance Program is now within the Division of Policy and Data. And really those transfers and those moves help us more effectively align the work on technical assistance training and supporting innovative activities related to ending the HIV epidemic.

In addition to these units aligning, and you can see it on the slides in terms of the organizational structure, we also have the opportunity to integrate new

positions for the EHE work. Many of our new EHE positions will be within the Division of Metropolitan HIV Programs, which will include the creation of two new branches, an Eastern Branch and a Midwestern Pacific Branch with project officers and branch chiefs that will be focusing specifically on EHE activity.

And this is really, you know, due to the fact that there are, you know, over 35 Part A jurisdictions that have received EHE related funding. There will also be project officers in the Division of State HIV/AIDS programs to help with the seven states in Ohio that have received EHE funding.

And then we also have other new staff throughout HAB that will be focusing on data analysis and evaluation, IT infrastructure, communications and basic administration of the EHE initiative. So really an opportunity across HAB to ensure that we are also with you all around the EHE initiative.

Next slide. In addition when the Office of Training and Capacity Development was disbanded, it also meant that our Division of Global Program transferred to the HRSA Office of Global Health within the HRSA Office of the Administrator.

And really this transfer is important because it provides the Division of Global HIV/AIDS programs to really work across HRSA and to be able to leverage HRSA programs to enhance their current and their future programming. So that is an exciting move for our global HIV/AIDS program colleagues as well. And, again, that was effective on June 7 as well.

I'll now turn it back over to Laura for our next update.

Dr. Cheever: That was great. Thank you. Next we wanted to share that we understand that the COVID-19 public health emergency has had an impact on recipient and

sub-recipient operations and workflows. We understand recipients and sub-recipients had to use the best information available at the time to make difficult decisions about the delivery of services to people with HIV during this pandemic.

The changes in service delivery were driven by your need to protect client and staff health during the public health emergency. The HHS treatment guidelines committee also provided guidance along these same lines.

We've heard that a number of changes to health service delivery included most commonly fewer routine well health care visits initially, the implementation of telemedicine visits over face-to-face clinic visits and postponing of routine labs.

While important changes occurred, the changes in service delivery may have impact on your retention and viral suppression measures.

Next slide. So we want you to consider a few items related to the effect of COVID-19 public health emergencies. Please we ask that you document the changes in operations and workflows, including when these changes went into effect and how long they lasted.

Second, think about and consider the impact the changes will have or have had on your performance measurement data, especially your retention measure as well as your viral suppression measure.

Key questions to consider include how did the changes impact retention and viral suppression or a measure of these two things? And what interpretation do we add to the performance measure data from this period of time?

For instance, if you require sub-recipients to meet performance measure thresholds to receive payment, how will you adjust the threshold given the changes in service delivery or how will you adjust your sub-recipient monitoring to account for changes in service delivery during the COVID-19 public health emergency?

In the next few weeks, HAB will disseminate a program letter reiterating the impact COVID-19 has had on recipient and sub-recipient operations and workflow. Finally on this matter, I want to remind you that HAB's clinical and quality branches are here to answer questions you may have about clinical quality management and to provide technical assistance.

Please email them at rwhapquality@hrsa.gov. Thanks. Heather?

Heather Hauck: So our next update is on our COVID-19 data report, which we call the CDR. So just a few quick updates on the CDR which is a new as of yet monthly data report which received OMB approval earlier this month. All providers, recipient providers, sub-recipient providers and second level providers who use FY2020 CARES Act funding are required to complete this report.

The first data submission was due on June 15 and then will be due on a monthly basis from here on out. Providers may enter data directly into the CDR, the COVID Data Report.

We know there have been several questions about the CDR and late last month the Division of Policy and Data held its technical assistance webinar called Preparing for the 2020 COVID-19 Data Report CDR Submission. That webinar is actually now posted on the Target Web site along with an updated set of questions and answers from the webinar and those were available as of last week.

So we strongly encourage you to review that webinar. In addition we also encourage you to act as the COVID-19 Report Instruction Manual, which is also on TargetHIV. Laura?

Dr. Cheever: Thanks. Next slide. So next we have an update on the 2020 National Ryan White Conference on HIV Care and Treatment. The conference is only about seven weeks away, which is a little startling to me. As many of you know, in light of the COVID-19 pandemic, the National Conference is going virtual.

The conference date remains the same, August 11 through 14. But the times will be adjusted to accommodate different time zones. Registered participants are still encouraged to attend the full length of the conference. However, we know the virtual platform will allow for more flexibility.

And if you haven't registered, there's still time. And no need to get a hotel room so you should really do it. Registration for the 2020 National Conference on HIV Care and Treatment is now open and will remain open until July 31. If you have not already done so, please visit the conference Web site to complete your registration.

Importantly there will no longer be a cap on the number of recipients and subcontractors that are allowed to attend. In the virtual platform, the National Ryan White Conference will still feature poster presentations and offer digital exhibiting opportunities.

We'll also be continuing to update our Ryan White Program recipient and stakeholders as more information is made available. And once again we have no caps. We often people that want to attend that can't so this is the year.

For all things 2020 Ryan White Conference, please visit the conference Web site at ryanwhiteconference.hrsa.gov. Heather?

Heather Hauck: Next slide, please. So our next update is on the postponement of the HRSA CDC integrated HIV prevention and care plan guidance.

On June 7, just last week, the week before, the HIV/AIDS Bureau and the Center for Disease Control and Prevention Division for HIV/AIDS Division, or DHAB, issued a program letter on the upcoming release of guidance for the integrated HIV prevention and care plans for Ryan White HIV/AIDS program grant recipients. That also includes the statewide coordinated statement of need, which is a legislative requirement for our program Parts A and B recipients.

The current guidance covers calendar years 2017 through 2021. Due to the COVID-19 pandemic, HAB and DHAB have determined that we will postpone the issuance of the new guidance, which would have been for calendar years 2022 through 2027 submission.

And we had anticipated that we would be issuing this guidance this summer, which we're in currently. So HAB and DHAB will notify grant recipients of the updated timelines for the guidance and the submission later this year.

Our expectation is during this time where we have postponed the guidance and the submission deadlines, our joint expectation is that Ryan White Part A and B recipients and DHAB funded state and local health department do continue to utilize your existing integrated HIV prevention and care plans as your jurisdictional HIV strategy or as your jurisdictional roadmap for HIV prevention and care planning and services. Laura?

Dr. Cheever: Great. Thanks, Heather. And I really want to thank Heather working closely

with CDC to allow us to manage that extension.

Now we're going to turn to frequently asked questions. Since our webinar last month, we continue to receive questions from many of you regarding the FY2020 Cares Act funding for the Ryan White HIV/AIDS program recipients as you continue to move forward with providing care and treatment for people with HIV during the COVID-19 pandemic.

Many of the questions and answers are available on our HAB COVID-19 FAQ Web site which earlier this month went through a makeover. The FAQ Web site features more user-friendly design and has a new search and filter feature to help our recipients and partners better access the information and it actually worked quite well.

This afternoon, Heather and Chrissy Abrahms, will provide you with responses to several recently added frequently asked questions from the FY2020 CARES Act awards. Heather?

Heather Hauck: Great. Next slide. So our first FAQ is around self-HIV testing and the Ryan White HIV/AIDS program. If we could have the next slide.

Our first question is on self-testing for HIV and the Ryan White HIV program. Several recipients have asked that given the support for self-testing from the CDC, which encourages access to HIV testing during our physical distancing restrictions, does the HIV/AIDS Bureau support self-testing strategies for the Ryan White HIV program recipients delivering early intervention services?

And the answer is that HRSA HAB encourages promoting access to and continuity of care in a safe way to support social distancing during the COVID-19 public health emergency. And one way of a safe way to encourage

HIV testing during this time is through self-testing.

Our HAB Policy Clarification Notice Number 1602 allows for HIV testing in a limited way under the Ryan White HIV/AIDS program. And this includes targeted HIV testing to help the unaware learn of their HIV status and seek a referral to HIV care and treatment services if found to be living with HIV.

So recipients should coordinate these testing services with HIV prevention and testing programs to avoid duplication of effort. HIV testing paid for by the Ryan White service category in PCN 1602 cannot supplant testing efforts paid for by other sources.

Chrissy, I'll turn it over to you for the next one.

Chrissy Abrahms-Woodland: Thanks, Heather. So the next question is on telehealth as a medical visit. Our next question is a recipient asks if the HIV/AIDS Bureau performance measures that require a medical visit to calculate the numerator or denominator, do telehealth encounters between a patient and provider count as medical visits?

The answer is yes. A medical visit can occur face-to-face via telehealth and in other settings. A medical visit is an encounter between a patient and provider with prescribing privileges such as physician, nurse practitioner or physician assistant for the HIV/AIDS Bureau performance measures.

HIV/AIDS Bureau Policy Clarification Notice 1602 states HRSA Ryan White recipients are encouraged to consider all methods or means by which they can provide services, including use of technology, for example, telehealth. And outpatient ambulatory health service settings may include clinics, medical offices, mobile vans, using telehealth technology and urgent care facilities for

HIV related visits.

I'll turn it back over to Heather.

Heather Hauck: Thank you, Chrissy. The next FAQ has to do with CARES Act funding for mental health for health care providers. A recipient asks can FY2020 CARES Act funding for Ryan White recipients be used for mental health support for staff working with clients during these unprecedented times? Is this an allowable cost?

The answer is that in the FY2020 CARES Ryan White HIV/AIDS program example, uses of funding, it lists promote behavioral health strategies to address well-being of health care workers caring for people with HIV in response to COVID-19 as an allowable expense of funds under the response category.

Based on this information, this use of CARES Act funding would be an allowable administrative cost. Chrissy?

Chrissy Abrahms-Woodland: Thanks. So the last question is on the topic of hazard pay during the COVID-19 pandemic. Several recipients asked can Ryan White HIV/AIDS program recipients pay hazard pay to subrecipients' staff during the COVID-19 public health emergency.

The answer is the HIV/AIDS Bureau recognizes that many recipients are working to address or may be impacted by COVID-19 emergencies within their jurisdiction, which may impact their ability to meet grant requirements.

We encourage recipients to continue to provide Ryan White services in the grant activities in a safe and efficient manner to include hazard pay for staff based on existing emergency protocols. Once the emergency has waned, hazard

pay should no longer be charged to the grant.

Thank you to our recipients that continue to submit to the HIV/AIDS Bureau questions.

Next slide, please. Hey, so as a director for the Division of Metropolitan HIV/AIDS programs, I am excited to introduce our next presenter for the recipient spotlight presentation.

First we'll hear from Graham Harriman with the Ryan White HIV/AIDS Program Part A recipient in New York. Graham Harriman is a long-term survivor and he has been the Part A Project Director for the New York eligible metropolitan area, or EMA, for the past nine years.

So thank you for today us today, Graham, and I will not turn it over to you.

Graham Harriman: Thank you, Chrissy. Next slide. I'm delighted to be here to share the story of the New York EMA COVID-19 response. It's an honor to share with all of you and I hope this information is helpful. Next slide.

I want to start by recognizing several persons with HIV in New York City who passed due to COVID-19 to honor their passing.

(Marina Bourhous) was a dedicated activist for transgender people, sex workers and undocumented New Yorkers. Over the past decade, she provided invaluable insights to the New York City Health Department and served as an example of how to do effective and compassionate outreach to oppressed communities that are often hidden from official view. We'll miss her terribly.

Next slide. Ed Shaw was a long-time HIV activist renowned for his

compassionate, kindness, and insistence on sharing his own stories, a long-term survivor, to combat HIV/AIDS stigma and discrimination. He served on numerous local HIV advisory bodies including serving as the community co-chair of the HIV Health and Human Services Planning Council of New York.

Next slide. Of course, in the midst of the global pandemic, we've been experiencing advocacy for longstanding social injustices and racial inequity. Racism is a public health crisis. The murder of George Floyd at the hands of police officers is part of the system of racism that permits police brutality, unjust policing and mass incarceration.

In New York City, Black and Brown communities face the disproportionate impacts, grief and loss from COVID-19 on top of the trauma of state sanctioned violence.

The New York City Department of Health and Mental Hygiene is committed to addressing structural racism within our own institutions and addressing racism as a social determinant of health as part of our mission to protect the health of New Yorkers.

Next slide. And in the midst of the very much related demand for social justice and racial equity, of course, we're experiencing a global pandemic. New York City has been hit hard. While we see drastic reductions in our numbers to date, we have 209,893 cases, 17,657 deaths. In addition we also have 6,686 probable deaths due to COVID-19.

New York City is now in Phase 2. All New Yorkers are encouraged to get tested, stay home if they're sick, keep physical distance, wash our hands using hand sanitizer if soap and water are unavailable and to wear a face mask to

protect those around us.

Next slide. Of course, we've seen parallels between COVID-19 and HIV. Those who experienced the early days of the AIDS epidemic in New York City as well as across the nation may be experiencing anxiety and other emotional responses.

They have concerns, as many of us may, about the government's response, anxiety about our own vulnerability, inequities in vulnerability and access to health care and other support services.

And people with HIV are experiencing social isolation and loneliness as are many of us, having to stay at home and isolate from their support networks.

Next slide. We had an opportunity to match a data set of COVID-19 cases to our HIV surveillance registry. The data was cut on April 22. Among 140,732 confirmed COVID-19 cases in this April 22 data set, we found 1,672, or 1.2%, matched the HIV registry.

People with HIV comprised 1.4% of the population. And thus, based on preliminary data, people with HIV do not appear to be overrepresented amongst New York City COVID-19 cases. Next slide. We do see a higher proportion of people with HIV with COVID-19 who are male or older, in comparison to New York City COVID-19 cases overall. You can see that amongst males with - people with HIV with COVID-19 who are male you can see 71% of those folks versus New York City COVID-19 cases are 52% of those are male. It's hard to say what this means at this point, given that this is an April 22nd data set. So we'll continue to look at this as time goes on. Next slide.

Black and Latinx people with HIV are disproportionately represented among

people with HIV with COVID-19. Forty-seven percent of people with HIV with COVID-19 are Black and 40% are Latino. You can see that that's drastically quite a bit higher than New York City COVID-19 cases overall. Next slide. We also see higher proportions of people with HIV and COVID-19 who were hospitalized or died than in comparison to those without HIV with COVID-19. You can see that this has increasingly affected the population of people with HIV with COVID-19 in comparison to the general population of folks with COVID-19. Next slide.

So the New York HIV Health and Human Services Planning Council has been working to respond to COVID-19 in a number of different ways. Next slide. In March the planning council created a special resources page on its Web site featuring prominently, a link to COVID-19 research services. This contains a vast menu of resources for consumers and providers including scientific medical updates, where to get housing, food assistance, accessing mental health support, sexual health. It's updated weekly and it's the page that gets the most traffic on the planning council's Web site.

Additionally, the planning council's consumer committee has been quick to respond by sponsoring free monthly virtual town halls to consumers but open to all. Over 110 people attended the first town hall in April and so that has included the Assistant Commissioner of the Bureau of HIV sharing updates on COVID-19 as well as people from the housing program, addressing issues of housing and concerns about housing. Next slide.

On April 23rd the planning council worked with the recipients to allocate CARES Act funding and reallocate Ryan White Part A funding to address identified needs. We had heard that due to unemployment there was increasing need for short term rental assistance as well as short term housing, as well as emergency financial assistance including nutrition services.

Those - these allocations are now in contract. In March in response to COVID-19, we authorized temporary changes to contacts to ensure service continuity for Ryan White Part A clients to prioritize the health and safety of program staff, clients and the community including substitution of in person encounters with telehealth services, such as video conferencing and telephone contacts wherever possible. Of course, programs can determine that home visits and patient navigation services provided in the community are not advisable.

And then each project program is expected to contact every client enrolled in their program, to check on their welfare, and follow up with them as needed. Next slide. Some additional considerations we implemented in the (doc) for supporting providers amid COVID-19, are we are providing provisional payments equal to 1/12 of their contracted amount each month through June, based on a submitted budget of allowable expenses. For New York City this is very different because we are usually reimbursing based on performance and fee for service methodologies.

But we wanted to ensure that our programs are able to maintain their integrity, retain their workforce, and continue to address the needs of people with HIV during this time, so we made the change to support them. So the system program has experienced a number of changes. The food voucher program has restructured from any persons (unintelligible) for clients or they can use vouchers to order food for clients for home delivery.

The 100 meal programs that we have are temporarily restructured to provide takeout meals or pantry bags. And then our tack on meals per client per week, have been lifted during this time. Additionally, all programs must report if COVID-19 is affecting service delivery, which of course it is for all of them, using their monthly program (unintelligible) support. Next slide.

So we're trying to sort of figure out where to go from here. we already can see based on the surveillance data, in terms of reported viral loads, labs that in comparison to April 2019, in April 2020 we saw a 77% decline in reported viral load (levels). Of course, this makes sense since people have been advised not to go outside, not to engage with a medical provider unless it's absolutely necessary. But this means that we don't know the health status of our clients. WE continue in this area, to have challenges in reaching clients. A number of clients aren't able to pay for phone and are having challenges using their smartphones if they have one.

And then, of course, clients are experiencing COVId-19 issues with ARC adherence, self-care, loneliness, and trauma, including race-based trauma. We're just at a point where we have to have sort of a long view and continue to support providers to do the excellent work they've been doing under unprecedented stress and uncertainty. And we've been incredibly impressed with their ability to innovate and be responsive to the needs of people with HIV during this challenging time. Next slide.

Thank you for this opportunity to share and I hope it was helpful to you. Have a great day.

Chrissy Abrahms-Woodland: Thank you, Graham, for that presentation and allowing us to reflect on the lives of those who have had such an impact on HIV and the work that we do, as well as sharing your COVID-19 data and response. So a very helpful presentation. Thank you. Next, we will hear from Michael Butler from the Ryan White HIV/AIDS Program Part A recipient in Indianapolis.

Michael is the Director of the Ryan White HIV Services Program for the Marion County Public Health Department in Indianapolis, Indiana. His

program serves the (unintelligible) County transitional grant area or TGA, in Central Indiana, with Ryan White Part A and AI, Part C and (unintelligible) the epidemic funding. So, thank you for joining us today, Michael. I'll now turn it over to you.

Michael Butler: Good afternoon and thank you for this opportunity to tell you about some of the wonderful things that are happening here in our TGA. One of our sub-recipients has initiated a no-contact HIOV testing protocol in response to the COVID-19 pandemic. The organization Step-Up Incorporated, I'll provide their contact information a little later here, initiated this procedure to conduct tests in the community while adhering to social distancing practices during the pandemic.

They recruit clients for the no-contact testing through advertisement on their Web site or on various virtual or online platforms such as Facebook, Twitter, Instagram, Grindr and (unintelligible). Clients can request a free, no-contact HIV test by emailing a contact person at Step-Up Inc. or sending a direct private message to a Step-Up staff member via social media.

Clients should not expect same day testing. A test will be scheduled depending on client eligibility for the no-contact testing, and that usually happens within two or three business days of the initial request. There are eligibility guidelines for the no-contact testing. They must be in a geographic location within a 20 mile radius of essentially downtown Indianapolis. If the client lives outside that radius eligibility may be determined on a case by case basis and they may be mailed at an at-home HIV test instead of receiving the no-contact test.

Clients must be at risk for HIV infection and that determination will be made by the outreach staff who will consider factors such as the date of their last HIV test, result of that last test, number of sexual partners, the status known or unknown of those sexual partners, and use of risk reduction methods such as

condoms and PrEP. Clients who report low or no risk for HIV infection might be asked to seek testing elsewhere or at a later date, due to the limited supply of no-contact testing.

The client must be willing and able to complete an electronic no-contact HIV test request form. This will require some personal information such as name, date of birth, address, phone number, sexual behaviors, and recreational drug use behaviors. The client must consent to meeting a Step-Up, that's the organization, outreach staff member during the day, at a mutually agreed-upon site location. And that meeting is then scheduled.

And there must be a willingness on the client's part, to have their HIV test result reported back to Step-Up. And in the event the client performs their own test using an at-home test kit or via video or phone guidance with the staff member, the client must be willing and able to report that result back to their test or for proper documentation and follow up.

The organization does conduct a COVID screening, checking to see if the client has experienced shortness of breath or fever within the past 14 days and if that's the case, they are not eligible for no-contact testing at that time. If the client meets all of the above requirements, they will receive a four-digit code from a staff member who will - and then the client will need to complete the electronic test request form.

Once that form is completed, a Step-Up staff person will schedule a no-contact test. Now the electronic test request form is compliant with HIPAA regulation. Once the staff person has scheduled the test they'll contact the client by - or actually they'll contact the client by phone or via social media, to establish a meeting time and location. And the testing really should occur during daytime hours only.

Once the tester has notified the client, either by sending them a private message - when they're ready to conduct the test they'll send them a private message or knock on their door, ring the doorbell, and identify and ask for the client only by first name. And the entire process is done within about a two to four-hour timeframe. The client will confirm their identity. They will complete a consent form and then the test is conducted with the staff person maintaining appropriate distancing during the process.

All pens and clipboards that may be used during this process, are sterilized after each use. The client will have their - have indicated their preferred testing method on their electronic consent form, which can be a collect and test method which is the most common one that's used. The tester will stay onsite and guide the client through the process of collecting their own sample, the tester will confirm that the client had not eaten, drank, has used oral care products within 30 minutes prior to doing the test, and that they have removed any dental products such as dentures or other products that cover the gums.

The tester will follow established protocols to open the test package and the OraQuick device and using all appropriate safety precautions such as wearing masks and nitro gloves and maintaining the six feet distance, they will work with the client to collect the specimen. During the time that the testing device is emerged in the developing solution, the tester will contact the client by phone or video chat, to conduct a risk reduction counseling session. Again, confirming their identity before proceeding.

And at the end of the 20-minute developing period the tester should document the client's result and provide guidance as appropriate. If it's a negative test, if it's been three months since the client had a risk event they'll discuss that with them. And if they regularly engage in activities that put them at risk for HIV

they'll remind them they need to test regularly. In the event of a reactive test, these are really - those results are delivered in person if at all possible.

But if the client is not available to do that in person they will deliver the presumptive positive result over the telephone and encourage that the client have a confirmatory test. And the confirmatory test will be done using another OraQuick collection device from a different lot number. And then once they deliver that confirmatory result, they work with the client to conduct counseling in the same manner as they would for in person testing, and complete all appropriate paperwork.

Then they notify the director of the testing program so that the director can coordinate establishment of care for the client. During the month of May the sub-recipients, Step Up Inc., delivered 26 tests using this no-contact testing protocol, two of which were reactive, and those individuals were linked to care within 24-hours of receiving their test result. So we're really excited about this and the fact that we are able to continue testing individuals even during these difficult times, and using a protocol that keeps both the client and the tester pretty safe from a risk of exposure to COVID.

The other thing that I'd like to talk about today is our investigation of a telehealth platform for clients who may not be able to access it because of limited resources. Many of our sub-recipients were attempting to continue to engage clients in either primary medical care or case management services during COVID, but some of the - oftentimes they found that the clients did not have access to video services, or perhaps didn't have a smartphone that would allow them to do telehealth.

So we've engaged with a local digital marketing firm who has developed a platform that offers a flexible way to meet the immediate need of telehealth.

This marketing firm handles everything from warehousing - from the warehouse to the (door) staff, as far as making these devices available to clients. Each client will receive an 8-inch tablet with a protective case and unlimited 4G LTE data capacity. This immediately addresses clients' ability to access technology and reliable networks.

The devices are locked into a focused interface that prevents nonmedical use. This makes it less desirable to hold onto these devices when the telehealth project has completed for that individual client. The platform is secure and the tablets are able to be used - are not able to be used for any other purposes. The devices receive daily software updates to ensure patient and electronic protected health information security. Any lost, damaged or stolen devices can be remotely wiped clean and replaced on demand.

Each of the devices are tailored to the specific needs of the organization and what that organization - the services they wish to provide the client to whom that device is assigned. They are set up with the profile with the specific needs of the organization and the client. And the organization can create unlimited profiles and make changes at any time.

The digital marketing firm fully manages all of this with an annual cost that initially is for acquiring the devices and then doing the setup, profile provisioning, coverage of any theft or damage claims, and application of the daily support and security updates. Once the telehealth project is completed for that client, the marketing firm sends out a postage-paid box for the client to return the device to their warehouse so that there is no cost or major inconvenience to the client for ending the service.

And then the telemarketing firm - the digital marketing firm completely manages the inventory and provides the support to this initiative. We as the

recipient of the COVID-19 funds, will engage in a contract with our sub-recipient who will then work with the digital marketing firm to acquire the number of devices that they need to meet their program goals and objectives, and to support the client that they are going to engage in telehealth.

After the initial acquisition of the devices it's estimated that each one will have about a 20-month lifespan and when that time is up we're working with the Part B program to see if they have additional resources or other resources that can be utilized to replace those devices and to continue this service moving forward. We're really excited about this.

The digital marketing firm has assured us that they will not install any advertising about them as an organization and services that they provide and that anything that is installed on these devices would be strictly related to the telehealth program that the sub-recipient is providing. Next slide, please. This is the contact information for our sub-recipient, Step-Up Incorporated, the director of outreach and prevention is Bo Dawson. You have his telephone number and his email address there as well as the Web site for the sub-recipient, Step-Up Incorporated.

They have some information on their Web site about their no-contact testing protocol. And Bo will be very happy to answer any additional questions or provide you with the information about their program and the protocols for that no-contact testing. And this slide is my contact information. I'm happy to provide you additional information about the telehealth platform and the organization that we're working with to provide this service here locally. That same organization is also working with the Part B program. They're currently doing a pilot statewide, but they've had some very positive feedback so far on the program.

I'm happy to provide any additional information and more details about the program if you wish that. We thank you very much. We appreciate this opportunity to tell you about some wonderful things that are happening here in the Indianapolis TGA.

Dr. Cheever: Great. Thank you, both to (Graham) and Michael. We really appreciate the work that you're doing - you and your teams are doing, both in Indianapolis and New York City, in response to the pandemic. Thanks so much for sharing how you're continuing to provide care and support services to people with HIV. I really appreciate kind of the innovative attitude of just sort of jumping in and meeting patients where they are. Next slide.

I want to remind everyone about several key resources that we have that are being continuously updated to support your work as Ryan White recipients. We know there are several questions and answers we were not able to get to today. We were seeing some of those in the chat and we'll make sure that we are getting those addressed for you. But we do encourage you to continue to visit the HIV/AIDS Bureau Web site, COVID-19 FAQ Web page. As I mentioned earlier, it has a new look and feel and a searchable format.

The page is being updated almost daily with new FAQs and information as it becomes available. And the URL is www.HAB.HRSA.gov/Coronavirus/Frequently-Asked-Questions. I would also encourage you to visit the other Web pages with critical information for COVID-19. They are listed on this slide here. Next slide. So in conclusion today, I just want to thank you all for joining this Have You Heard webinar. A recording of today's event will be posted on the HAVE COVID Web page.

And I wanted to just take a moment to remind you to continue to care for your families, your patients and your communities. So please take some time for

your own self-care. This is getting to be a long and trying time for many of us both as we work on doing our social - our isolation as we are also trying to manage our work and working communities.

We want to - we hope that you and your families are staying safe and healthy. And thank you again, for that vital work that you are doing in your communities and for your participation on today's call. I hope to talk to you again soon. And please remember to register for the National Ryan White Conference if you haven't done so yet. Thank you.

Coordinator: This concludes today's conference. All lines may disconnect at this time. Leaders please stand by.

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