HAB You Heard Webinar
July 22, 2020
3:30-4:30 PM ET

Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen-only mode. Today's call is also being recorded. If you have any objections you may disconnect at this time. I would now like to turn today's meeting over to your host Dr. Laura Cheever. Thank you. You may begin.

Dr, Laura Cheever: Thanks so much. Good afternoon and welcome to the Health Resources and Services Administration HAB You Heard, our monthly update from the HIV/AIDS Bureau. I'm Laura Cheever, the Associate Administrator for the HIV/AIDS Bureau, the HAB in HAB You Heard, and I'm joined today by Antigone Dempsey, Director of HAB's Division of Policy and Data.

Tamika Martin, one of our 2020 National Ryan White Conference co-chairs and public health analyst in HAB's Division of Community HIV/AIDS Programs, Heather Hauck, Deputy Associate Administrator of HAB, Chrissy Abrahms Woodland, Director of HAB's Division of Metropolitan HIV/AIDS Programs and CAPT Mahyar Mofidi, Director of HAB's Division of Community HIV/AIDS Programs. We're so glad you could join us this afternoon for our webinar, next slide.

We once again have a full agenda for you today including sharing our COVID-19 data report highlight January through May, an update of next month's virtual 2020 National Ryan White Conference including a sneak peek at the virtual platform, HWA Bureau updates including the Ending the HIV Epidemic update and our Ryan White HIV/AIDS program 30th anniversary, a discussion of frequently asked questions and key resources and in addition we

are very excited today to have two presentations. Joining us is the Ryan White Part A recipient in San Francisco EMA and a Ryan White Program Part C/D recipient PrEP of care in New Orleans, Louisiana. Next slide.

Before we turn over the webinar, I just want to thank all of you listening in today. Among our Ryan White HIV/AIDS Program recipients, subrecipients, stakeholders and partners, as we continue to navigate together this really unprecedented public health emergency, we are so humbled that — of your continued commitment in providing HIV care and treatment in your community and people with HIV, including the most vulnerable populations around this country.

We definitely have to been able to see your dedication especially to those of you serving on the front lines of the COVID pandemic and we're reminded why we need to do this work each and every day. I'd now like to turn it over to Antigone Dempsey, the Director of HAB's Division of Policy and Data who will provide an update on COVID-19 data reports, the CDR as we call it now, highlights of January through May 2020 data, (unintelligible)?

Antigone Dempsey: Thank you Laura and again I also want to echo what Laura just shared. We want to thank all the recipients and providers who have been diligently working to submit the new COVID-19 data report or CDR. We understand that this has been a difficult time for all of us to implement new activities and to start a new data reporting system. These data are incredibly important for HAB's efforts to monitor activities related to the CARES Act funding.

And as we will show you over the next few slides, you'll see that providers have been reporting how they've been using the CARES Act funding to implement services to prevent, care for and respond to COVID-19. Next slide.

So a little bit of background, so this summary includes — the (unintelligible) presenting includes data from the first reports for the COVID-19 data report or CDR and these were submitted June 15 and covered three time periods. So the first time period is January 20 to March 31 and we went back to January 20 because folks were able to use funds back to that time period. So we wanted to make sure to capture any time services or activities that happened during that time period.

The second period is April 1 to April 30 and then May 1 to May 31. Data submitted during this recorded period were just submitted to us on July 15 and thank you all for getting that in to us but they're not included in this presentation. HAB is reviewing the data now and we will include it in future presentations.

So HAB is aware that many recipients requested and receive extensions on CDR reporting in order to establish contracts and set up reporting mechanisms. And I just wanted to note that because it's important to keep this in mind because the data that we'll be presenting — that I'll be presenting does not include all of our recipients and so these numbers will change. Next slide.

So take a look at our telehealth capacity and services. So as you can see on this slide providers are providing telehealth services. Among the providers who submitted CDR for the January through March reporting period 71% reported that they had some kind of telehealth capacity.

And then among providers who submitted the CDR for May, that increased to 83% that they had any telehealth capacity. The most common telehealth services reported by those with any telehealth capacity are listed here. They all make sense in terms of outpatient medical care, medical case management. It's important to also highlight that emergency financial assistance services are here

and food bank and home-delivered meals. Next slide.

So preventers are also expanding and implementing COVID-19 testing. The percentage of provider sites conducting any COVID-19 testing increased from 31% in the January time period to 44% in May. Through the extended capacity for testing providers are testing larger numbers of Ryan White eligible clients and household members.

Over 7000 tests were conducted in May. Providers have also served almost 3000 Ryan White eligible clients who have COVID-19. Both of these are — and to reiterate these are preliminary figures and we know this is an undercount of the number of clients that have been served and have been tested and we will be seeing changes in those numbers as people begin to submit their data. Next slide.

So next you'll see that providers served over 50,000 Ryan White eligible clients and immediate household numbers in May. And some of the most common services that were provided here were medical care, outpatient, inventory health services, medical case management, AIDS drug assistance program or ADAP treatment, health education enrich production, food bank, home-delivered meals and non-medical case management. And again we know that the 50,000 persons served is an undercount of total numbers. Next slide.

So as we shared last month we know that there's been a lot of questions about the CDR so we wanted to share a reminder about the resources that we have currently available on the target HIV website, including set of questions in Q&A, questions and answers that we developed from our technical assistance webinar that we did. We also have that webinar online of target HIV that we conducted in May that you can rewatch again. And in addition we encourage you to ask us the COVID-19 data report instruction manual as well. Next slide.

So next we have an update on the 2020 National Ryan White Conference on HIV care and treatment and I'd like to turn it over to one of our three conference co-chairs, Tamika Martin. She is a public health analyst in the HIV Bureau's Division of Community HIV/AIDS Programs. Tamika?

Tamika Martin: Good afternoon. Thank you (unintelligible). We are less than three weeks away from the 2020 Ryan White National Conference on HIV care and treatment. The conference theme is 30 years of innovating care, optimizing public health ending the HIV epidemic. The Ryan White HIV/AIDS Program clinical conference is scheduled for August 9 through 12 with the National Ryan White (unintelligible) taking off August 11 concluding August 14. Next slide.

Here's a look at the agenda at a glance. The National Ryan White Conference schedule is as follows. HAB business day meeting begins on Tuesday, August 11 at 11:00 a.m. Eastern Daylight Time wrapping up by 11 — by 1:00 p.m. Eastern Time, followed by a 30-minute break. The opening (unintelligible) will begin at 1:30 p.m. Eastern Time followed by two workshops.

On Tuesday and Wednesday, August 12 and 13 sessions begin at 10:00 a.m. Eastern Daylight Time with a (unintelligible) section starting at 11:00 a.m., followed by three workshop sessions and a dedicated 30-minute poster segment. Friday, August 14 workshop sessions begin at 10:00 a.m. and there are three sessions on Friday followed by the closing (unintelligible) which kicks off at 2:30 p.m. Eastern Daylight Time. Next?

Thank you. The conference consists of over 250 workshop sessions and two dedicated poster sessions. Pre-recorded sessions are available after the presentations to accommodate different time zones. However in order for conference attendees to receive continuing education credit participants must

attend this session in real time and complete the evaluation. The full agenda will be available online next week. Next?

As a reminder (unintelligible) for the National Ryan White Conference are population-based approaches for improving access, engagement, re-engagement and health outcomes, data utilization, innovative system level models for HIV delivery, service delivery, clinical quality management, Ryan White HIV/AIDS program planning and resource allocation, community engagement and collaborative partnership and fiscal and grant management boot camp. Next?

The virtual platform sign will be password protected meaning all attendees will receive a user name and password which is auto-generated. This information will be sent out the week before the conference with a reminder email a couple of days prior to the start of the conference. Some of the features of the platform have tasks for the agenda, lists rank to the session and the rate of build your own schedule, an exhibit hall, ---, attendee networking and socializing options as well as a help desk for questions the week of. Next?

We want to give you a sneak peek of the virtual platform. Here's a snapshot of the home page. Each day attendees will see the (unintelligible) speakers at the bottom with various tasks to the left. Pop-up notifications will appear drawing attention to attendees of high priority information. Next?

Thank you. The tab on the left side that reads agenda, once you click there it'll lead you to this screen. So here attendees are able to sort the agenda by date, track and other key search words. There's also an option to build your own agenda. It reads my schedule and once you select the sessions, you're interested in it will load to your schedule. Next?

(Unintelligible) sessions will open in a Web-based video player window. Breakout sessions will open in a meeting application. This session will take both the pre-recorded presentation along with a live question and answer segment. Next.

One of the best options about the virtual platform is the ability to interact with your fellow conference attendees. Although we are not meeting in person, we encourage all attendees to still network. Please create your own profile, upload a picture, add connections, post those in the hashtag and socialize. Next?

HAB business day meetings begin at 11:00 a.m. on Tuesday, August 11 Eastern Daylight Time at 11:30 a.m. and we'll operate on the platform. You'll join them as you would a breakout session. Next.

So what are the next steps for conference attendees? Please keep an eye on your inbox for an email with your user name and password for the virtual platform and don't forget to visit the conference website next week, and get excited for the conference. We're excited and we look forward to virtually seeing you. Thank you.

Dr. Laura Cheever: Thanks Tamika. I am really looking forward to the conference as well and getting a look at that virtual conference platform. I can't believe we're only a couple weeks away. I do want to just reflect on what you said, that some of the sessions will be pre-recorded but then there'll be a live Q&A. We'll be able to continue to have it interacting. I think the most meaningful part often is really being able to talk to presenters and share your own experiences and we'll still be able to do that. So thank you for making that possible.

Next on the agenda is to turn to a few HIV/AIDS Bureau updates. I'm going to start by turning it back to Antigone Dempsey to give you an update, the

importance that would mean data, Antigone?

Antigone Dempsey: Thanks, Laura. I was just thinking more data. So yes, we wanted to talk a little bit about the data question around ending HIV epidemic. So there are going to be several key data question changes that will support the assessment of progress for the ending the HIV epidemic initiative goals. Some of these changes will apply for all Ryan White HIV/AIDS Program recipients and sub-recipients and then some will only apply to those that are receiving funding for the EHC initiative. Next slide?

So HAB has been sending additional details on this short lead but just for a high level the data collection changes are — there will be two new RSO for Ryan White HIV/AIDS Program report changes at client level sessions for all recipients and sub-recipients in the provider report.

The AIDS Drug Assistance report or ADR changes are there'll be one new AIDS Drug Assistance report question for ADA, the new ending the HIV epidemic triannual module which will be an advocate data that is reported will happen three times a year.

And then new ending the HIV epidemic initiative allocations and expenditure reports will also be available. And those have been approved by OMB and then we're just working on making those available. Next slide.

So as we mentioned, HAB will be sending additional information shortly. However the (unintelligible) Notice of Award list as the typical pointing timeline for the EHE triannual module. So wanted to mention an updated reporting timeline for this requirement.

This is a new aggregate data report due once per trimester. The trimesters will

be based on the calendar year. In order to align with the calendar year the first reporting period will begin at the start of the funding period which is March 1, 2020 and will continue through August 31 which is six months.

Data submission for this reporting period will be due October 15, 2020. The portal will be open September 15 and after the first report triannual data reports will be due based on the schedule displayed in the — in this table right here. Next slide.

So please note that the EHE triannual module is a data reporting requirement and that's different from the triannual progress report. Unfortunately they both use the (unintelligible) so the progress report is a program requirement for cooperative agreement and is a narrative of progress made during the trimester on program activities. And for the progress report that first report will be due in May, August or early September. Next slide.

So EHB reporting requirements online will be updated as applicable. And so you'll see that in terms of the data reporting and the progress report and additional details of all reporting requirements will be sent via email. So you'll all have that as the email. Now I'll turn it back over to Dr. Cheever.

Dr. Laura Cheever: Thanks very much (unintelligible). That was great and really, I appreciate everyone submitting their data with these initiatives. It's always very important that we are able to document what we're doing as we request funding to Congress. So I know it is a burden but I really appreciate it, and we've been very successful in the past with the data that you've given us so thank you.

Turning now related to our work on ending the HIV epidemic we understand that the COVID-19 pandemic has significantly impacted the ability for viral recipients to do their everyday work and now we're asking them to do new and

different things through ending the epidemic. And although the pandemic has affected normal operation it's also forced us to do things differently. As (Jim Warren) said the other day the impossible became possible overnight and we've definitely seen that.

And we really believe that many of these innovations can accelerate our work to meet the challenges of EHE. A few examples of this on the slide include the adoption of telework. In a short time we've shown that through telemedicine, also telework for us but in a short time we've been able to reach those out of care. We've improved the retention rate in many programs although we do need to remain really vigilant about the digital divide as we see disparities and who has access to different types of technologies we could actually see an increase in disparity.

Second, we've had a better continuity to access to medication as we've now been able to really extend 90-day medication refills to many people and increase home delivery. We've accelerated self-testing, HIV and STI testing. People have said that telemedicine really was made for PrEP and for certain people that are doing PrEP through this health center program have been able to greatly expand their program as an example and we've really had some innovations around streamlining eligibility and recertification.

So we had looked forward to learning more innovations from the Ryan White Program recipients as you can see to provide this critical care. I'm now going to turn it over to Heather Hauck?

Heather Hauck: Sorry, I'm on mute. Thanks Laura. Our final update before we turn (unintelligible) on question section is that we are expected to share a major milestone for the Ryan White HIV/AIDS Program. As many of you may know August 18, 2020 marks the 30th anniversary of the Ryan White Comprehensive

AIDS Resource Emergency or CARE Act.

The themes of the 30th anniversary is 30 years of innovating care, optimizing public health, ending the HIV epidemic. This is also the theme of the 2020 National Ryan White Conference which immediately precedes the 30th anniversary.

So with any anniversary the state really offers them all a moment in time to reflect on the incredible impact the Ryan White HIV/AIDS Program has made in the lives of more than half a million people with HIV each year and (unintelligible) going to give the highlights of program accomplishments in the effort to end the HIV epidemic in the United States over the last 30 decades.

So this here, our 30th anniversary commemoration will begin with the closing preliminary session of the national conference. We have a preliminary session with some very special guest speakers who will highlight the history of the program, the impact the program has made and look forward to the future of the program. Be on the lookout in your email inbox for more information about how you will be able to participate in the 30th anniversary commemoration next month. And now I'm going to turn to frequently asked question section.

Since our webinar last month we continue to receive questions from many of you regarding uses of the FY 2020 CARES Act funding for Ryan White HIV/AIDS Program recipients as you can see to move forward with providing care and treatment for people with HIV during this pandemic. Many of these questions and answers are available on our HIV/AIDS Bureau COVID-19 FAQ website so we always encourage people to go and check the FAQ website as it's being updated very frequently to find responses to the previously (unintelligible) FAQs.

This afternoon for the FAQ session I'm going to invite Chrissy Abrahms and CAPT Mahyar Mofidi to provide you with the responses to several recently added FAQs. So the first question is around recipient site visit. A recipient asked us were site visits required for the FY 2020 (unintelligible) grant. And the response is that the answer is based on the Notice of Award.

Recipients must monitor the activities of their sub-recipients as necessary to ensure that the sub-award is used for authorized purposes in compliance with federal statute, Ryan White program legislative requirements, regulations and the terms and conditions of the sub-award and that the sub-award performance goals are achieved.

Recipients must ensure that recipients — that sub-recipients track appropriate use and report program income generated by these sub-awards and you must also ensure that sub-recipients expenditures adhere to legislative mandates regarding the distribution of funds. However we also understand the (unintelligible) of the AIDS Bureau the business of public health emergency and that some grant activities including site visits may be impacted by the COVID-19 emergency in your jurisdiction, and obviously that would impact your ability to meet grant requirements.

We strongly encourage you to talk with your project officer regarding alternative approaches to planned activities such as site visits and once the emergency has waned, we will work with you on the completion of those required activities. I'm going to now turn it over to (Kelsey) for our next question.

CAPT Mahyar Mofidi: Thanks Heather and good afternoon everyone. Our next question is on self-attestation. A recipient asks will Ryan White HIV/AIDS Program recipients be permitted to continue to use access stations in the fall for those

individuals who previously were provided with access stations during the re-enrollment this past spring.

The answer is HRSA has policy clarification known as 13-02, provides guidance and flexibility for Ryan White client certification and recertification including the ability to conduct these processes electronically and through self-access station.

PCN 13-02 does not require such processes occur in person although many recipients have imposed this as an additional requirement. In this time of public health emergency HRSA has continued to recommend flexibility in annual certification and recertification processes which support social distancing. This includes conducting these processes electronically and through self-access stations to protect the health of Ryan White clients and service providers.

We expect that recipients will ensure that all certification and recertification processes are conducted and documented within a reasonable timeframe. And as you know recipients and sub-recipients assume the risk of recouping any HRSA funds. HRSA Ryan White funds utilized for clients ultimately determined to be deemed eligible and in fair charge and ultimate payment source or otherwise ensure that funds are returned to HRSA Ryan White program. With that I'm going to turn it back over to Heather.

Heather Hauck: Great, thanks (unintelligible). Our next question is on the topic of six-month recertification for CARES Act funding so the COVID-19 related funding. A recipient asks can HAB respond if we are required to use six months recertification for services provided using CARES Act funding, again COVID funding.

If so, can we incorporate that into our existing eligibility processes or do we

need to have a separate process in place for that recertification for those services? And the answer is that under the FY 2020 CARES Act funding for Ryan White Program recipients the six-month recertification requirement is waived for those services providing using CARES Act or COVID funding. Now I'm going to turn it over to Chrissy Abrahms. (Chrissy)?

Chrissy Abrahms: Thank you Heather. So the last question is on the topic of (unintelligible) vehicle. Several recipients whether it is an allowable cost to purchase vehicles with CARES Act funding. Is there a special request necessary to use CARES Act funding for this purpose?

And the answer to this question is per the CARES Act Notice of Award which states funds may not be used by recipients or sub-contractors for the purchase of vehicles without written prior approval from HRSA's Division of Grants Management Operation or DGMO.

Recipients will need to submit a prior approval via EHB before the purchase of a vehicle using CARES Act funds. And thank you to that question to answer. That is the last question so we thank you to all of our recipients who have continued to submit questions to the HIV/AIDS Bureau question. Now we will move on to the next portion of our call, recipient spotlight.

So as a Division Director for the Division of Metropolitan HIV/AIDS Programs, I am excited to introduce our next presenter for our recipient spotlight presentation. First, we'll hear from Bill Blum and Dean Goodwin with the Ryan White Program Part A recipient in the San Francisco eligible metropolitan area. Bill Blum has been working in HIV since the late 1980s. He has been with the San Francisco Department of Public Health for more than 14 years and currently serves as both the Director of HIV Health Services as well as Director of Program for Primary Care.

Joining him Dean Goodwin who has been with the HIV Health Services in the San Francisco Department of Public Health for over 20 years. He first served in HHS as programmatic and budget analyst roles and has now served as Assistant Director for the past 11 years. So thank you for joining us Bill and Dean. I'll now turn the presentation over to you.

Bill Blum: Thank you. It's really a pleasure and an honor. Thank you to HAB for inviting us to share our experiences. I also want to also start with some acknowledgment. We are a small group of nine staff and actually fewer if you go by FTEs, and actually three of us were deployed as disaster service workers including yours truly.

So want to acknowledge one of our staff, (John Aim) (unintelligible) who worked tirelessly and their work to actually really I think help our HIV services as well, and also want to give a shout out to (Dean), the one who's joining me in this presentation who really always holds down the fort with the extra duty with our reduced staffing.

I'm struck by how much folks working HIV have been kind of called to help out with the COVID response. I think there's a future presentation to be had on that and I'm sure many of you listening or participating in this webinar have done that work so I want to thank you as well. We're going to be presenting fairly briefly.

We aired on the side of - and I'll give you more detailed slides, particularly in the first half which I'll be presenting. I will kind of touch on some of the highlights of each slide rather than reading them and then after the webinar if people have specific questions that weren't able to be answered to answer those offline. Next slide, please.

So then - I want to start by kind of showing you the situation of HIV in San Francisco. You can see here the total number of folks tested, the cases, the deaths, as well as the incidents of cases per 100,000. You can see kind of below on the fourth and fifth lines both Marin and San Mateo counties.

They are our sister counties which are part of our EMA. Marin is similar in size. San Mateo is a bit smaller - rather Marin is a bit smaller and San Mateo is the same size. We all function fairly autonomously and so they've had their experiences which I'm sure they'd also be happy to share with you. Next slide, please.

This is a daily situational report. What you have here is from last week. It's the way we kind of as a system, through EDOC we have an incident command system and this is kind of how we look at our ability to deal with an epidemic. You can kind of see at your far left the category of how we respond, the indicator that we're using, as well as kind of our current outcomes.

And I think you can kind of see where it's highlighted in red, is how we kind of sit except on the far column on the far right which is highlighted in kind of a bolder white. So in terms of where we are and kind of the high level, high alert areas, we have here - this is last week's data so we've actually gone down somewhat, although we're still on high alert in terms of hospitalization - we're about 23%, 24%.

And in terms of our disease situation, the number of new cases, we've actually kicked up to about 11. You can look at our test per day - this is on the disease situation and we're averaging close to that. Next slide, please.

I'm going to focus a little bit as I shared with you kind of what COVID looks

like in San Francisco. I want to focus a little bit on the kind of different demographics and also call out kind of some specifics in each of our groups because it does inform kind of our response.

So I'm going to start on the far right, you can see race, ethnicity data. You can probably - I should say that San Francisco is about around 30% - Latin lacks about 30% lighter Caucasian, about 30% Asian and about 6% African-Americans, 5.6%, and then other groupings making the rest of it.

So probably what's popping up for most folks is that the Latin population is kind of proportionately impacted in San Francisco. A couple of things to say about the Latin-ex population it is actually a more significantly younger, it's more significantly female, it has a higher number of people living in the household that is actually over five and it's about 1.5% over what one would expect if we were following purely demographics.

The white Caucasian population is about a half percent as expected and also, it's a higher incidence in women, as well as those that have hematological suppression other than HIV. Int terms of the Asian population, it's also lower, but much higher rates of hospitalization, and I'll show later depth and folks that are more likely to have a living disease, more chronic conditions.

And our black African-American population it is basically at the rate than what would be expected based on the population. It is more likely to be male living in single-room occupancy and also dealing with diabetes and other pre-existing conditions. And also interestingly more likely to be asymptomatic.

Finally, I want to draw your attention to the bottom right of the screen which is looking from the state of homelessness. About - this shows about 4% of the folks have been diagnosed with positive COVID positive are homeless. Our

extent is about 1% of our population - looks like 180,000 and we have something like 8,500 people that are kind of street-based or shelter homeless.

That said different methodologies -so likely to the extent if we were to have a similar measure. That several people are experiencing homelessness as measured by the EOC would be slightly less that holds probably some significance. Next slide, please.

I finally want to draw your attention this is looking at depth and what you can see here is that Asians by looking at the far right are far more likely to be at risk for death. We think that in part because it's a proportionately elder population, as well as living in a congregate living situation. So you know in nursing facilities and such. Next slide, please.

This is looking at in terms of our case investigation. We did a study to kind of look at you know, folks that were testing COVID positive and so you can kind of see what pops out here. It's really around the Latino population and the need for Spanish language services and also addressing the fact that people are more likely to be essential workers than to live in (routed) housing. So the next slide, please.

So this is kind of a groovy slide. It is showing San Francisco by neighborhood and so it's kind of the shade reflects the neighborhood itself. There are three things that I am going to call out which are not going to surprise anyone is the density of although we are the City by the Bay, we are pretty tightly packed in the neighborhoods.

Second, is income over $110,000 for a median-to-median income of a household and while we define what is an $83,000 a year for an individual will not surprise folks to learn that the vast majority of the folks you see don't come

anywhere meeting that. And then finally under-identification, San Francisco and Oakland got named in a very recent article to be among the areas most quickly gentrifying. So that kind of continues the pace here in the Bay Area. Next slide, please.

This is going to focus on the timeline of kind of how we responded and basically you'll see you know before we had a fairly low number of deaths compared to many folks and I would say in part that has to do with the fact that our mayor was kind of very proactive in terms of responding to the epidemic and you know we were quick to do shelter in place and to stand up and EOC and to do a response. I will say it's still very much a work in progress.

We've you know as our cases are beginning to drift up a bit, we are having kind of revised our Phase II. Our clinics, however, have reopened and we are seeing people for primary care visits. Next slide, please.

So I'm going to focus on a little bit on who just we are on HIV services and then we'll turn it over to (Dean) who can kind of tell you how our HIV/COVID specific response. We are community health services. We are a unit in primary care in the Department of Public Health. We are the grantee for all three counties. As you can see on the right-hand bottom side, Marin and San Mateo are the other counties that I've already mentioned we all operate fairly autonomously.

On the left side, you can see a kind of our total budget. I just want to draw your attention to a couple of things. One, we probably stand out in terms of the amount of the local general funded probably much larger than many other folks and mostly that's offset kind of reduction rewind to Part A that have happened over the last 15/20 years. We also, at the very bottom there, we have a local initiative getting to zero prior to VHE kind of funding being identified and so

additional funds are helping that work as well.

So like I would like to now turn it over to Dean who will talk about the response that we've done at the local level in HIV health services.

Dean Goodwin: Hi, everyone. So this first slide is presenting the HIV service position during the COVID-19 pandemic. So just a few bullets points for you all.

All of the HIV health services funded providers continue providing HIV clients services during the pandemic in some way. Clinical services and other services have been continued via telehealth or by phone. Clients who had urgent issues were seen in person at many primary care clinics throughout the pandemic. Dental services were basically only offered to those needing emergency dental care by our largest dental provider until frequently we started non-emergency services in the last few weeks.

Residential programs, of course, continue as previously. Other services continued by phone or via the internet. One of our largest providers of HIV home medical services noticed an increase in patients that were experiencing at this time, kind of an uptick in the engagement of homeless clients which we thought was interesting and worth sharing. Next slide, please.

And then this slide talks about affecting client impact and what HIV health services did during the pandemic, especially at the very beginning. We had - we were fielding a lot of questions like via email from providers because as you know, it is a very scary and chaotic time for a lot of us. We were very often sending out large scale email announcements and updates through our providers to keep them updated on everything regarding the shelter in place progressions, the steps, and directions involved in that.

Safety measures, updates on testing availability, just anything we thought would be helpful for providers and clients. We also sent out multiple short surveys. You know, we did not want to overwhelm people at the time when they were all very busy distracted.

But multiple surveys to kind of check the level of services for the clients, how they were being provided by each of our credit providers, what the stacking levels were like, the use of telehealth and phone services and if any adjustments were being made to health care services and the services and referrals and things like that.

We continued to have monthly meetings with our HIV aids provider network or (HAPPENS) which is a coalition of all of the COVID (GMA) based organizations here in San Francisco. These were getting services funding through us or financial funding for colleagues in HIV prevention.

And then also of course we continue to make remaining dates with our HIV community planning health so many of the messages will be sent to the planning council and to our providers. We were also sending to others to help pass the word out to our clients as well, especially who were (FOG) or frontline organizers. Next slide, please.

Determination of the allocation of the CARES funding. So we were very, very happy and very grateful to receive this money. It's been put to very good use here in San Francisco, as I'm sure it has across the country. We had a lot of discussions/feedback from our planning council support steering committee. They were the only body of our planning council to meet during the month of April and then in May. The general membership and all the standing committees resumed.

But in April, we engaged with them and got a lot of feedback from them as far as ideas, priorities, and suggestions. We also got some direct feedback on the impact and unexpected COVID related expenses like many providers which kind of led us to develop a budget survey early on to gauge how these CEOs were impacted in the early stages of COVID which was unexpected and unplanned for expenses.

So these frequently cited expenses were PPE which you all know was a) very difficult to find and b) very, very expensive especially in the very beginning. Plexiglass barriers, signage - anything to help with keeping safe distancing and social distancing. Cleaning supplies, materials, extra security, hazard pay, etc. and especially IT costs for telecommuting and telehealth.

I just want to let you know that not all of our CEO's earned profits requested or required in any of this care funding. But the majority of them did. Next slide, please.

This next slide just shows how the funding that we received in CARES, funding in how we just sorted divided between two interests. So overall for the three (ME) counties, you'll see at the top half of the slide, they received a little over $488,000. The shared in San Francisco, and each county based on our 85% of the cases in the three counties, was $413,458. Above that, we negotiated about 48% for a little over $198,000 for those COVID expenses that I talked about on the previous slide that were communicated to us by providers through that budget survey.

And then another - and then 52% of that CARES funding was used spending essential services particularly to meet the increased needs to security and emergency financial assistance for those clients being impacted by the general downturn during the emergency and we also had some certified emergency

house and client incentive vouchers were in very high demand.

And then, you know the bottom half of the slide here we're kind of demonstrated what some of those COVID-related expenses were. Next slide, please.

So I just wanted to share the HIV COVID-19 client impact in a few notes here. Some really good news from what we were really happy to hear over time and surprised by the incidence, morbidity, and mortality of COVID on HIV positive clients was less than we feared and what all our providers locally had feared even among long-term survivors and those experiencing homelessness and hopefully you all have seen the same trends.

Data thus far seems to be indicating that HIV, ART may be providing some protection. And COVID-19 which was discussed recently in the AIDS 2020 content story which we see some of that. And then another note to share many of our clients, but not all seem to be adapting very well to these challenges and are responding well overall - many, but now all. This has been recorded back to us by our providers and is also what we've seen by the consumers on our local planning council we've been interacting over the last few months. Next slide.

Next to - the last slide, I just want to thank you for your time and I wanted to share some of our information from the email.

CAPT Mahyar Mofidi: Thank you so much Bill and Dean for that great presentation. Next, we're really looking forward to hearing from a community-based provider. Dr. Nicholas Van Sickles is from the Ryan White HIV/AIDS Program Parts C and D, recipient CrescentCare in New Orleans, Louisiana.

Dr. Van Sickles is a chief medical officer at Crescent Care and he will shine the

spotlight on some innovative HIV care activities that Crescent Care has undertaken and responds to the COVID-19 pandemic. Thank you so much for joining us today, Dr. Van Sickles to reflect with us some of your experience in response to the COVID-19 pandemic

Nicholas Van Sickles: Sure. Thank you all so much for having me. I just want to make sure that you can hear me. It looks like it's transcribing, so yes.

So yes, I'm the Chief Medical Officer at Crescent Care. We are a federally qualified health center here in New Orleans and we are also an HIV service provider to the community here along with many other viable programs in the City. So what I'm going to do today is go through kind of our transformation in the last few months.

We have set up a pretty robust COVID casting program here at our health center and I'll discuss some of our telehealth innovations and just our story about that as I'm sure many of you can relate to the kind of struggle and sometimes successes of setting up a telehealth program in short order time, as well as where we are with our tracking numbers and how some of our HIV-related innovations digital rapid start program and our rapid re-entry program have been affected.

I want to pause as I said, I do have one error in the numbers in the slide that I'll go over verbally that are incorrect. So the next slide, please.

So just kind of an overview of where we are in New Orleans, we were one of the cities that were hardest hit by the pandemic in April and if you look at the graph and the New York Times had a nice pictorial of the different states and New Orleans and actually Louisiana is actually that - is looking like it's having a second peak unlike other states, the curve is declining. The state did never have

a peak until now. We, unfortunately, are in dread of another peak which is very unfortunate and distressing.

But we were hardest hit really in April. Our hospitals in New Orleans were getting overwhelmed and it was very difficult. We here at Crescent Care during COVID-19 our coronavirus testing, in March - we were plagued by the same issues that everyone across the country was seeing such as lack of testing supplies, long turnaround times. We only tested based on symptoms and I'll kind of go through that and our timeline there.

IN terms of our agency, we really tried to move almost everybody out by March 16th, it took a little bit of time because of internet issues at home and trying to get our workforce mainly at home and we moved pretty quickly to an all telehealth platform by March 20th. We did have a small risk of conditions, where we bring people in.

We've since had to modify that of course as the pandemic has gone on, we've seen more cases and you know more people were having to be seen in the clinic and I'll talk more about our blood pressure program and how we're trying to mitigate some of that with home devices, but it's not the perfect solution.

The telehealth platform and moving it to moving that quickly was also very much enabled by the fact that we are fortunately going to be in a Medicaid expansion state and we are also a state that the Medicaid program did expand their payment to (FPHC) specifically for audio-only visits. So we were very fortunate I do want to say, it wasn't just us, it was the system here in our state. I want to give them some credit for helping us be able to do this and make it more sustainable.

We held labs for about three weeks, we've been given lab visits, while we were

trying to figure out how to do it as safely as possible. It started back on the 13th of April and expanded services at all of our sites by May 20th. We still have this to some extent although we've expanded it a little a bit. We had a provider of the day for urgent visits like FTI treatments, occasionally with our rapid starts, our rapid re-entries were actually doing audio-visual or over the phone.

And in our day-to-day structure we are limiting people in the building and right now, I told everybody, everybody wants an office, now you have an office. So everybody has their own room and we're keeping as far apart as possible. We really don't want people crowding or spending more than a couple of minutes gathering and it's a very small crowd of people, a small number of people in our buildings right now.

We also implemented a reentry committee. This has been a very big success for us at our agency at least because it's kind of like our patient care, but more for staff who wanted to come back into the building - a way for us to kind of think through it, regulate who comes in, make sure it's safe for them to come in, make sure that we can act quickly if cases are on the rise, which they are now, so we've actually paused our reentry committee at the moment - paused our reentry of anyone coming into the building as cases are surging here in the State of Louisiana.

And New Orleans is not as heavily hit, but our numbers are still increasing -we're very worried. Next slide, please.

So in terms of Telehealth, this is one I talked to (Amy) and we'll talk a little bit more about so we kind of looked at the day-to-day issues and I'll tell what we've seen, who we've seen, the numbers we've seen and how we've dealt with this. And I would love to hear from other (Ryan White) providers you know innovation and thoughts.

The biggest issues of course and was in New Orleans is the digital divide between us and our patients and not everybody has high-speed internet. Even if they do have internet, you know when we do these television, audio-visual needs they'll time out or the internet will go down or it will get a delay or lag or something goes on. So that was a big challenge for us and again we're very fortunate to have the Medicaid program in Louisiana that support audio-only visits that we know that's now going to continue forever.

Also first ask if they were at home and they didn't have sufficient internet at home, we wanted to provide options for them to work from home, able to help them work from home or find spaces in our building very separated from others where they could just use the internet and use that space to do televisits or chart graphics for the nurses or callbacks, things like that. So they had a safe space to work with a good high-speed internet.

For infrastructure, our EMR and I'm not trying to bash our EMR, but we do use it in clinical work. It is a little bit of a challenge on the patient side and even for us when we try to go through it with the patient where you link to an audio-video visit, is it does take several steps and it took a little while for us to learn it enough to coach the patients and then also make sure that it had the internet bandwidth to be able to connect on those platforms.

We have explored using softphones for our programs and our nurses who are working at home to make a call without having to use their personal cell phone number and we're still looking at third-party solutions like (Docfinity) for example to have a second platform that's a little bit easier than EMR but EMR keeps promising us some innovations which hopefully will come because it's obviously easier to have it in EMR.

A couple of big things that we had to think through was that we shut off all of our reminder calls and text messages which is a great retention effort for us to make sure patients get reminders, texts to come into the clinic. And of course, we didn't want them to come into clinic and our EMR was the reminders was all driven by the visit types.

We had to overhaul all of the visit types which took quite a bit of work and manual labor to fix all of them. And that's been fixed now and now we're able to tell people no, we're going to call you for a visit and send them a text and they expect a phone call or they're going to have an audio-visual visit, to get ready and check their email for a link or that they're going to come in especially if we need to see.

There's quite a bit of work, but I think it's worth it and we can track the visits much better. And on the financial side, the reimbursement like I said we've been really lucky but I don't know how long that will last and CMS has been able to let us bill for audio visits through a virtual check-in it's called.

Again, we don't know how long that will last and we're trying to think through with different solutions such as devices to the community for Medicare beneficiaries or others who might need them to be able to engage in audio-visual visits and we can't do in-person visits.

And then the billing and coding is challenging on the provider's side just because already providers we struggle sometimes with billing and coding it's not one of our areas that we're trained on in nursing school or T school or PA school or medical school. So trying to navigate that in an engaging atmosphere was something very difficult for us and it's something we're having to do on an ongoing basis.

We have provider meetings, almost every week to kind of update us on billing or other things that need to move quickly and change on and pivot very fast and make real-time decisions.

In terms of our numbers, I think Dr. (Shafer) had mentioned some of the (show) rates and people reporting higher (show) rates. So we've been doing the same thing. So I looked at our just our B20 diagnosis, the HIV diagnosis, and looked at the visits that we had providers who are predominately seeing people on cases of HIV across audio, audio-visual, and in-person visits.

We've scheduled about 4800 and we saw almost 3800. Our show rate was about 78% which is higher than our previous showing of closer to 70% before the pandemic doing audio-visual and audio visits and this is just for HIV, not across the spectrum. And across the spectrum, it's actually closer 82%, 83%. So we've certainly seen a higher show rate using the audio especially platform.

In terms of what we've completed, we've done about 500 audio-visual visits since about March 10th. The audio and in-person visits composed the rest before we switched our visit types. Unfortunately, I don't have - I only have parts of the data but we are predominately proud of our audio-only which we are currently working to figure out how we can optimize that. As we know that the billing sets is not going to be sustainable and we don't anticipate it to being that way.

But like I said, we have had an increase in retention or rather show rates for these visits which has been quite nice I think on our part. Next slide, please.

In terms of care for HIV, we want to talk a little bit about our programs that we have been really keeping and we were about to enter into a new phase of retention program of course the pandemic hit and that kind of hit out. But I

wanted to touch on a little bit about our rapid start and our rapid reentry program. So we've seen actually quite a bit of patients over the last couple of months for both visit types, both rapid start and rapid re-entry.

There certainly was a decline at the beginning of the pandemic, but going across March, April, May, June we saw about five months of rapid starts which is about half to a third of what we normally saw, but still a pretty impressive considering there's not a lot of widespread, there wasn't a lot of widespread testing. There still isn't a lot of widespread testing for HIV in the City like there was before the pandemic. It had picked up again and we are doing targeted testing again but not to the extent we were before.

In terms of our rapid reentry, we actually saw anywhere from 10 to almost 20 patients per month who are out of meds coming for their reentry and care and these are people who have been out of care for at least nine months, or were transferring and not with any medications.

So we were able to get them in within 72 hours and we are doing those actually - the rapid starts we've been mainly bringing them in in-person just because of the need to get them in many cases physical medications. Our rapid start program we do give a 70-day supply of (Hefty C) and (nototagravere) and so it's advantageous to bring them in the building but right now our infection control measures in the building are much safer so we feel better about that. Rapid Reentry, we are generally doing if they have Medicaid active or other - another payer active that will pay for their antivirals.

We are doing the first visit over the phone. It is a little bit uncomfortable. I won't lie to you. And most of our new patient visits we are doing over the phone are audio/visual and then we bring them in afterward.

We're trying to figure out the best way to ensure transportation and other measures, specifically safety. But we have seen quite a bit, so in total about 80 visits over Rapid Start and Rapid Reentry, so lower than we usually are, but still good to keep going and we want to improve this program.

Our biggest challenge and our biggest fear is even though I said our show rate has been perhaps better, we haven't drilled down as much as we should in terms of retention and lost to care and that's something we're slowly picking back up on.

We had a project, we worked with UAB. They were very kind to us to help us look at one of their dashboards for retention in care and we were -- before the pandemic -- working on getting that developed and we've just restarted that work. It did get quite a bit delayed.

A lot of it was just due to the fact that we've - we shifted a lot of people to work in COVID testing. Next slide, please. And actually, I'll go through this quickly, but then I'll -- I want to go to the next slide. I'll kind of go through some of our numbers.

So, we started COVID testing on March 10. We were very -- at that time we went off the symptoms that people were most attributing to Covid-19 at that time which were fever, shortness of breath, cough. We added sore throat.

We started adding more and more as we saw more GI symptoms, more, you know, even conjunctivitis, loss of sense of smell and taste, things like that. So we extended on April 13 to any symptoms. So really anything.

And then actually on June 9, we expanded to really anyone, contacts, people -- a lot of people needed it to go back to work. Here in New Orleans, their job

required it.

A lot of people needed it for various surgeries and the hospitals hadn't set it up as well as they have now, which they have now set it up very nicely. We started testing children.

Our city has done a really good job doing testing throughout the city - different pop-up sites - they're doing, especially in hot spots and various demographics like New Orleans East or the West bank.

But they weren't testing children, so we talked to them and they thought it would be advantageous for us to start testing children, so we have been testing children as well for the last month and ten days or so. And that number is the one that is wrong.

We've actually tested almost 5,000 -- actually over 5,000 people since March 10. Next slide, please. So I'll tell you a little bit of how we started. So we started with -- if you look at this picture on the left, we had a caravan that was donated to us from the Elizabeth Taylor Foundation right after Katrina when our city was especially hard hit by that hurricane.

And we had that set up. And we still use it for testing. We repurposed it actually to start doing COVID testing back in March. It was fine. It worked okay. It was good for a low volume. And it was fine. I'll just say that.

It did have air conditioning, which is nice. The van only has two rooms, which from an infection control standpoint was a little bit difficult to manage as our volume grew.

And over the month of April and into May, we did notice we were going from

15 to 20 people a day to 20 to 30 people a day that were coming in for testing.

Over the course of June, that increased to 100 people a day. And now we are seeing routinely about 200 people a day who are coming in for testing. So the van over those several months, obviously could not handle that kind of capacity.

So we were able to secure some donations and funds and use some of the funds we've gotten from Hertz and other grants to secure several tents. So we have three tents now. We have an outdoor waiting room.

We -- our building is on the second and third floor as is the typical structure for New Orleans. You want to prevent flooding, so most of our building is up high. So we use our garage to do the testing. We have three tents.

They both have -- they all have portable air conditioning units in them. We've had to install fans in our garage. As you can imagine, in New Orleans, in July, it is quite hot. And that PPE you see our lovely doctors and nurses in, is also quite hot.

And so we have multiple fans going. And we have breaks for them to get - N95 mask - breaks especially since we're seeing so many people now coming in for testing. We've also changed our testing hours.

We, you know, we are open to the community. We as a community health center felt strongly that we couldn't just do testing on our own patients, so that is not any judgment to centers that are doing that.

I think, you know, there's logistics that went into this that we are fortunate to have and we also have several ID doctors who helped put this together. But we

have changed our hours to where we're open to the community from 9:00 a.m. to 2:00 p.m. and those are our hours and we kind of cap it based on wait time.

So if the wait time goes, you know, an hour to get a test, which we don't like, then we would stop taking new patients at 1:00 p.m. We've kept the 2:00 p.m. to 4:00 p.m. hours for our established patients and our staff.

And that way we schedule them and they can come in and get tested as well if they're having symptoms or if they have an exposure or any other reason. So like I said, to date we have tested almost - actually over, by this point, 5,000 people.

Our last daily report was from the 18th, so we surpassed that by this date. We've had over 1,000 people test positive for Covid-19. We are currently seeing an unfortunate lag in our testing results as is the case for most of the country. It's taking about seven to eight days.

We generally use LabCorp. We do have a rapid testing machine we got from the State at the beginning of the pandemic. The Abbot machine, which as many of you know, has some issues in terms of sensitivity.

We can't use it very often. Really, I mean we use it for our staff because it takes about 30 minutes and we can only run one test at a time. So for high volume, it's not very good. But yes. We tested over 5,000 people.

Again, the testing lag is there. In terms of kids, one thing that was interesting - so we've only tested so far - and it's picking up now as some camps - day camps for the summer opened up.

We've tested over 159 children, the majority of whom did not have symptoms.

103 did not have symptoms, 56 did. And our overall positivity rate in kids who were symptomatic was 15% and asymptomatic kids was 8.7%.

So, interesting because we hadn't done a lot of kids' data here in New Orleans. The other thing we've been looking at are demographics.

Around week seven, we started doing -- or actually week six -- we started doing targeted advertising on Latinx radio stations here in New Orleans as well as some outreach, specifically in the African American community.

And we started seeing increases in numbers in those demographics. Unfortunately, they kind of peaked around week seven/eight, then started declining and we've seen an unfortunate increase especially in Latinx community coming to our health center.

The good news is we're -- they are coming here. You know, we are a health center. We don't have any federal oversight or guidance in terms of, you know, troops or National Guard or anything at our site, so it is a safe place, but we are seeing a peak in our community in the Latinx community and we have communicated that to the Health Department because they are doing targeted testing at pop-ups.

The last thing I want to talk about -- I know I'm probably at time. We did look at - in one of our newer innovations for our primary care but also for the care of everybody given hypertension and heart disease is such a risk factor for Covid-19 for worsened - worsening outcomes specifically heart disease at least.

We did get some grants from Children's Health Fund and from PEC through United Way to do a blood pressure and device program and we've done - so far, we've given out 50 blood pressure cuffs and are doing telehealth visits and

medical monitoring for people with hypertension, you know, across all the primary care spectra to try and really reach out as people are home and we're able to contact them mainly through phone and telehealth.

And we're looking now to expand that in other ways, such as diabetes care as well and asthma. So, I'll stop there. Thank you all so much for your time. I know I'm kind of at the limit of time, so I'll stop there.

If there's any questions, please feel free to contact me. Thank you so much for having us.

Dr. Laura Cheever: Great. Thanks so much Nick and to Bill and Dean for those great presentations. It's really - it's so exciting to hear about what's actually going on in the field and some of the great successes and innovations that you all have been able to make happen in both San Francisco and New Orleans in response to the Covid-19.

I also want to remind everyone that we have several key resources that are continuously being updated. There are at least one question in the chat box, I'm like, "Oh, we just put up that FAQ on our site."

So I really encourage you to look there. We know we have several other questions that we couldn't get to today and we do have our FAQ web page. It's up there first. It has a new look and feel and a searchable format and a little "new" in red that tells you where the new information is.

So please look. It's updated almost daily and we will continue to update it based on some of the questions we got here today. There are also some other websites here that I would encourage you to look at. Next. Good. Thank you.

Please mark your calendar. We have less than three weeks until our 2020 National Ryan White Conference and our next HABYou Heard webinar will take place in mid-September, so please be on the lookout for that date.

And finally, as we conclude, I just want to thank you so much again for attending the HAB You Heard webinar and remind everybody to please continue to take care of yourself, your families, your patients, and your -- as you take care of everybody - everyone else to please take some time out for yourself.

I hope that you and your families are staying as safe and healthy this summer and are having some opportunities to do something fun.

So please take care as you continue to do the vital work in your communities. Thanks very much. Thanks for sticking with us. We'll see you at the conference. Bye-bye.

Operator: Thank you. And that concludes today's conference. You may all disconnect at this time.

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