HRSA's HAB You Heard Webinar

September 22, 2020
3:00-4:00 PM ET

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

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

I'm Laura Cheever, the Associate Administrator of the HIV/AIDS Bureau, the HAB in HAB You Heard. And I'm joined today by HRSA's Administrator, Tom Engels; Antigone Dempsey, the Director of HAB's Division of Policy and Data; Heather Hauck, Deputy Associate Administrator of HAB; Melinda Tinsley, one of the 2020 National Ryan White Conference Co-Chairs and Senior Public Health Analyst in the Division of Policy and Data; Captain Mahyar Mofidi, Director of HAB's Division of Community HIV/AIDS Programs; and Chrissy Abrahms-Woodland, Director of HAB's Division of Metropolitan HIV/AIDS Program. We're so glad you could join us for this afternoon's webinar.

Next. It says share my screen, so we've lost the slides. In terms of the agenda, we once again have a full agenda with you today, including a COVID-2019 update on the topic of eligibility and recertification. Next slide. Really based on information we requested we've had from you; highlights of

HAB's new COVID-19 program letter; discussion of the FY 2020 CARES Act funding draw down; and virtual site visits. And for HAB updates, we'll include several Ending the HIV Epidemic Initiative updates.

In addition, we're excited to have two presentations today. Joining us is the Ryan White Program Part A recipient from the Atlanta EMA and the Ryan White Program Parts C and D recipient for West Virginia University, Positive Health Clinic in Morgantown, West Virginia. Next slide.

As many of you know, it's been an exciting month for the Ryan White HIV/AIDS Program. For the last few weeks folks had the opportunity to highlight the incredible work of our Ryan White Program recipients at both our 2020 National Ryan White Conference and on the critical progress our program has made over the past three decades, during our 30th anniversary on August 18th.

Joining us this afternoon to share a few words, is HRSA's Administrator, Tom Engels. Tom, thank you so much for being here today.

Tom Engels: Thank you, Laura. And I just want to check, can everybody hear me okay?

Dr. Laura Cheever: Yes.

Tom Engels: Okay. Well thank you, Dr. Cheever. And good afternoon everyone. I'm pleased to join you today for the HAB You Heard webinar. I appreciate the opportunity to speak with you again. We know that this year has brought many challenges and I want to take a moment to say thank you for your continued dedication to meeting those challenges.

The efforts of our grant recipients and stakeholders have been truly inspiring. As the novel Coronavirus and COVID-19 illness has affected our lives, communities, friends, patients, and loved ones, we fully recognize the extraordinary impact this public health crisis has had on grant recipients and organizations that are important partners with HRSA.

HRSA continues its commitment to our programs and grant recipients. All while playing an important role in the response to the COVID-19 pandemic. At this time, more than ever, we understand the critical role that we and you, our partners, play in improving healthcare to people with HIV.

Last month on August 18th, HRSA honored the 30th anniversary of the historic legislation that created the Ryan White HIV/AIDS program. As many of you know, the Ryan White Comprehensive AIDS Resources Emergency Act, also known as the CARE Act, created this vital program which is the largest federal program that focuses uniquely on providing HIV care and treatment services to low income people with HIV.

Today this program serves more than a half million people each year and continues to be the cornerstone of public health response to HIV in the United States. The anniversary theme is 30 years of innovating care, optimizing public health, ending the HIV epidemic.

I ha the privilege to watch this theme come to life last month, with all of you, during the virtual 2020 National Ryan White HIV conference, HIV care and treatment. I was and continue to be in awe of the work that this program has accomplished over the last three decades. As you know, last year the administration announced Ending the HIV Epidemic, A Plan for America, a ten year initiative to reduce new HIV infections to fewer than 3,000 cases a year by the year 2030.

The initiative is focusing efforts on 48 counties, Washington, DC, San Juan, Puerto Rico where more than 50% of the HIV/AIDS or HIV diagnoses occurred in 2016 and 2017. As well an additional seven states with substantial number of HIV diagnoses in rural areas. For three decades, HRSA's Ryan White HIV/AIDS Program has played a critical role in the United States' response to ending the HIV epidemic.

Through HRSA's Ryan White HIV/AIDS Program and the HRSA-funded health center program, the agency is playing a leading role in helping to diagnose, treat, prevent and respond to end the HIV epidemic in the United States. During this pivotal moment for the Ryan White HIV/AIDS Program, grant recipients and providers continue to demonstrate your dedication to improving the lives of people with HIV, by serving on the front lines, supporting clients and communities who are among the most vulnerable populations.

And moving forward, HRSA is dedicated to continuing its commitment to addressing health disparities in underserved communities to ensuring access to the retention of high quality integrated care and treatment services for all people with HIV as we advance our role in the administration's Ending the HIV Epidemic Initiative.

Thank you for the work you continue to do and the opportunity to speak with all of you today.

Dr. Laura Cheever: Great. Thanks so much, Tom. We really appreciate your ongoing support for the program and your participation today. Next…

Tom Engels: Thank you, Laura.

Dr. Laura Cheever: Yes, thank you. Next, it's been a busy summer for the HIV/AIDS Bureau and I want to share a number of COVID-related updates with you as we continue to navigate this unprecedented public health emergency. To begin with, I'd like to turn it over to Antigone Dempsey, Division Director for Policy and Data, who will provide certifications on eligibility and recertification. Antigone?

Antigone Dempsey: Yes. Thanks, Laura. So the next few slides present a revised FAQ on the topic of eligibility and recertification. This response is now available on the HAB COVID-19 FAQ page at the link at the bottom of this slide. And these slides - again, these slides will be made available after today's call.

I won't take time to read this to you word by word, but I want to take a few moments to talk about eligibility determinations and six month recertification because I know this is an issue for so many recipients and subrecipients that you all have been struggling with around COVID-19.

So HAB does not have the authority to alter or waive statutory requirements for the Ryan White HIV/AIDS Program at this time. But however, we want to point out that there are many flexibilities that currently exist in the HAB policy.

And that recipients can put - recipients can put into effect, to maintain social distancing and requirements related to this in their jurisdictions. And these also reduce administrative burden for providers and clients, while ensuring Ryan White remains the payer of last resort.

We have received a lot of questions from recipients about these requirements and many of you have requested flexibilities to the circumstances that you're

all facing around COVID-19. But we want to point out that many of these flexibilities currently exist. So next slide.

So we recognize that COVID-19 pandemic has dramatically altered how we do things. And we want to emphasize that there are these existing flexibilities, and encourage you to implement them if you haven't already. And so on this slide you can see a number of bullet points that really go over practices that are not required per PCN 13-02. And we have these listed because we've been getting questions about these that people think that they are requirements but they actually aren't.

And during our recipient spotlight today we'll hear from one Ryan White HIV/AIDS Program Part A recipient on how they've been able to maximize flexibilities. Next slide. So this is a continuation of the response to the questions, you know, what are HRSA HAB's requirements regarding eligibility and certification for Ryan White during this epidemic.

And so this is in the FAQ. And we really want to encourage you to reassess your organization's processes and procedures with keeping in mind the existing flexibilities that have - that do exist. And in the next few slides Dr. Cheever is going to go into a little bit more detail about the eligibility and recertification requirement sand some common practices that are actually not required by HAB but some people have - do think are required but are not.

So Dr. Cheever, I'll hand it back over to you.

Dr. Laura Cheever: This - thanks, Antigone. The eligibility and recertification processes are necessary to ensure that Ryan White remains the payer of last resort. And as many of you are aware, the eligibility for the Ryan White program, clients must have HIV, be low income and be residents of the service area.

Recipients are allowed to further refine their eligibility standards but they're not - but they may not expand eligibility beyond these elements.

Recipients define what is low income, HAB does not. Recently recipients used percentage of federal poverty level or FPL, to define low income in their area. Next slide. This table lays out eligibility elements that require documentation as described in HRSA HAB PCN 13-02.

It should be noted, HAB has identified the elements to be documented during eligibility and recertification processes. HAB leaves it up to the recipients to determine what constitutes documentation of each element. Remember, to be eligible for Ryan White HIV/AIDS Program service a client must meet three requirements - living with HIV is the first.

You will note that documentation of HIV status is only necessary upon determination of initial eligibility as we know that will not change. So HAB does not require further documentation of HIV status once it's been determined. Furthermore, if a client has evidence of a positive HIV test in an electronic health record, in person verification of HIV status is not required even for initial eligibility.

For the purposes of eligibility, HAB does not at any point, require documentation of CD4 or viral load. We know many recipients may require documentation as part of their Ryan White Program for good reason, however it's not a requirement for eligibility determination or recertification purposes. These may be necessary for other aspects of the Ryan White Program such as client level reporting, but it shouldn't impede a client's access to care.

Remember, low income is the second part of eligibility for the Ryan White Program. As I just explained, it's up to the recipient to determine what

constitutes low income. Because it's an essential component of eligibility, recipients and subrecipients will need to document this element of eligibility.

Six month recertification only requires recipients and subrecipients to document income if the client's income changes their eligibility for Ryan White. HRSA HAB's PCN 13-02 does not require documentation of every change in client income. Only income changes that result in a person with HIV being eligible or ineligible, must be documented for six months recertification.

Eligibility and recertification processes are necessary to ensure payer of last resort. As such, insurance status is required to document the initial eligibility. If a client's insurance status changes, for example, if they go from having no healthcare coverage to receiving Medicaid coverage, it would need to be documented as the client has a payer source for at least some of their Ryan White services. Next slide.

The last slide looks at elements of eligibility that require documentation. You will see here some of the common procedures that recipients may use to collect documentation necessary to demonstrate a client's eligibility for the Ryan White Program. You will see many of these are not required means by which recipients and subrecipients must demonstrate a client's eligibility or that the Ryan White Program is payer of last resort.

The use of in person procedures, is not required. There are good reasons why recipients may require in person interaction but the HRSA HAB PCN 13-02 does not require it. PCN 13-02 also allows for self-attestation. This is the flexibility that recipients may choose to implement. And we encourage all recipients to implement self-attestation.

PCN 13-02 does not require that self-attestation have handwritten signatures, nor does it require that self-attestation be notarized. In fact, as I just stated, self-attestation doesn't need to even happen in person. Many recipients view electronic (unintelligible) communications as a means of self-attestation. As on the last slide, you are not required to document every change of income at six months recertification. Only those changes that result in a change of a client status for Ryan White eligibility need to be documented.

Self- attestation is a common practice in healthcare settings where recipients - where a provider's office staff asks patients if there is any change in address for insurance. The purpose of self-attestation is principally the same for Ryan White, to ensure that the payer of service - that the payer for the service - that there is a payer for the services rendered.

It is feasible for Ryan White recipients to develop processes that maximize a client's ability to self-attest, but do not change - I'm sorry. It is feasible for Ryan White recipients to develop processes to maximize a client's ability to self-attest that there is no change in eligibility.

Rapid eligibility determination allows recipients some flexibility in the timbre during which a client must provide the needed documentation for Ryan White eligibility. HRSA HAB PCN 13-02 states that although recipients may determine a reasonable timeframe during the eligibility and recertification can be documented. Some of you may recall there's a grace period.

This reasonable timeframe is an important flexibility that can make the difference in keeping a client engaged in care, taking their medicine and staying healthy. HRSA HAB PCN 13-02 does not require recipients or subrecipients to stop clients receiving services because they did not provide documentation exactly on time. Next slide.

So to sum up, your eligibility and recertification policies and procedures are necessary to identify other possible payers for services provided by the Ryan White eligible client. As is the case for other statutory requirements, Ryan White recipients and subrecipients assume risk in ensuring those requirements are met. Specifically, for payer of last resort, recipients and subrecipients assume the risks associated with not meeting the statutory requirements.

Your policies and procedures may be able to help mitigate some of that risk, which is to say in the event Ryan White services are provided to clients ultimately determined to be ineligible for those services, it's incumbent on the Ryan White recipient or subrecipient to ensure that those funds are returned into the Ryan White program.

We know the implementation of eligibly and recertification is not always simple or easy. We hope it is helpful for all of you - this is helpful for all of you as you continue to provide services to your Ryan White clients. If you have additional questions please reach out to your project officer. I'll now turn it back over to Antigone.

Antigone Dempsey: Okay. Thanks, Laura. So our next item is a follow up to the June 2020 HAB You Heard. Last week we released a program letter on the COVID-19 public health emergency, which is now available on our HAB Web site on the policy notice and program letter Web page. Because the HIV/AIDS Bureau is aware of the impact of COVID-19 the public health administration has had on recipient and subrecipient operations and workflows, we wanted to provide some information on how to think about documenting that.

During the COVID-19 recipients and subrecipients have used the best information available at the time, to make difficult decisions about the

delivery of service that folks are providing and the safety of staff. So some of the common changes that we've heard about include fewer routine well care medical visits initially, especially in the early months of this; implementing tele-health medical visits over face to face clinic visits; and postponing routine labs. Next slide.

So in order for recipients and subrecipients and HAB to better document and understand the impacts of these changes, we're asking recipients to consider the following actions - the first item is related to performance measure data. First, recipients - we're asking that recipients document the changes that they've made to operations and workflows as these changes may have an effect on performance measures.

Next, we're asking recipients to take into account changes of service delivery and performance measures as they set performance thresholds or payment models based on measures that were set prior to COVID-19. Also, we're asking folks to document the impact that COVID-19 has had on health outcomes, such as changes in clients' behavioral health needs and other health needs.

So finally, please continue to follow the Department of Health and Human Services' guidelines including related to the antiretroviral human and COVID-19 guidelines. Next slide. This letter also provides the number of uses for the CARES Act funds during the COVID-19 public health emergency.

And on this slide I want to highlight the importance of screening and address the client needs that have emerged related to COVID-19. We have all heard about clients, especially older adults, experiencing new or exacerbating mental health and substance use needs. All members of the healthcare team,

physicians, medical case managers, and medical assistants can be a part of this process, to screen and address such client needs.

We've encouraged recipients to think about how they can use their CARES Act funds to address these emerging medical and psychosocial needs. Next slide. So it's important for recipients to review and monitor trend performance measures data during this time, in order to understand the effect of the changes that you all have made during this public health emergency, and determine additional actions that we'll all need to take.

Finally, I want to remind folks that we have staff in the HIV/AIDS Bureau that provide wonderful clinical quality management technical assistance. You can contact them at the email that's listed here, with any questions that you have about clinical quality management. I'll turn it back over to Dr. Cheever.

Dr. Laura Cheever: Thanks, Antigone. I also want to briefly comment on the FY 2020 CARES Act funding and the importance of drawing down funds. HAB really encourages all the recipients of the CARES Act funding to continue to draw down funding in a timely manner. During upcoming monitoring calls your project officer is going to highlight this as a topic for discussion. And please if you're having any problems or technical issues with drawing down your funds, please talk to your project officer. Thanks so much. Next slide.

Next I want to share an update on virtual site visits. As you know, comprehensive site visits are really a crucial part of oversight monitoring of grants and helps provide an opportunity for technical assistance. However, given the importance of all of your work in the state, local and national response to COVID, as well as CDC guidance, HAB is going to put some all onsite site visit plans through December 31, 2020.

Since also during the COVID pandemic we've significantly restricted travel, HAB has conducted nine virtual site visits and one comprehensive site visit in the last few months. The virtual comprehensive site visit that we've provided, follows the same format and covers the same topics as the in person site visits. And technical support is provided by HAB staff and contractors.

The Bureau plans to continue virtual comprehensive site visits for FY '21 and we want to get your feedback as we go along, to make them as streamlined and as productive as possible, as both you and we learn how to best use this new format. Next slide. Now I'd like to turn it over to Heather Hauck, HAB Deputy Associate Administrator, for some HAB updates.

Heather Hauck: All right. Thank you, Dr. Cheever. I wanted to begin with some exciting new initiatives that HAB funded earlier this month, in support of Ending the HIV Epidemic Initiative. And we can go to the next slide when they're back up. So the Minority HIV/AIDS fund also known as MHAF, helped us fund an initiative called Reducing Stigma at Systems, Organizational, and Individual Client Levels in the Ryan White HIV/AIDS Program.

This cooperative agreement was awarded to (MMAC) as a four year project. The second project is again, a MHAF supported project called Building Capacity to Implement Rapid ART Start for Improved Care Engagement in the Program, evaluation and technical assistance provider. This was awarded to the University of California San Francisco. And that will help support 15 demonstration sites.

The third project, also MHAF supported, is improving care and treatment coordination focusing on Black women with HIV. This is an evaluation and technical assistance provider cooperative agreement which was awarded to the Universality of Massachusetts and will help support 12 demonstration sites.

All of these initiatives began on September 1st. In addition, we also awarded the Enhancing Engagement of People with HIV through Organizational Capacity Development and Leadership Training Program, which was awarded to (NMAC) and this is a four year cooperative agreement that will launch ELEVATE, which stands for Engaged Leadership through Employment Validation and Advancing Transformation and Equity for people living with HIV. Next slide, please.

In terms of other EHE engagement, we wanted to quickly update you on our community engagement plans. So as many of you know, in 2019 the HIV/AIDS Bureau visited 23 Ending the HIV Epidemic Initiative jurisdictions. And we really appreciate the valuable insights that we've received from our community engagements both in 2019 and obviously throughout the history of the program.

We plan to resume community engagement listening sessions to discuss successes and challenges that our recipients, stakeholders, people with HIV And other community members, are experiencing as we continue to move forward with coordination of the initiative. These sessions obviously will be held virtually for now. And stay tuned for more details during the October HAB You Heard webinar.

And with that, I'd now like to turn it over to Melinda Tinsley who is one of the three executive committee co-leads for the 2020 National Ryan White Conference. Melinda?

Melinda Tinsley: Thank you, Heather. I would like to begin with a thank you to the nearly 7,500 people who participated in the 2020 National Ryan White Conference on HIV care and treatment. We were so glad you could be a part of this

virtual experience. Recordings for the national conference plenary sessions are now available on TargetHIV. In addition, the recordings for the workshops are still available online in the conference portal for those registered. And will be available on TargetHIV in the fall.

For access to the critical conference, slides are now available and recordings will be available in the near future, on the (AETC) National Resource Center Web site. Now I will turn it over to Antigone Dempsey, for a policy update.

Antigone Dempsey: Great. Thanks, Melinda. So we wanted to be sure of some updates that we recently in this past month, we rereleased PCN 15-01 which is related to treatment of costs under the 10% administrative cap for the Ryan White Program Parts A through D, as well as PCN 15-02 on clinical quality management.

So we provide additional clarifications that issue these PCNs related to staff training costs. Previously, HAB policy related to staff training costs was articulated in policy 11-04. And as a result of these additional clarifications that we wove into 15-01 and 15-02, PCN 11-04 is no longer in effect. But generally speaking, the guidance on staff training has not changed. These costs may be allocable as an administrative cost, a CQM or a clinical quality management cost or as addressed service costs where such training is necessary, to ensure that the vision of high quality Ryan White services.

Staff training costs allocated to address service cannot exceed 5% of the dollars allocated to provide that given service. The clarifications also note that membership dues for the recipient are allowable under administrative costs.

So and another important policy change to note is that Ryan White HIV/AIDS Program funds may be used to pay for professional licensure and related costs. We recognized that this additional flexibility may be useful to recipients as they recruit and train providers. And it may help all recipients to be able to expand their workforce to include providers like community health workers in those areas where such roles require continuing education, licensure or accreditation.

So now I'd like to turn it over to the Division of Community HIV/AIDS Program Director, Captain Mahyar Mofidi for a rural health update.

Captain Mahyar Mofidi: Thank you, Antigone. I wanted to share a policy brief and recommendations to the HHS Secretary on HIV prevention and treatment challenges in rural America. This is truly a landmark report published by the National Advisory Committee on Rural Health and Human Services. It is the first time ever, since its inception over 30 years ago, that the committee has focused on HIV as the timing aligns well with the Ending the HIV Initiative and its focus on rural areas.

The committee is a federally chartered independent citizens' panel whose charge is to advise the Secretary of HHS on issues related to how HHS and its programs can better serve rural communities. Next slide, please. As you can see on this slide, there were multiple recommendations made to the HHS Secretary in the policy brief and I won't read through all of these.

One is modernizing the Ryan White HIV/AIDS Treatment Extension Act of 2009 by focusing on enhancing the ability of the program to meet the needs of rural communities. And another is maximizing the scientific advances made in HIV prevention to increase to PrEP for rural communities.

The HIV/AIDS Bureau was invited and participated in the committee meeting and contributed to the development of the policy brief. Now I would like to turn it over to Chrissy Abrahms-Woodland who is the Director for the Division of Metropolitan HIV/AIDS Program, to kickoff this month's first recipient spotlight. Chrissy?

Chrissy Abrahms-Woodland: Thanks, Mahyar. (Unintelligible) the Division of Metropolitan HIV/AIDS Program. I'm excited to introduce our first presenter for our recipient spotlight presentation. So first, we'll hear from Jeff Cheek within the Ryan White HIV/AIDS Program Part A in the Atlanta eligible metropolitan area. Jeff Cheek is the Director of the Fulton County Department of HIV for HIV Elimination, formerly known as the Fulton County Ryan White Program.

The name was changed two years ago, to reflect a commitment to reducing HIV in the Atlanta (unintelligible). In addition to HAB-funded programs, Jeff also coordinates Fulton County's regional HIV strategies. Jeff has been associated with the Part A program since 1992. So thank you for joining us today, Jeff. And the floor is yours.

Jeff Cheek: Thanks, Chrissy. I appreciate the opportunity to participate today. Next slide. When I first started thinking about the changes in eligibility and recertification, the theme I kept coming back to was flexibility and how flexibility from HRSA and from our office, have improved the way we approach program eligibility.

When I Googled flexibility this is what I found - willingness to change or compromise. And the example that was given was the government has shown flexibility in applying its policy. HAB has a long history of providing program policies but allowing flexibility for local jurisdictions to implement those requirements in a way that makes sense locally.

To begin our eligibility requirements are similar to those of most other Part A programs. You must be living with HIV, you must reside in the EMA, and you have an income less than or equal to 400% of the poverty level and no third party payer source. Next slide. Next slide. Thank you. Oh, I'm sorry. Back one. I'm sorry.

In the early years we developed strict eligibility requirements basically as a way of showing auditors just how good we were in making sure that no ineligible person got past us and because we believed that this was what was required by HRSA.

For example, for HIV status we required actual confirmatory lab results, mostly Western (blot). And for residency proof of where you were living. And for the homeless we required a letter from a shelter or proof of a PO Box as eligibility. Next slide.

Over time we recognized the importance of moving from a process focused on exclusion to one with the purpose of bringing as many eligible (PLWH) indicators as possible. After our last HRSA site visit we received a programmatic finding because not all of our policies were written down and readily accessible.

This provided us with the opportunity to rethink our policies as we fought to codify them. We began to examine what was actually required by the Ryan White HIV/AIDS Program and how we could revise our policies to better serve (PLWH) and our EMA. Next slide.

We developed a series of programmatic fiscal and recipient policy and procedure notices. PPPN001 client eligibility guides eligibility determination

and reassessment, rectification of clients. This policy lists what documentation is acceptable for each of the eligibility requirements. It describes processes to be followed and provides details on presumptive eligibility and provisional enrollment. Next slide.

So you can find this PPN on our Web site, RyanWhiteATL.org. You will go to the poor provider section. You would select policies and procedures and from there select PPPN and then client eligibility. This is also where you can go to download our Atlanta EMA Part A manual which further details grant management and service delivery requirements. Next slide.

Our policies now allow for a presumptive diagnosis based upon HRSA guidance. There is no requirement for a confirmed HIV diagnosis prior to linkage to care, nor a requirement for western (blot) testing as the only confirmatory test. Next slide. And it is not necessary to have two antibody tests before initiating care. Next slide.

We reexamine proof of HIV status through the lens of HRSA's guidance. What is essential is that we are serving eligible (PLWHA) but there are many ways that HIV status can be verified. In addition to preliminary test results, we allow for a variety of things including a statement or letter signed by a medical professional with a lab test to confirm current HIV status within 60 days; presumptive diagnosis based on medical therapies prescribed by a previous medical provider as shown in medical records or even on a prescription bottle. Next slide.

We hear from clients and providers that people rarely have all eligibility documents with them at the time of enrollment, which delays access to care and lifesaving medications. Three developed provisional enrollment policies -

ideally all documentation should be present but the lack of documents should not be a barrier to care. Next slide.

If a client is able to provide proof of HIV status but does not have income or residency documentation that client may be enrolled in the core services and some support services such as patient navigation and transportation. And the eligibility documentation must be provided at the next visit. Next slide.

I mentioned earlier that our income requirement is less than or equal to 400% of the federal poverty level. However, 1/2 of our 19,000 clients have incomes that are less than 50% of the federal poverty level. Frequently they are homeless or unstably housed. So to make things easier, we revised residency documentation to allow for a written statement from the client describing their living circumstances or even a physical observation by enrollment staff. Next slide.

HRSA's willingness to be flexible has probably never been clearer than during COVID-19 when regular guidance and updates were given. While our PPPN001 allowed for flexibility in the submission of documentation, COVID created a situation where it became vital to ensure that our subrecipients understood the flexibilities and that they had the tools needed to enroll clients into care from a distance.

The first thing we did was to reiterate that agencies could accept photos of documentation which can be texted or emailed to the agency and stored in the client file. We also use CARE funding to support enrollment recertification. We purchased DocuSign for a number of our agencies so that clients and employees can sign attestations and certifications from a distance.

We purchased cell phones and prepaid phone cards for clients so clients will be able to send in that documentation. Next slide. We also funded wi-fi hotspots, software and subscriptions including Zoom, and hardware such as webcams and staff laptops. Next slide.

So what else are we working on? First, an eligibility portal - one of the greatest barriers to enrollment and recertification has been the need to provide eligibility documentation to each service provider. Agencies were unable to share documents with other providers. So we're now using Ending HIV Epidemic Funds to support a centralized eligibility portal which is accessible to all of the client service providers, including the City of Atlanta's (unintelligible) providers and hopefully, ADAP at a later date.

The system will also send recertification reminders to providers and the clients. Second, we're looking at the purchase of tablets. Primarily we were looking at these for tele-health but they could also be used for recertification. Many of our clients do not have access to video ready phones or tablets. And what we recently learned that for some the screen is too small for tele-health or for reading documents.

Many clients lack access to reliable and affordable internet connection. So we're currently working on a learning collaborative with (Laura Delorenzo) and she shared information from the Jefferson Health Foundation in New Jersey, about a program they implemented using a vendor called Continued Calm. The provide 8 inch tablets with an unlimited data connection to clients.

Each device ships with a secured environment and limited functionality. They're customized by the healthcare provider, to include the tools that clients need to access care and the vendor history in a simple deployment and

warehousing solution to make it easier for organizations to get started quickly. Next slide.

Thank you. This concludes my presentation. My contact information was on the first slide. And as a reminder, our Web site is RyanWhiteATL.org. Thank you.

Captain Mahyar Mofidi: And thank you, Jeff, for that great presentation. Next, we will hear from Andrea Rogers and Tabatha Coombs from the Ryan White HIV/AIDS Program Part C and D recipient, West Virginia University Positive Health Clinic in Morgantown, West Virginia. They will reflect with us on the West Virginia University's Program's response to the COVID-19 pandemic. Andrea is the director and Tabatha is the Associate Director of the Positive Health Clinic. Thank you so much, for joining us today. Andrea and Tabatha?

Andrea Rogers: Thank you so much for having Tabatha and I share our experience over the last several months. Next slide. So this is a picture of the outpatient clinic which is part of the larger health sciences complex at WVU.

We're located just - I know everyone knows where Atlanta is, but just so everyone knows where we are in Morgantown, West Virginia, we're about 3-1/2 hours West of Washington, DC, about an hour south of Pittsburgh, and about 2-1/2 hours North of Charleston, West Virginia, which is the state capital. And Charleston is the location of the only other Part C - Ryan White Part C-funded clinic in the state. Next slide, please.

So West Virginia has 55 counties. We're - the area that is highlighted in yellow is our designated 33 county service area for Ryan White Parts C and D. Next slide please. These are some of the demographics from our year to date RFR. We currently have 349 patients. So we're a relatively smaller

program. The majority of our patients are male, the majority are White and the risk factor most represented is men who have sex with men.

Twenty-seven percent of the patients who have actually turned in their proof of income, are below the federal poverty level. In 2020 we haven't received financials on a little over half of our patients. Next slide, please. So in early March things were looking good for West Virginia. We were the last state without Coronavirus infection. And then four days after this was published, West Virginia had its first confirmed case. Next slide, please.

West Virginia is a very rural state with a population of about 1.8 million. We have had over 14,000 infections statewide since our first case in March. And we have about 3500 active cases today. Next slide, please. So some of you may have heard of the COVID reproduction rate. A simple explanation of COVID RT is if the RT is above 1 the virus will spread quickly. If the RT is below 1 the virus will stop spreading.

West Virginia has been well over 1 for several weeks and has had the highest RT value in the United States in the month of September, up until this snapshot on September 14th. Today we're at 1.03. Back then I think - I think we went as high as 1.53. But now we're at 1.03 today. So we're moving in the right direction. If you want to look at this and see where your state is, how your state is doing with the reproduction rate for COVID, it's RT.live. Next slide, please.

So this is a brief timeline beginning with Friday the 13th of March. It began with a cancelation of in person outpatient visits and lasted through the end of May in West Virginia. In mid-April we received the CARES Act funding which really allowed us great flexibility to explore ways to focus on keeping our Ryan White patients healthy.

The funding was completely unexpected and very, very much appreciated. We were able to purchase iPhones for staff who were working remotely so that they could keep in touch with patients and they didn't have to use their own personal cell phones. We - as well as iPads for providers to help with the increasing number of video visits. Next slide, please.

In early May we held a brainstorming session, actually over Zoom with staff, to make the best use of the funding. Everyone got very excited about it and we divided the tasks among staff to research what - to actually talk to patients and see what their needs were. We kind of doled out so that everybody could look at availability and pricing of PPE. And then we really looked at cell phone coverage areas and service costs.

Our weekly multidisciplinary patient care conference was set up as a virtual meeting to accommodate staff that were working remotely. And it's actually worked out so well that I think we plan to continue using this platform. Right Tabatha?

Tabatha Coombs: Yes.

Andrea Rogers: So the multidisciplinary patient care conference, if we have time at the end of the presentation, Tabatha can like go into a little bit more detail about that. So in June - June was devoted to the devil in the details which were all - we all experienced. Getting the patient set up with iPhones; there were many steps that Tabatha will go over. Shipping necessary supplies, contacting patients and rearranging schedules to be in person, telephone or video visits.

The in person outpatient appointments resumed in June, actually with an initial target of about 50%. And those appointments were set up according to

patient's preference and provider preference. Next slide, please. So these are some pictures of the assembly line set up in our office space, to prepare the COVID prevention kits for our patients. Next slide, please.

And I'm happy to report that 66 of 67 iPhones have been distributed to date, with an overwhelmingly positive response from patients. Now Tabatha will take you through the individual steps that it took to accomplish each of our goals. Next slide, please.

Tabatha Coombs: Thank you, Andy. As everyone can imagine, the process for patient iPhone purchase, approval, and setup was challenging. Being part of a large institution presented many challenges during the planning process, since nearly everyone in West Virginia was working remotely. As you can see, multiple staff, administrators, IT staff, and legal counsel, were involved in the purchase, approval, and setup of the devices. Next slide, please.

Listed here are some of the steps that we needed to take to get the patient iPhone project off the ground. It wasn't something as simple as, you know, purchasing the phones, handing them out and everyone is good to go. We worked with an advanced computer technician to set up the devices and that entailed creating an Excel spreadsheet which I'll show you in a moment, that was created for inventory tracking and activation tracking.

The technician installed all of the apps that were required to participate in tele-medicine. The tech then locked down the devices. You know, we didn't want to be responsible for paying for cellular service for a patient and then to have maybe questionable apps downloaded or have more of their personal information stored on the phone than necessary. So iCloud, Apple ID, and the App Store was basically locked down so that the patients could only utilize the apps that were related to the tele-medicine services.

However, they were granted unlimited access to phone, texting, and the apps for the tele-medicine. At the end of our service period - now COVID funding will be ending on March 31, 2021 and at that time, and the patients are aware that the devices will be wiped remotely and then deactivated with the cellular service company.

However, we are currently exploring ways to continue funding the data service plans beyond March 31st to continue tele-medicine for these patients. Next slide, please. This is the inventory tracking spreadsheet. This allows us to document which device was distributed to which patient. And will allow us to monitor whether the device is active.

That would allow us to reconcile billing and IT services. It will also allow us to document and track the devices that have had any data wiped and apps deleted if forward funding is not secured. Next slide, please. These are some of the additional steps that were required of the - of WVU prior to the project go live. As with any large institution there were multiple hurdles and red tape to go through.

All IT purchases regardless of funding source, had to be approved through the IT department so that it was complying with their standards. Multiple meetings were held with IT administration and legal counsel. Finally, we created a policy and procedure for iPhone use for tele-medicine, a patient eligibility screening tool and patient usage contract. Next slide, please.

This is just the policies and procedures that were created that we would be happy to send out to folks if you reach out to us via our contact information. Eligibility criteria is less than 200% of the federal poverty level. And then one or more of the second eligibility criteria. Next slide, please. The contract

- basically the patient just had to agree to utilize their phone for tele-medicine services as requested. Next slide, please.

And of course we had to figure out how to capture this data for the COVID-19 data report. And this just indicates all of the services and contracts that were set up en masse in (Careware). As of our August (Careware) 19, I'm sorry, COVID-19 data reports, 58 patients have been screened for COVID-19 and only two tested positive. And of course we also track other things such as educational services, not just the iPhone usage. Next slide, please.

This is just an example of some of our documentation for the COVID iPhone usage. Next slide, please. Patients were handed out the tele-medicine video instructions as well as a tech support line and - but more than likely they usually call our staff to walk them through the process. Next slide, please. So progress to date for the COVID - our COVID-19 response, as Andy said, 66…

Andrea Rogers: Sixty-six.

Tabatha Coombs: Sixty-six of 67 patients now have received an iPhone. We've had 326 COVID-19 prevention kits distributed, 336 patients have received education, 51 patients completed tele-medicine video visits, and 77 patients completed telephone tele-medicine visits. We've continued to enroll patients and have had 70 - I'm sorry, 37 new referrals to date. And we're planning on a second round of prevention kits to be mailed out early October, to coincide with our flu season.

Challenges, as everyone can imagine - next slide, please. Challenges, as everyone can imagine, there were some significant challenges with the billing process and separating charges to appropriate funding streams. Next slide, please. Thank you for allowing us to share our COVID-19 response. We'd

also like to extend a special thanks to the staff of the Positive Health Clinic, for their extensive work and long hours, committed to this project.

It really does take a village. Next slide, please.

Andrea Rogers: This is our contact information.

Tabatha Coombs: Yes. And this is our contact information. If anyone would like to see those documents more in detail.

Andrea Rogers: Thank you.

Tabatha Coombs: Thank you.

END