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ESCALATE

Ending Stigma through Collaboration And Lifting All To Empowerment

Concept Note

September 13, 2021

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HRSA Grant Number: U69HA39335

ESCALATE is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) and the Minority HIV/AIDS Fund (MHAF) as part of a financial assistance award totaling $1,600,906. 100 percentage funded by HRSA/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA/HHS, or the U.S. Government.

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Foundation

"ESCALATE" (Ending Stigma through Collaboration And Lifting All To Empowerment) is a first-of-its kind training and capacity-building initiative specifically designed to address HIV-related stigma that creates barriers at multiple levels of the HIV care continuum.

NMAC created ESCALATE to reflect its mission and relationship to the communities of people with HIV. NMAC "leads with race" as the burdens of the HIV/AIDS epidemic are most deeply felt in racial and ethnic minority communities. HIV stigma reflects these structural inequities and amplifies the multiple stigmas experienced by communities impacted by HIV based on their race, ethnicity, sexual orientation, gender identity, social status, mental health and substance use, and relationship to sex work or incarceration. Only by viewing HIV stigma through these multiple lenses can we address its deep and insidious impacts.

ESCALATE works across multiple levels of the Ending the HIV Epidemic in the U.S. initiative and the HIV National Strategic Plan to address internalized and externalized HIV-related stigma within the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) Ryan White HIV/AIDS Program (RWHAP):

Pillars of the Ending the Epidemic Initiative	**HIV National Strategic Plan 2021 Goals**	**ESCALATE Activities**
Prevent Diagnose	Goal 1: Prevent New HIV Infections	ESCALATE activities indirectly enhance existing prevention efforts. RWHAP providers and systems that are aware of the impact of HIV-related stigma and are trained in stigma-reduction strategies will be better equipped to have conversations with individuals and communities about harm reduction strategies, destigmatize testing and diagnosis, and more consistently prescribe pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP).
Treat	Goal 2: Improve HIV-Related Health Outcomes of People with HIV	ESCALATE Training infuses the RWHAP system with approximately 1,200 individuals trained in stigma-reduction practices to proactively eliminate stigma at RWHAP agencies.
	Goal 3: Reduce HIV-Related Disparities and Health Inequities	ESCALATE Technical Assistance (TA) builds support for organizational embrace of practices that reduce HIV stigma and other intersectional forms of stigma experienced by the communities that are most deeply impacted by the HIV epidemic. Because HIV stigma is deeply associated with barriers to diagnosis, engagement, and retention in care, reducing its impact should, in the long-term, reduce demographic and other disparities across the HIV continuum of care. TA will reach up to 150 RWHAP agencies, creating a critical threshold of RWHAP professionals, clinical staff, medical providers, and community members engaging in stigma reduction and providing models for other agencies to do so.

	Goal 4: Achieve Integrated, Coordinated Efforts that Address the HIV Epidemic among All Partners and Stakeholders	ESCALATE Learning Collaboratives (LCs) bring together RWHAP agencies from across the program parts to build practices and supports for cultural responsiveness and humility that can be disseminated throughout the RWHAP system.
Respond		ESCALATE activities will not directly impact this pillar.

To meet the goals of ESCALATE, NMAC has partnered with Abt Associates (Abt), TRX Development Solutions (TRX), and NORC at the University of Chicago (NORC). For a full list of partners, staff, and roles, please see Appendix A.

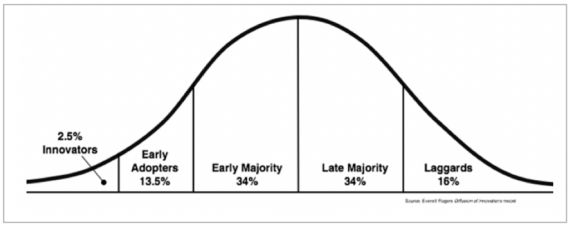
Informed by Lived Experience, Academic Rigor, and Theories of Change

ESCALATE is informed by community and subject matter expert input, academic rigor, and behavioral theories of change.

- Lived experience: Subject Matter Experts (SME) are comprised of community stakeholders, people with HIV, and expert trainers who provide targeted input and support throughout the development and implementation of Training, TA, and LCs.
- Academic rigor: Training, TA, LCs, and evaluation activities are informed by evidence-based strategies for content delivery.
    - Training will build participant knowledge and skills to recognize and address HIV-related stigma through "difficult dialogues" and the development of culturally humble practices. The Training utilizes best practice methods and approaches for health facility stigma-reduction interventions including (1) the provision of information, (2) skills-building activities, (3) participatory learning, (4) contact with the stigmatized group, and (5) and an empowerment approach. Training is informed by the following evidence:
        - Stigma in health facilities: why it matters and how we can change it (Nyblade, Stockton, et al.)
        - Mapping the margins: Intersectionality, identity politics, and violence against women of color (Crewnshaw)
        - Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education (Tervalon & Murray-García)
        - Difficult dialogues, privilege and social justice: uses of the Privileged Identity Exploration (PIE) Model in student affairs practice (Watt)
        - Cultural humility: a concept analysis (Foronda, Baptiste, et al.)
          Examine your LENS: a tool for interpreting cultural differences (Williams)
        - The impact of unconscious bias in healthcare: how to recognize and mitigate it (Marcelin, Siraj, et al.)
        - Understanding and addressing contemporary racism: from aversive racism to the Common Ingroup Identity model (Gaertner & Dovidio)

- TA activities are grounded in the Dick and Carey Model of Instructional Design, providing a structured mechanism to progressively elaborate and improve on content delivery through a nine-step approach (further described below).
- The LC Framework is based on the Institute for Healthcare Improvement's (IHI) Breakthrough Series Collaborative (BSC) model[1] and on AHRQ's Innovations Exchange Learning Community "5S Model"[2] focused on Supporting, Sharing, Strengthening, Sustaining, and Scaling up.
- The ESCALATE Program Evaluation will utilize the RE-AIM Implementation Science Framework to understand the adoption of anti-HIV stigma practices and interventions widely throughout RWHAP-funded agencies. The RE-AIM Framework orients evaluation to five dimensions of program implementation—Reach, Effectiveness, Adoption, Implementation, and Maintenance—to fully document the challenges, facilitators, costs, opportunities, and promising practices that can inform dissemination and/or further piloting for evidence-based solutions.

- Theory of Change: The Diffusion of Innovations theory guides individual- and organization-level engagement throughout ESCALATE, informing how new knowledge and practices are disseminated, piloted, and modeled throughout the RWHAP organizations and communities. "Innovators" and "early adopters" will take advantage of opportunities provided by the new practices disseminated in Year 1 of ESCALATE, and these ESCALATE alumni will lead the way. The Diffusion of Innovation Theory suggests that innovators and early adopters are willing to take on new ideas, risks, and change opportunities. They are aware for the need to change, and are interested in participating pioneering efforts. Their efforts, however modest or grand, will constitute the models for dissemination that will help later adopters join the effort, especially when the models of successful early innovation are disseminated through conferences, other marketing, or, in the case of ESCALATE, the TargetHIV Website. This paves the way for the early and late majority to participate. By the end of ESCALATE's fourth year of implementation, the program expects to have moved from engaging innovators and early adopters and into the period in which the late majority can effectively participate in the program.



[1] Institute for Healthcare Improvement. (n.d.). Testing changes. Institute for Healthcare Improvement. Retrieved March 15, 2011, from http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove/testingchanges.htm
[2] Carpenter D, Hassell S, Mardon R, Fair S, Johnson M, Siegel S, Nix M. Using Learning Communities to Support Adoption of Health Care Innovations. Jt Comm J Qual Patient Saf. 2018 Oct;44(10):566-573. doi: 10.1016/j.jcjq.2018.03.010. Epub 2018 Jul 9. PMID: 30064957.

ESCALATE Activities

ESCALATE has three primary activities: Training, TA, and LCs.

- Training meets the needs of individual RWHAP care providers (e.g., clinicians, administrators, patient navigators, etc.) who acknowledge the impact of HIV-related stigma on their client populations and communities. These individuals are ready to create change but may not have the organizational capacity needed to create change across their clinical setting.
    - Training applicants can apply for the training as a Stigma Reduction Team. Stigma Reduction Teams will represent a collaboration between community and organization, and consist of one person with HIV and at least one RWHAP partner. A Stigma Reduction Team may have multiple RWHAP workforce professionals but must always have one person with HIV as a partner.
    - Through Training, individuals will learn how to facilitate transformative and relational change in RWHAP and the communities they serve through deepening awareness of and practices for cultural humility amongst people with HIV and RWHAP providers and professionals.
    - Individuals will learn how to address their own internalized stigma through Training.
    - Stigma Reduction Teams who complete Training should consider approaching their respective organizations to participate in future TA/LCs. Organizations that show a willingness to implement anti-stigma interventions demonstrate potential readiness for TA/LCs.
- Organizations can also form Stigma Reduction Teams to apply to receive tailored, individualized **Technical Assistance (TA)** or to be part of a **Learning Collaborative (LC)**.
    - TA is best suited for organizations that are looking to tackle a specific concern related to HIV-stigma on a one-to-one basis (meaning, one organization working with one TA provider).
    - LCs are best suited for organizations who have all the resources and preparations in place to begin implementing a stigma-reduction program or have already begun implementing such a program.
    - Stigma Reduction Teams that have graduated from TA can apply to participate in a subsequent LC.
    - Organizations that are not ready to participate in TA or LCs will be encouraged to participate in Training to bolster their readiness and capacity to engage in TA and LCs in future years.

There are multiple opportunities for and pathways to participation in the three core activities (Training, TA, and LCs).

- Training participants may choose to continue their anti-stigma work through TA or LCs in future years of ESCALATE.
- Organizations that have graduated from TA can apply to participate in a subsequent LC.
- Organizations that are engaged in LCs may need (and can receive) additional, one-on-one TA.
- Organizations that have participated in Training, TA, or LCs may continue to grow and send new staff members to Training.

- Organizations can participate in multiple activities each year, depending on their needs and staffing changes.

Applicants who are not selected for Training, TA, or LCs will be invited to be added to a dedicated NMAC listservwhere the ESCALATE team can share trainings developed by the RWHAP community, foundations, partners, and more. These listserv updates will provide self-paced capacity building and resource sharing.

- Organizations that are not ready to participate in TA or LCs – perhaps because they lack organizational resources or their leadership's support to participate, have not assessed community needs, or have not begun implementing a stigma-reduction initiative – can participate in Training to bolster their readiness and capacity to engage in TA and LCs in future years.

Project Technologies

ESCALATE will use two platforms to communicate with participants:

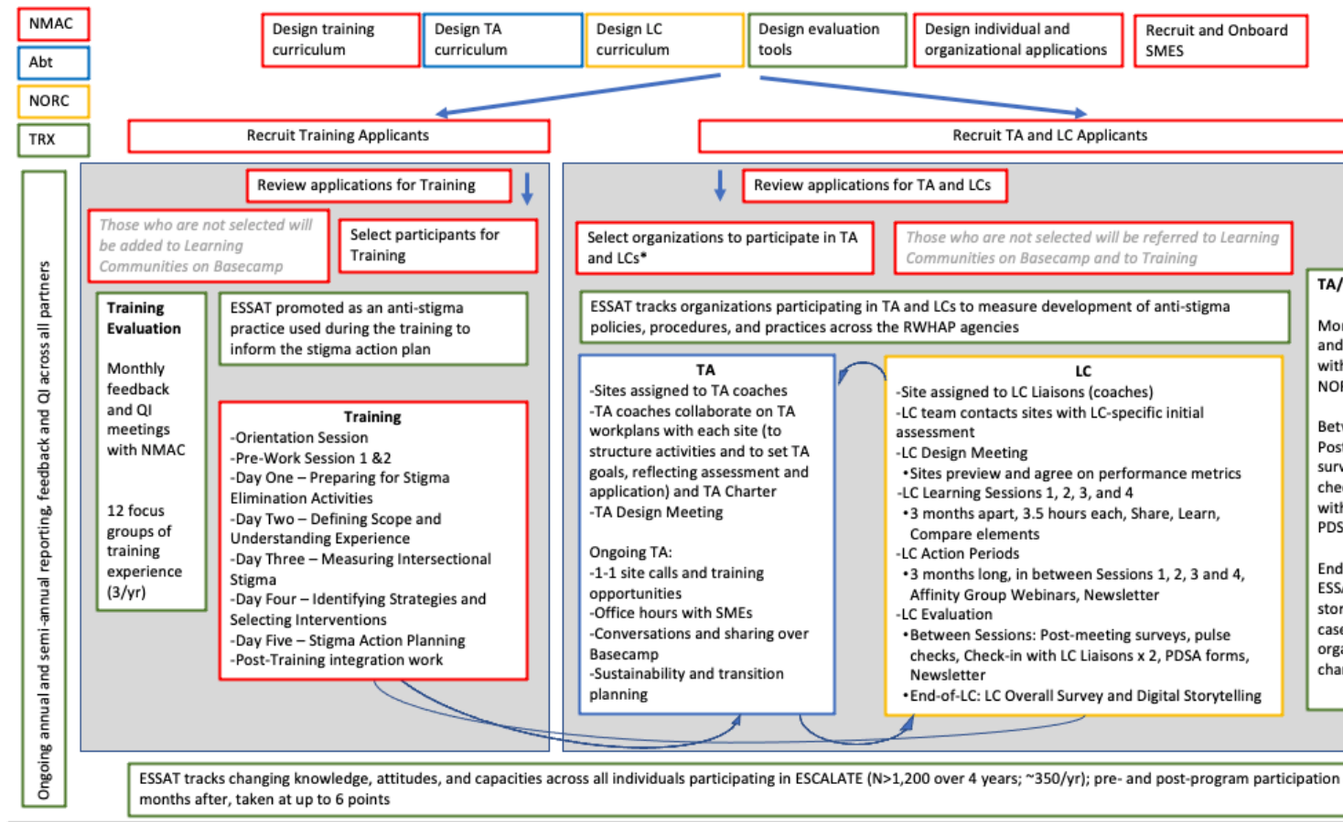
HIV-E is a learning management platform that will be used for delivering Training content and providing post-Training knowledge assessments.

Basecamp is a project management platform that will be used for document and resource sharing and communication with TA and LC participants.

By having three distinct activities, ESCALATE ensures that the greatest number of RWHAP providers and organizations are learning about HIV-related stigma and tools to combat stigma in their clinics and communities. ESCALATE creates multiple points of engagement with the RWHAP community to make the learning opportunities accessible, meet providers and organizations where they are at, and share knowledge through the RWHAP system and community.

The following diagram depicts how Training, TA, and LC activities will be conducted. Activities outlined in this diagram will continue each year throughout the project period (September 2020-August 2024).

ESCALATE MODEL AND PROGRAM FLOW



Training (Directed by NMAC)

Goals

Training will facilitate transformative and relational change in RWHAP by increasing their knowledge and skills to recognize and address HIV-related stigma within their organizations and communities they serve. This is facilitated through a deepening awareness of and practices for cultural humility amongst people with HIV. Trainers create an equitable and transformational environment for RWHAP providers to learn with and from their people with HIV partners. Through the Training, the Trainees will:

NMAC Training Team
Paul Kawata
Terrell Parker
Christopher Paisano
Adam Thompson
Dottie Dodwell

Goals

1. Learn about the impact of HIV-related stigma, bias, and discrimination in health care
2. Learn the skills to engage in "difficult dialogues" to address HIV-related stigma at the interpersonal and organizational levels
3. Learn about the role of implicit bias in decision-making and health outcomes
4. Demonstrate skills to engage in critical self-reflection of implicit bias and privilege
5. Learn about and demonstrate approaches, strategies, and methods to deepen cultural humility and culturally humble practices
6. Utilize an organizational assessment to identify opportunities to address HIV-related stigma
7. Identify one area of privilege for further examination and self-reflection
8. Develop an action plan to address HIV-related stigma at the organizational level
9. Learn methods for and engage in self-care activities to support RWHAP providers and people with HIV involved in anti-stigma work

Marketing and Recruitment

NMAC promotes the Training to individual RWHAP recipients and subrecipients (Parts A, B, C, & D) via NMAC's own listservs and social media platforms, HRSA HAB's communications channels (including the HAB biweekly informational email), direct presentations to HRSA RWHAP project officers, public webinars and direct outreach to potential participants. The promotional materials describe the Training, benefits of participation, time commitment, and an overview of activities, and direct audiences to the Training application, which will be open for three weeks.

Application Process

Stigma Reduction Teams will be invited to apply to participate in Training through an application posted on TargetHIV. Applications will be open six weeks prior to each individual training. Applications will be open for three to four weeks.

Applications will ask questions related to the following inclusion criteria:

- Commitment to engage in critical self-reflection
- Relationships between people with HIV and RWHAP to create a learning team to address HIV-related stigma
- Resources to participate in virtual learning (computer, smart phone, reliable internet access)

Once applications are received, they will be scored by the NMAC using a standardized rubric assessing the above criteria.

Application Review and Trainee Selection

NMAC will make a list of recommended applicants for selection to share with HRSA. During a half-day meeting, NMAC will present these recommendations to HRSA and, in partnership with HRSA, determine the final candidates. 30 participants will be selected for each Training, and will be comprised of 25% people with HIV and 75% RWHAP professionals.

- Selected Stigma Reduction Teams will be notified and connected with the appropriate contact for TA or LCs.
    - Selected Stigma Reduction Teams will receive a link to complete the ESCALATE Survey and Self-Assessment Tool (ESSAT). They will have one week to complete the assessment. Once the ESSAT is completed, TRX will share the results with Abt and NORC to inform and prioritize TA and LC activities.
- Applicants that are not selected will be added to the Learning Community on Basecamp to receive updates on training opportunities provided by federal, local, and private partners that may aid in internal capacity building prior to the next application cycle.

Activities

Using the guiding principles from the G/MIPA and Denver Principles, Training leverages partnerships between people with HIV and RWHAP providers. This allows for the shared experience of community and providers to inform the critical conversations needed to address longstanding stigmatization of people with HIV.

Training is grounded in the principles of cultural humility as defined by Melanie Tervalon and Jan Murray-Garcia: 1) lifelong learning and critical self-reflection, 2) recognizing & challenging power imbalances, and 3) institutional accountability. Trainees will learn about transformative and relational methods to affect systems-level change to address HIV-related stigma and discrimination in RWHAPs. These methods include shifting the mental modes of organizations and addressing power dynamics. Through the inclusion of people with HIV served by the RWHAP, the Training leverages best practice in stigma-reduction interventions by centering the experience of people with HIV throughout the training. Trainees begin will individual self-critique and reflection, and then learn the interpersonal skills needed to disrupt stigma and discrimination. Trainees will learn the Multidimensional Model of Privilege and Privileged Identity Exploration model to support effective engagements in the difficult dialogues needed to name and address HIV-related stigma. Following individual and interpersonal skills development and demonstration, trainees will utilize the ESSAT to build awareness of organizational and structural stigma and discrimination. Lastly, Trainees will make a privilege pledge and build an action plan to address an area of organizational stigma while learning how to effectively reintegrate into their organizations with new knowledge, skills, and awareness.

Trainees will become familiar with the following terminology: stigma, HIV-related stigma, discrimination, power, privilege, single-target group approach, cultural humility, intersectionality, racism (including dominative and new or modern racism), relational change, mental model, bias, implicit bias, explicit bias, difficult dialogue, privileged identity exploration.

Training objectives include:

- Creating a shared mental model of cultural humility in theory and in practice
- Defining the "American Dilemma" in the context of race and health care delivery
- Defining intersectionality and demonstrate how it impacts outcomes for marginalized people and groups
- Introducing the Multidimensional Model of Privilege as a tool to disrupt the single-target group approach
- Introducing and utilize debiasing tools and strategies
- Using reflection and self-critique to explore participant attitudes and beliefs
- Reviewing individual and organizational strategies to disrupt implicit bias in health care settings

ESCALATE Training Schedule: Year One (Sept 2020-August 2021)
*Year 2 training dates will be posted in Fall 2021

TRAINING #	TRAINING REGION	DATES	Check-In 1	Check-In 2
Training One	Southwest	Week of July 12th	August 12th	September 16th
Training Two	Midwest	Week of July 26th	August 26th	September 23rd
Training Three	Indian Country	Week of August 9th	September 9th	October 7th
Training Four	South – EHE Rural Epidemic States	Week of August 23rd	September 23rd	October 21

ESCALATE Training Format

- Orientation Session (60 mins; delivered virtually)
  - Three weeks prior to the training
  - Stigma Reduction Teams – Overview of ESCALATE Training
- Pre-Work Sessions One (60-120 mins; delivered virtually)
  - Two weeks prior to the training
  - People with HIV Partners – Preparing for Anti-Stigma Work
    - The role of the Person with HIV Partner
    - Preparing for anti-stigma work – mind, body, and spirit
  - RWHAP Partners – Power in Partnerships
    - The role of the RHWAP partner
    - Power in team dynamics & fostering equity
- ESCALATE Five-day Training (5 hours per day; delivered virtually in year 1 and then delivered both virtually and in-person in years 2-4)
  - Day One – The American Dilemma and Transformative and Relational Change
  - Day Two – Cultural Humility and the Multidimensional Model of Privilege
  - Day Three – Intersectionality and Implicit Bias
  - Day Four – Difficult Dialogues and Organizational Change
  - Day Five – Action Planning and Integration
- HIV-E Platform –
  - ESCALATE Didactic Information
  - ESCALATE Cultural Humility Tools

Transitioning Trainees post-Training:

- Post-Training, Trainees will be equipped with an action plan to guide their activities when they return to their communities. Trainees will also be introduced to the TA and LC teams and activities in the event that Trainees want to deepen their learning through those activities.

Training Evaluation Activities:

Evaluation activities will occur on multiple levels:

- **Organizational and Individual** – ESCALATE Survey and Self-Assessment Tool (ESSAT) (see Evaluation section below and Appendix B)

Continuous Improvement

- The Training team will meet with the Evaluation team throughout training for:
    - (a) Data monitoring: Every month, the Training and Evaluation teams will meet to discuss data collection (applications, ESSAT, fidelity monitoring, and tracking of adaptive actions) to identify and address shortfalls, bottlenecks, or under-performance as they occur. All minutes, notes, documentation, communication, and adaptive actions protocols will be collected from each monthly meeting and documented in the ESCALATE RE-AIM Dataset.
    - (b) CQI: Data monitoring will inform the development of adaptive actions to address data collection or performance challenges, identify methods of measurement for adaptive actions, and establish goals for adaptive actions.
    - (c) Semi-annual meetings: Twice yearly, meetings will be held which will focus on adding or changing adaptive practices, determining which are building an evidence base of success, and the potential to document them as “lessons learned” or “promising practices” that could be piloted and validated in future studies.

When the post-Training surveys indicate a need for adjusting Training facilitation or Training materials, the Curriculum Development team may be involved to codify adaptations within the curriculum of evidence-based practice. The Evaluation team can also recommend additional training for trainers.

Technical Assistance and Learning Collaboratives (Abt, NORC)

Goals

Through participating in TA and LCs, RWHAP recipient/subrecipients (Parts A, B, C, & D) increase their capacity and readiness to address HIV-related stigma within their organizations and communities. Activities are designed to create organizational-level change through targeted work plans and collaborative working groups (further described below).

Marketing and Recruitment

NMAC (with support from Abt and NORC) promotes TA and LCs to RWHAP recipients and subrecipients (Parts A, B, C, & D) via NMAC's own listservs and social media platforms, HRSA HAB's communications channels (including the HAB biweekly informational email), wider dissemination options like HIV.gov, direct presentations to HRSA RWHAP project officers, , public webinars and direct outreach to potential participants. Communication is tailored to three key audiences: RWHAP staff at organizations whom may participate in the TA or LCs; executive directors or leaders of such organizations who will encourage their staff to participate; and members of populations served by those organizations who can advocate for the organizations to participate. Promotional materials describe TA and LCs, benefits of participation, time commitment, an overview of activities, and recommended team make-up, and direct audiences to the joint TA/LC application which will be open for 12 weeks for the first cohort recruitment and three weeks going forward.

Application Process

The joint TA/LC application allows Stigma Reduction Teams within organizations to submit one applications into one or both of the organization-level activities (TA and/or LC). Stigma Reduction Teams will represent diverse organizational levels, roles, and experience across organizations. Applications will open in summer 2021 for the first cohort of LC and TA member organizations and in winter 2022 for the second cohort of LC and third cohort of TA member organizations. TA will select organizations in partnership with NORC and HRSA. Organizations are only able to submit one application per cycle.

Once applications are received, they are scored by NORC and Abt using a standardized rubric assessing the following criteria:

- Shared criteria for across TA and LCs:
    - Demonstrated understanding of HIV stigma;
    - Description of HIV stigma challenges in organization and community;
    - Commitment to implementing stigma-reduction strategies into organizational activities, policies, practices, and behaviors;
    - Organization-level buy-in as evidenced by CEO letter of support, including a:
        - Commitment from leadership to allow identified staff to receive TA or participate in the LC;
    - Identification of a Stigma Reduction Change Agent who will provide the visible leadership needed to drive a program forward, create a vision for change, and lend credibility to the stigma-reduction initiative; and
    - Identification of a Stigma Reduction Team consisting of 3-5 people (in addition to the Stigma Reduction Change Agent) which has:

        - support from the organization's leadership to participate;
        - representation from members of the population on which the stigma reduction initiative focuses (or a means to receive input from that population); and
        - representation from a wide range of roles and responsibility within the organization.
    - Resources, including:
        - dedicated time for developing/implementing stigma-reduction program (to be defined by the organizations);
        - dedicated time for participating in the TA and LCs;
        - dedicated space/time to meet;
        - dedicated time/funds for training others at the organization;
        - dedicated funds for communications and media (as necessary, if the stigma-reduction program requires communication with the public/clients); and
        - resources to participate in virtual learning (i.e., computer, smart phone, reliable internet access).
- Additional Eligibility Criteria for TA:
    - Description of interest and commitment to tailored TA to address specific HIV stigma within the organization and community; and
    - Identification of key staff to participate in TA who will serve as informal trainers to share tailored approaches with staff.
- Additional Eligibility Criteria for LCs:
    - Identification of need for stigma reduction with a given population;
    - Existing anti-stigma policies at the organization;
    - Commitment from the Stigma Reduction Change Agent, the rest of the Stigma Reduction Team, and organizational leadership to disseminate lessons learned with staff at their own organizations and with others via digital storytelling;
    - An implementation plan for a stigma-reduction initiative; and
    - An evaluation plan for measuring current and ongoing perceptions of stigma at their organization (or a draft plan).

Beyond this, the application asks about organizations' prior experience with TA or LCs and the stage of development or implementation of the organization's stigma reduction activities or program.

Answers to the application allows NORC, NMAC, Abt, and HRSA to prioritize which organizations should receive TA, which should participate in LCs, which should be re-directed to participate in the ESCALATE Training and which should be deferred to a subsequent LC or another HRSA-funded program. Ideally, if organizations have an identified need for stigma reduction, anti-stigma policies, a designated team with training, leadership support, resources, and a written plan for their stigma-reduction program, as well as an evaluation plan for measuring current and ongoing perceptions of stigma at their organization, they should be ready for participation in a LC regardless of any subsequent work they may have done implementing a stigma-reduction program. If they do not have these elements or if at least one of their team members has not been trained on stigma reduction, they may be better suited to request TA from Abt or to participate in the ESCALATE Training. If they do have each of these elements but have not yet begun implementing their stigma-reduction program, organizations may still be able to participate and may be paired with other organizations at the same stage as part of an affinity group.

TA will be offered in two, nine-month cohorts to both align with the LC timeline (18 months) to streamline organization application and selection, and to provide for mid-course corrections for selected applicants. Cohort 1 will be selected during this initial review process (described above). Throughout Cohort 1, TA Coaches will identify Cohort 2 participants through the following participant pools: Training graduates, participants of the LCs who need individualized coaching, conversations with HRSA, and waitlisted participants from the original application process.

In addition, answers to the application questions will also enable NORC, NMAC, Abt, and HRSA to select types of organizations to participate in each LC and to select the particular topic(s) for each LC, based on the groups with the most common needs. As with the organization's stage of readiness, types of organizations, and groups of organizations focused on particular populations or aspects of stigma, will be grouped together in affinity groups. Multiple affinity groups (maximum of four) can participate in the same LC to both learn from similar organizations and from organizations at different levels of readiness working with different populations of interest, as long as all are addressing stigma.

Application Review and Participant Selection

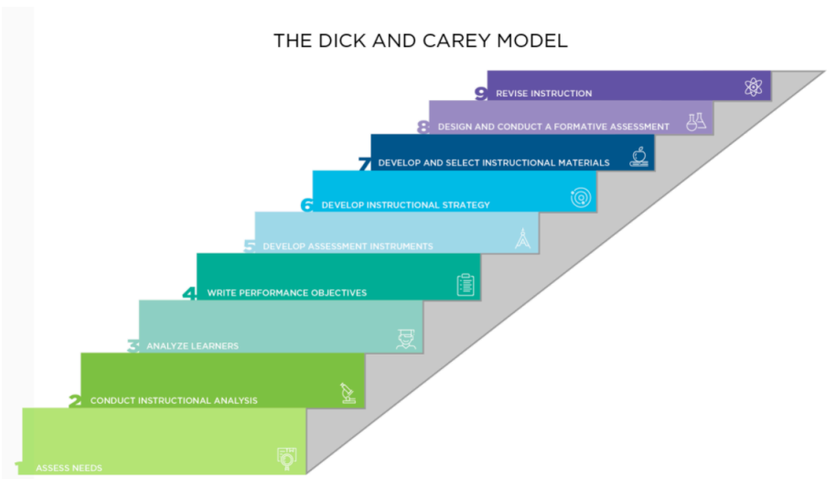
Abt and NORC will make a list of recommended applicants for selection with supporting rationale to share with HRSA in the form of a memo. Upon receipt of HRSA's response, Abt and NORC will meet to discuss and ratify HRSA's choices.

- Selected organizations will be notified and connected with the appropriate contact for TA or LCs.
    - Selected organizations will receive a link to complete the ESCALATE Survey and Self-Assessment Tool (ESSAT). LC members will have between the time of acceptance and the Design Meeting to complete the assessment. Once the ESSAT is completed, TRX will share the results with Abt and NORC to inform and prioritize TA and LC activities.
    - In addition, selected organizations will complete other TA and LC-specific baseline evaluations.
- Applicants that are not selected will receive written feedback on their application and suggestions on ways to bolster internal capacity to participate in the subsequent year of ESCALATE. These organizations will be added to a dedicated NMAC listserv to receive updates on training opportunities provided by federal, local, and private partners that may aid in internal capacity building prior to the next application cycle.
- Those that are not selected will be encouraged to engage in the Training opportunity to bolster individual and organizational capacity and readiness.

Technical Assistance (Directed by Abt)

Overview

TA activities will be guided by the Dick and Carey Model for Instructional Design (see below). This model provides a structured pathway for providing tailored TA to individual organizations by assessing TA needs, aligning TA activities and learning opportunities to those needs, and assessing the impact of TA on organizational behavior and change.



Preparing for TA (assessing needs, conducting instructional analysis, analyzing learners, writing performance objectives)

Once organizations are accepted to participate in TA, Abt will assign each organization a trained TA Coach who will deliver and implement a tailored TA plan for each organization and serve as the primary point of contact and ease the flow of communication and information. Each TA Coach will be assigned 2-3 organizations during each cohort.

Abt TA Coaches
Jane Fox
Alexis Marbach
Sharon Pollack
Niki Reddy
Hunter Robertson
Elyse Yarmosky

TA Coaches will review the organization application and ESSAT to develop a preliminary work plan for each organization, outlining goals and potential TA activities.

TA Coaches will prepare a Basecamp project page for each organization that will be used to request TA, document progress towards the goals outlined in the work plan, and share resources. This central hub will also be used to facilitate conversations on discussion boards and share rapid evaluation feedback (described below). Basecamp will also hold a calendar of cohort-level TA activities to reduce confusion and email traffic.

Design Meeting (develop instructional strategy, develop and select instructional materials)

Informed by the application process, ESSAT, organization kick-off meeting, and the organization-specific work plan, TA Coaches will host a TA-planning meeting with the SMEs. During this design meeting, SMEs will be engaged to plan activities, and throughout the TA Action Period (described below). This half-day planning meeting will review all work plans and proposed activities to develop and select instructional materials and assign SMEs to various organization-specific TA and cohort-level activities.

TA Action Period

Organization Kick-Off:

Each TA Coach will conduct a kick-off call with staff identified through the application process (the TA Stigma Reduction Team). During the kick-off call, TA Coaches will collaborate with each organization on an organization-specific TA charter (e.g., outlining expectations for participation, frequency of interactions, communication strategies, and other expectations for the nine-month TA period) and finalize the TA work plan for each organization. Using motivational interviewing and reflective listening skills, the TA Coach will ensure that the TA work plan accurately reflects the organization goals and feasible, reasonable, measurable, and achievable action steps to reduce HIV-related stigma. Organization kick-off will also be an opportunity to discuss leadership engagement in the TA process. Implementing any modification into an existing delivery system involves change management. Change management strategies, when considered and implemented, lead to a higher chance of a successful and sustainable change within the organization. Therefore, the commitment from leadership and identification of a Stigma Reduction Change Agent, which are two key eligibility criteria noted in the TA/LC application, will set the organization up from the start for a receptive and engaged TA process.

Organization kick-off will be an opportunity to identify routine touch-points between the TA Coach and the organization (at least once a month). Outside of the established touch-points and activities documented in the work plan, organizations will be able to request ad-hoc TA phone calls though an online form on Basecamp. This online form will help TA Coaches document their effort and best prepare for the interaction with the organization.

Simultaneously (depending on organization-specific kick-off scheduling), TA Coaches will host a cohort-level kick-off call to welcome all TA organizations into TA, introduce them to each other to facilitate peer-to-peer learning and sharing, and welcome the organizations to the Basecamp resource library and communications platform.

TA will be offered in two forms: organization-specific and cohort-level. By having two forms of TA, organizations can build capacity and identify solutions through multiple pathways.

Organization-specific TA	Cohort-level TA
• 1-1 TA Coach and organization calls (conducted at least once a month) • 1-1 TA Coach trainings for each organization (organization-specific with frequency and duration determined by work plan)	• TA affinity calls (where organizations with similar challenges can share ideas and strategies with each other) • Weekly open office hours (co-facilitated by a TA coach and by a SME, topics vary week to week. Informal opportunity to ask questions and share across organizations)

• Ad hoc TA Coach, organization, and SME calls (organization-specific, with frequency and duration determined by work plan)	• Basecamp-facilitated conversations and resource sharing

TA Coaches will be the primary touch point for each organization, and will facilitate the development and execution of all work plans. Depending on the specific activities outlined during the Design Meeting, TA Coaches will invite SMEs to co-lead trainings and resource development for individual organizations throughout the TA process.

Throughout the TA Action Period, TA Coaches and SMEs will meet on a monthly basis to review TA activities, discuss mid-course corrections and potential need to intensify effort in a given organization, and structure upcoming activities. Given the responsive nature of TA, TA Coaches and SMEs will need to be in consistent communication to progressively elaborate on activities and interactions with organizations.

Transitioning organizations post-TA:

- From the start, TA Coaches will build sustainability and transition planning into all organization and group-level activities to continually affirm that TA activities build internal capacity, rather than offer staff augmentation.
- At the end of TA, organizations will be introduced to the LC team. LC leads will describe the LC activities and how LCs can build upon the work done through TA. Participation in future LCs will be optional but encouraged.
- Highly engaged organizations will be invited to serve as SMEs in the subsequent year of TA (for example, organizations that participate in TA in year 1 of ESCALATE will be invited to be SMEs to organizations in year 2).

TA-specific evaluation activities (develop assessment instruments, conduct assessments) will include the following:

- TA encounter forms: TA Coaches will complete a brief TA checklist for every interaction with an organization. The brief checklist will identify the organization, method of communication (e.g., email, phone), duration of the TA provided, topics covered, resources provided, progress made toward goals and objectives and follow-up needed. TA Coaches will complete one form, per organization, per day. Encounter forms will be reviewed every two weeks by the TA Coaches to inform TA activities. For example, if all organizations are individually struggling with a certain concern, TA Coaches can organize an affinity call or use the concern as a prompt for the office-hours (tracked through a form in Basecamp).
- Monthly reports: TA Coaches will develop monthly summary reports highlighting TA provided to each organization, ongoing challenges, and progress made toward goals and objectives. These monthly reports will guide future ad hoc TA efforts (tracked through a form in Basecamp).
- Pulse-checks: TA recipients will have access to a feedback form that is always open for responses. They can complete it at any time to give just-in-time feedback to their TA Coach (tracked through a form in Basecamp).

- Case studies: Each year, beginning in the second year of ESCALATE implementation, the TA team will indicate four case studies to the Evaluation team at TRX. Each case study will follow a common case study protocol that collates data from the ESCALATE Implementation Science Database related to the case, collects new documents, and conducts key informant interviews with stakeholders. Each year, the four case studies will be reported in the annual evaluation report and reviewed by HRSA and NMAC for dissemination.
- The summative TA Evaluation will include an overall TA survey that captures TA participants' experience and progress overall. During this time, TA participants will also be asked to complete a second ESSAT to be able to compare their pre-and post-TA engagement to identify any changes in their organizational capacity to address HIV stigma.

Continuous improvement (revising instruction):

- Monthly meetings with the Evaluation team at TRX will follow the regular documentation and CQI process outlined in the Evaluation section below. With regard to TA, specific processes include continuous collection and documentation of TA encounter forms, monthly reports, pulse-checks, action plans, specific practices or interventions used, and any other related implementation documents that emerge in the process of TA. These documents will be stored and subjected to mixed-methods analysis in the ESCALATE Implementation Science Database.
- TA Coaches and SMEs will hold a post-TA debrief to revise instruction in future iterations of TA. TA Coaches and SMEs will use data collected throughout TA (encounter forms, monthly reports, pulse-checks) as well as data collected for the ESCALATE Implementation Science Database to inform proposed changes.
- TA Coaches and SMEs will identify TA participants to serve as peer-mentors and support networks for future TA participants.

Learning Collaboratives (Directed by NORC)

Overview

The Institute for Healthcare Improvement's (IHI) Breakthrough Series Collaborative (BSC) provides a model for multidisciplinary teams from different organizations to work in a structured way with each other and recognized experts to accelerate the spread of a best practice[3]. As noted above, the LC Framework is based on this model and on AHRQ's Innovations Exchange Learning Community "5S Model"[4] focused on Supporting, Sharing, Strengthening, Sustaining, and Scaling up.

ESCALATE will implement two LCs with organizations selected across RWHAP. The first LC will run from Fall 2021 to Fall 2022 with up to eight organizations seeking to implement stigma reduction initiatives. The second will run from Winter 2023 to Summer 2024 with up to another sixteen organizations also seeking to implement stigma-reduction programs. LC1 will focus on cultural humility, an overall topic selected during the RFP process and supported by subsequent discussion with NMAC's community advisory bodies. The overall topic for LC2 will focus on another aspect of HIV stigma to be informed by the interest expressed in the LC2 applications and by lessons learned from LC1.

The LCs will support organizations in addressing HIV stigma at organizational and structural levels to engage staff, clients and those organizations to whom they refer. Ideally, these organizations will either be ready to implement a stigma-reduction program focused on a population of interest or have already begun implementing such a program. LC participation will assist organizations in reaching the next stage of implementation (and/or overcoming barriers to successful implementation) of their program.

Figure 1 presents the NORC LC framework which has been informed by input from HRSA and NMAC's community advisory bodies.

Fig.1 Overview of Proposed ELEVATE Learning Collaboratives

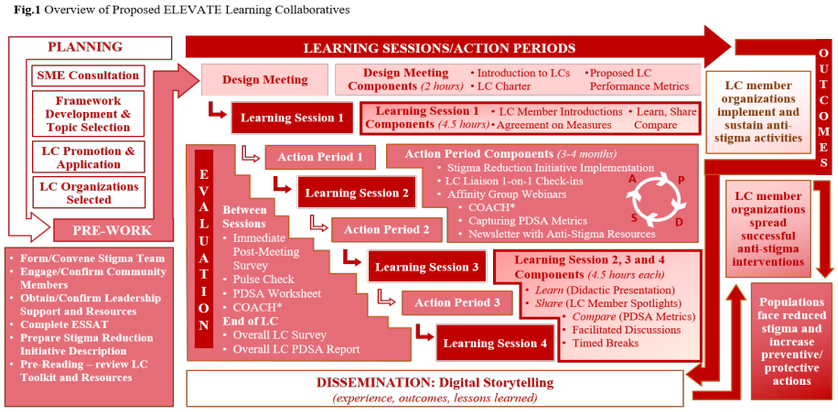


Figure adapted from Institute for Healthcare Improvement (IHI), Breakthrough Series Model, 2003
** Client-Organization Assessment of Cultural Humility*

[3] Institute for Healthcare Improvement. (n.d.). Testing changes. Institute for Healthcare Improvement. Retrieved March 15, 2011, from http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove/testingchanges.htm

[4] Carpenter D, Hassell S, Mardon R, Fair S, Johnson M, Siegel S, Nix M. Using Learning Communities to Support Adoption of Health Care Innovations. Jt Comm J Qual Patient Saf. 2018 Oct;44(10):566-573. doi: 10.1016/j.jcjq.2018.03.010. Epub 2018 Jul 9. PMID: 30064957.

LC Planning

NORC LC Team
Chris La Rose
Shannon TenBroeck
Jessica Fox
Tracy McPherson
Chandria Jones
Sarah Hodge

NORC will manage the LCs, including planning, providing logistical and communications support for, implementing, and evaluating the Learning Sessions and Affinity Group Webinars. NORC staff will schedule these events based on a LC Calendar that has been constructed to allow sufficient time between Learning Sessions (i.e., Action Periods) for LC member organizations to implement their programs and gather performance data. The NORC LC Coordinator will send save-the-date notifications and invitations for these events and host and record them. The NORC LC Lead and Project Manager will facilitate each event.

Presentations during the Learning Sessions and Affinity Group Webinars will focus on different aspects of the overall LC1 topic, cultural humility. The specific aspects of cultural humility that each presentation will focus on will be informed by interests expressed in the LC1 applications. The NORC team will review the applications and select topics associated with cultural humility in collaboration with HRSA and based on advice from our Senior Advisor. The LC Project Manager will then update the LC Calendar with topics and propose SMEs for each event and submit it to HRSA. Once approved, the NORC team will contact identified SMEs and support them in developing and delivering presentations.

In addition, the NORC LC team will identify resources and integrate resources from the ESCALATE Training curriculum related to cultural humility, Plan-Do-Study-Act (PDSA) cycles, stigma, discrimination and unconscious bias, and power and privilege for the LC Member Packet and the LC Newsletter based on the applications and create and submit an editorial calendar to HRSA for review and approval. NORC is also developing tools to evaluate member organizations' experience of the Learning Sessions and Affinity Group Webinars and intent to use LC content in their work, and tools to evaluate PDSA cycles conducted by member organizations during each Action Period, as well as a survey of member organizations' experience of the LC as a whole. NORC will submit an LC evaluation plan with these instruments to HRSA for review and approval and thereafter will program the instruments and manage the LC evaluation in collaboration with TRX Development Solutions and NMAC.

Participant Preparation

Once selected, LC organizations will convene their Stigma Reduction Team which includes members of the populations each organization serves who are experiencing stigma, confirm prior commitments for leadership support and resources, complete baseline evaluations (as noted before, these include the ESSAT and other LC-specific assessments), and complete preparation and pre-reading activities before the Learning Sessions and Action Periods begin.

During this phase, NORC will communicate with the LCs via letters of acceptance, declination (in the case of excess qualified applicants) as well as confirmation of acceptance, and will share the LC Member Packet with those organizations accepted into the LCs. This packet will include a calendar of events or activities, an FAQ, an overview of the evaluation requirements, resources for participants to review, and forms for them to fill in. Each organization will also be paired with an LC Liaison from the NORC team who will be their primary point of contact throughout the LC time period. Each LC Liaison will be assigned up to two LC member organizations during LC1 who will check-in with each LC member organizations twice during each learning session, to provide them with advice and support and help them identify and brainstorm solutions to barriers that emerge.

Design Meeting

Thereafter, NORC will host an initial design meeting with incoming LC member organizations to discuss the LC activities and events, and refine a collaborative LC Charter that LC members will be asked to commit to, as well as a proposed common set of performance metrics for three ongoing PDSA cycles that member organizations will report on during each of the LC Action Periods that they will need to review and ratify before the first Learning Session.

Learning Sessions and Action Periods

Learning sessions are ~4.5 hour-long interactive sessions facilitated via online video conferencing[5] that offer an opportunity for LC members to interact with and learn from each other and SMEs. Each of the four Learning Sessions will focus on *Learn, Share*, and *Compare* components:

- *Learn* components will include facilitated discussions as well as didactic and interactive presentations by SMEs intended to build LC members' knowledge about stigma reduction.
- *Share* components will provide an opportunity for LC members to:
    - Introduce their Stigma Reduction Teams and their stigma reduction initiatives (first Learning Session only); and
    - Share their experiences implementing a PDSA cycle during the last Action Period, including describing planned actions taken, studied and revised, as well as opportunities to request input from other LC members; and
- *Compare* components, during which the LC team will share progress toward common performance metrics across LC member organizations.

In addition, Learning Sessions will feature breaks and activities between each component intended to reduce the burden of and barriers to virtual participation, and a closing to allow for evaluations of each session and remind members of upcoming activities and expectations during the Action Periods.

Action Periods are 3-4 month periods between the Learning Sessions, during which LC members are expected to develop and implement their stigma-reduction activities. They will be supported by two regular check-ins with their LC Liaisons (who will discuss progress and help organizations problem-solve and find resources), Affinity Group Webinars and an LC Newsletter that shares resources and overall LC progress via reporting on PDSA cycles, between each Learning Session.

Assuming a minimum of 12 weeks between each Learning Session -

- LC Liaison Check-ins (which fulfill both learning and evaluation purposes) will take place approximately four and eight weeks after each Learning Session;
- Affinity Group Webinars will take place six weeks after each Learning Session; and
- LC Newsletters will be disseminated at 10 weeks after each Learning Session.

Transitioning Organizations post LC:

Our intention is that, as a result of participating in the LCs, organizations will have completed three PDSA cycles during the Action Periods and that they will be at a further step along the continuum of planning, implementation, improvement and maintenance of success in terms of their stigma-reduction initiatives. As such, if they entered the LC with just a plan, they should be well on their way through implementation, and if they entered with an already implemented program facing challenges, they should have overcome those initial challenges, improved their performance, be further along in

[5] NORC currently uses Zoom for video conferencing but is transitioning to Microsoft Teams and can utilize whichever common platform is used for training and TA to ensure seamless transitions for training participants and TA recipients.

implementation and on their way to application of ongoing PDSA cycles beyond the LCs for the purpose of continuous improvement.

As noted below under Dissemination, LC members will be encouraged to develop digital stories to be shared on the TargetHIV site describing their challenges, successes and lessons learned, as a means of disseminating best practices in addressing and reducing stigma. NORC will provide them with a template during the last Action Period and will support them with editing to highlight key elements of their programs before sharing their digital stories with NMAC for production and posting on TargetHIV.

LC Process and Summative Evaluation and PDSA Cycles

As described previously, a robust LC evaluation will incorporate baseline measures, process evaluation, PDSA cycles, and summative evaluation. Baselines measures will include the ESSAT and the Stigma Reduction Initiative Description or 'SRID' which describes LC member organizations' initiatives in more depth than their applications. Process evaluation will include immediate post-meeting surveys and Affinity Group Webinar surveys, digital pulse checks, and LC Liaison check-ins during the Action Periods. In addition, NORC will implement regular PDSA cycles during the Action Periods and ask LC members to complete a PDSA worksheet during each of the three Action Periods. LC members will also administer a Client-Organization Assessment of Cultural Humility (COACH) form to gauge client perceptions of LC member organizations' cultural humility during each of the three Action Periods. Finally, a summative LC Evaluation will include an overall LC Survey and a PDSA Report. NORC will develop the evaluation instruments which will then be programmed by TRX Development Solutions via Qualtrics and administered via NMAC. NORC will provide descriptive statistics on evaluation quantitative data and analyze qualitative data to make ongoing recommendations for the next Learning Session or LC activity. PDSA data will be aggregated across organizations and presented in the LC Newsletter and Learning Sessions, enabling each organization to track its own progress against the group as a whole. It will also be used by LC Liaisons during their regular check-ins to assist in characterizing progress, identifying barriers and brainstorming solutions.

Assuming a minimum of 12 weeks between each Learning Session:

- Immediate post-meeting survey will be conducted directly after each Learning Session;
- Digital pulse checks (i.e., brief check-in surveys) will be conducted approximately three weeks after each Learning Session;
- PDSA worksheets will be completed between 6 and 8 weeks after each Learning Session.

The summative LC Evaluation will include an overall LC Survey and a final PDSA worksheet to be completed immediately after the fourth Learning Session, which will capture LC members experience and progress overall. During this time, LC members will also be asked to complete the ESSAT a second time to be able to compare their pre-LC assessment to post-LC to identify any changes in their organizational capacity to address HIV stigma.

Implementation Science Evaluation

As with the Training and TA components, the LC team will meet monthly with the Evaluation team from TRX to collect and review documentation of LC implementation for the ESCALATE Implementation Science Database. Additionally, LC member organizations and their individual participants will complete the ESSAT at multiple time points (pre, post, and [for the first LC cohort only] three-to-six months following participation in the LC).

Continuous Improvement

- During each LC, we will gather process data via the Post-Learning Session Surveys, Digital Pulse Checks, Post-Affinity Group Webinar Surveys, and notes from the LC Liaison check-ins to refine and improve the functions of that LC over time. Findings from each round of evaluation will be discussed during bi-weekly team meetings where recommendations for improvement of LC functioning and implementation will be discussed, prioritized, applied, and reviewed.
- PDSA worksheets completed during the Action Periods between each Learning Session will provide opportunities for continual innovation, assessment, and improvement for the LC members themselves.
- LC facilitators will have full access to all analysis of LC data collected over TRX platforms, ESSAT, and the Implementation Science Database.
- Finally, the overall LC Survey, final PDSA report and the immediate post-LC ESOA will also provide valuable data from the first LC, which, triangulated with the process data described above, will provide key recommendations for strengthening the implementation of the second LC.

Evaluation Activities

Evaluation Technologies:

- Qualtrics-powered survey platform for the collection of all data in program applications, surveys, and tracking tools.
- Dedoose mixed-methods analytical platform, developed by behavioral scientists at UCLA. Dedoose enables systematic thematic coding of word documents, transcripts, audio and video recordings, PDF files, and other data sources. Qualitative coding in Dedoose can be connected to quantitative survey data for mixed-methods analysis.

The ESCALATE RE-AIM Framework for Program Evaluation seeks to provide documentation of the challenges, facilitators, costs, opportunities, and replicable practices involved in the implementation of the ESCALATE Training curriculum, TA provided to RWHAP organizations, and the Learning Collaboratives' development of replicable best practices. The goal by the end of the third and fourth years of ESCALATE is to have a basis for providing recommendations to HRSA and the RWHAP on promising practices or interventions for further research, replicable practices than can be disseminated without (or notwithstanding) further piloting, case studies that will inform the research agenda for HIV stigma and other stigma-reduction interventions and health promotion programming, and the structuring of RWHAP funding requirements to incorporate stigma reduction into support for organizations across RWHAP.

Data Sources

Data sources for the ESCALATE Program Evaluation will include several types of data across individual and organizational levels of analysis. Most data sources across all ESCALATE components will be developed and implemented by TRX and the evaluation team. Specialized tools for Training, TA, and LCs will be implemented in modules of larger instruments—for example, the ESCALATE Survey will contain specific modules for each ESCALATE component. These data sources will include:

- The ESCALATE Survey and Self-Assessment Tool (ESSAT), which contains two instruments in one survey:
  - The ESCALATE Survey
  - ESCALATE Organizational Self-Assessment (EOSA)
- Facilitated EOSA

- Case Studies
- Implementation Science Documentation

The ESSAT contains two distinct tools, the ESCALATE Survey and the ESCALATE Organizational Self-Assessment (EOSA). By combining the two instruments into one survey, the evaluation reduces the number of survey events for participants. Because the EOSA has been included in all three ESCALATE components as a training tool, Trainers, TA coaches, and LC facilitators will implement the ESSAT for pre- and post-surveys and enhance the response rate.

The "Facilitated EOSA" will be utilized with up to 10 organizations annually that have supported 10 or more staff and community members for participation in Training, TA, or LCs (any combination across these program components). For the Facilitated EOSA, the TRX team will meet with a group of at least three participants from the organization and engage in a guided process of reviewing aggregate results from the individually-completed EOSA surveys taken by participants during training, TA, or LC activity; engage in a group process to complete the EOSA for the organization together, as a committee; and then score the EOSA results to provide for the organization a baseline assessment of how it is dealing with HIV stigma and opportunities for developing better practices and policies. During the implementation of ESCALATE, the Evaluation team will train ESCALATE staff at NMAC, Abt, and NORC in the process and utilize an iterative implementation science approach document evidence for a draft Implementation Manual for the Facilitated EOSA that HRSA may utilize after the completion of the program.

Other, specific data sources for the LC process will be developed and partially implemented by NORC. These will include additional instruments and measures. The additional LC evaluation data sources will include:

- Stigma Reduction Initiative Description (SRID)
- PDSA Cycle Documentation
- Digital Stories
- Client-Organization Assessment of Cultural Humility (COACH)

The data sources and their correspondence to RE-AIM Framework elements and other components of the program or the evaluation are displayed in Appendix B: ESCALATE Data Table. Following the data table, specific notes on data sources are included.

Feedback Loops and CQI

Evaluation meetings with each partner (NMAC for training, Abt for TA, and NORC for LCs), will take place monthly. Monthly, quarterly, and biannual timepoints will serve particular purposes in the annual cycle of feedback, adaptation, and documentation of ESCALATE implementation (see Feedback Plan and Timeline Table, Annual cycle, next page). The annual cycle is based on HRSA reporting requirements. The cycle of monthly → quarterly → monthly → semiannual → monthly meetings divides up implementation science tasks with types of meetings according to the timetable provided in the Feedback Plan Table, Appendix C.

- ***Monthly meetings*** (January, February, April, May, July, August, October, and November) address documentation and troubleshooting of data collection with each partner. In these meetings the evaluation team works with individual partners on ESCALATE components to

ensure that documentation and data collection is meeting evaluation needs. The documentation is loaded in Dedoose monthly by the Evaluation team and coded for its relation to the five elements of the RE-AIM Framework, to enable feedback in the Quarterly meetings.

- In the ***Quarterly meetings***, evaluators and ESCALATE partners examine how program implementation is proceeding, if goals are being met, and how adaptations to challenges are performing. Quarterly meetings conduct mid-stream check-in on implementation and adaptive processes.
- ***Mid-year semiannual meetings*** check in on progress on goals that are set in the full-year semiannual meeting following the annual report. The mid-year meetings offer an opportunity to check progress toward annual goals and develop any necessary adaptations to address challenges or to consolidate promising achievements.
- ***Full-year semiannual meetings*** occur following the completion of the annual report, and in these meetings, evaluators and ESCALATE partners review annual results, including achievements, challenges, and adaptations. At this point, the partners will (a) select best practices and strategies for HIV stigma reduction from the previous year to discuss with HRSA for potential dissemination throughout the RWHAP organizations and communities; (b) identify and triage challenges, selecting some for adaptive action to be developed and tracked throughout the year; and (c) identify other promising practices that should be more fully documented during the next program year.

Dissemination

Case Studies: The Evaluation Team will produce eight case studies each year (Years 2-4) for a total of 24 across the ESCALATE Program. Eight case studies will be taken from the TA and LC components of ESCALATE annually. These case studies will document real-time, actionable, and practical information from staff and clients who have experienced the impact of HIV stigma on the community and who share the trials and joys of working to move RWHAP providers in the direction of great cultural humility and openness to the communities they serve.

Digital stories: TA and LC members will disseminate challenges and successes, and lessons learned via a digital storytelling program supported by NMAC on the TargetHIV website. Organizations will be provided with a template or storyboard at the conclusion of their TA engagement or LC participation and asked to document and communicate their journey, activities, and outcomes. This will enable them to spread successful stigma-reduction activities to other organizations beyond their communities, and ideally, positively impact HIV stigma and encourage populations most affected by stigma to engage in and increase preventive and protective behaviors, thus improving viral suppression at a societal level and contributing to ultimately ending the HIV epidemic.

RWHAP-wide Opportunities: ESCALATE will share findings through traditional RW platforms including webinars to the RWHAP community, the annual Ryan White Conference, posts on the TargetHIV site, and newsletters geared towards the RWHAP community.

Facilitated EOSA Implementation Manual: The Evaluation team at TRX will utilize the iterative process of completing Facilitated EOSA processes with RWHAP organizations to develop an Implementation Manual that may be disseminated as a tool to help organizations establish a baseline of their

engagement with HIV stigma. The manual will also provide opportunities to implement other practices and policies to address stigma and enhance the cultural humility of an organization's staff and l setting.

Annual HRSA Debrief: The ESCALATE team will meet with HRSA on an annual basis to share findings and progress to date, implementation lessons learned, and information to support future HRSA initiatives and funding notices. At the end of the initiative, ESCALATE will produce an evaluation report summarizing outcome and implementation findings, measures used to collect data, and future directions for evaluating HIV-related stigma.

Evaluation Report: Each year, the annual evaluation reports will provide feedback into the implementation process throughout ESCALATE. The goal is that by the conclusion of the program, the final evaluation report will constitute a state-of-the-art review of the stigma-reduction programming and efforts across the RWHAP communities. This will include:

- Documentation of 24 case studies that will provide a nucleus of future study, piloting, and translational research.
- An anti-stigma curriculum with proven effectiveness that can be provided to the RWHAP organizations on an ad-hoc basis to continue developing an "HIV stigma-informed" RWHAP workforce.
- Metrics for HIV stigma and cultural humility that are more brief than current scales and thus more easily included in client assessments and consumer satisfaction surveys.
- An agenda for future piloting and research that will enable HRSA and the RWHAP to establish the research base for the rapid deployment of anti-HIV stigma interventions nationally.

Sustainability

Participants will leave Training, TA, and LCs with action plans outlining concrete, measurable steps to embed this work into their individual organizations, sustaining the effort long-past their engagement in the various project activities.

ESCALATE will create significant changes in the RWHAP community's approach to addressing HIV-related stigma, but the work can continue in a number of ways.

- While this is not an expectation of the ESCALATE program, trainees, TA recipients and LC members could go on to:
  - be ambassadors for the ESCALATE program and describing the benefits of all aspects of the program to others, essentially becoming key opinion leaders in the field of HIV stigma reduction;
  - create communities of practice, potentially supported by the AIDS Education and Training Center (AETC) program, that provide a platform for ongoing discussion of stigma-reduction strategies, interventions and programs; or
  - teach AETC practice transformation programs the ESCALATE systems-level intervention model for use in practice transformation projects
- Best practices and lessons learned across Training, TA, and LCs could be compiled into a toolkit or playbook to be disseminated beyond ESCALATE and RWHAP through Target HIV.

As outlined in the Diffusion of Innovations Theory of Change, these innovators, early adopters, and adopters can demonstrate that it is possible to embed stigma-reduction programs into organizational theories, practices, and policies.

All of these potential activities hold the promise of additional capacity building and dissemination of best practices to other organizations to address and reduce HIV stigma, thus having a broader, RWHAP-wide or systems-level impact. Sustainability post-ESCALATE will allow HRSA an opportunity to leverage the investment in, and progress through, the ESCALATE program and contribute to the project's goal of ultimately "Ending Stigma through Collaboration And Lifting All To Empowerment".

Appendix A: Partners and Staff

Name	Pronouns	Organization	Role on project
Paul Kawata	he/him/his	NMAC	ESCALATE Co-PI; NMAC Lead/PD
Terrell Parker	he/him/his	NMAC	NMAC Activities Project Manager
Christopher Paisano	he/him/bii	NMAC	NMAC Activities Coordination Trainer
Chip Lewis	he/him/his	NMAC	Marketing & communications
Jas Florentino	they/them	NMAC	Marketing & communications
Adam Thompson	he/him	NMAC, Curriculum	Curriculum Development
Dottie Dowdell	she/her/hers	NMAC, Curriculum	Curriculum Development
Alexis Marbach	she/her/hers	Abt	ESCALATE Co-PI; Abt Lead/PD
Jane Fox	she/her/hers	Abt	Abt Project PI and Project Quality Advisor
Niki Reddy	she/her/hers	Abt	ESCALATE Project Manager; Abt project PM
Elyse Yarmosky	she/her/hers	Abt	Technical Assistance Coach
Sharon Pollack	she/her/hers	Abt	Technical Assistance Coach
Hunter Robertson	he/him/his	Abt	Technical Assistance Coach
John Guidry	he/him	TRX	TRX PD, Lead Evaluator
Kevin Williams	he/him/they	TRX	Evaluator
Sarah Trench	she/her	TRX	Evaluator & Data Analyst
Isabella Gonçalves	she/her	TRX	Data Coordinator
Erin Hou	she/her	TRX	Administrator
Chris La Rose	he/him/his	NORC	NORC PD
Shannon TenBroeck	she/her/hers	NORC	NORC Project Manager
Jessica Fox	she/her/hers	NORC	Project support/RA
Tracy McPherson	she/her/hers	NORC	LC SME
Sarah Hodge	she/her/hers	NORC	LC Liaison and Communications
Chandria Jones	she/her/hers	NORC	LC Liaison

Appendix B: Data Collected through the ESCALATE RE-AIM Evaluation

Data Source & Level of Analysis	Description	Relationship to RE-AIM Framework (Reach, Effectiveness, Adoption, Implementation, and Maintenance)	Responsible Party, Data Collection Method, & Frequency
ESCALATE Survey			
Individual Level ***Analysis: Stata SE16***	• The ESCALATE Survey is the primary source of data related to individual participants in the three components of ESCALATE. The survey will be composed of some modules that apply to all participants and some that are individualized for each ESCALATE component (training, TA, and LCs). • The survey will be designed to take 20-25 minutes to complete and will be written at an eighth-to-ninth grade reading level. The survey will be available via a customized URL on TRX's Qualtrics survey platform. Respondents may take the survey on any mobile device, tablet, or computer with internet connection.	The ESCALATE Survey measures: • ***reach*** and distribution of ESCALATE through RWHAP communities, which is elemental to ESCALATE's Diffusion of Innovation model. • ***effectiveness*** of creating a new knowledge base around HIV stigma and HIV stigma interventions • supports, costs, and challenges to ***implementation*** of anti-HIV stigma practices and strategies	• Collected by TRX evaluation team over the ESCALATE Data Platform (powered by Qualtrics) as part of the ESSAT. • Individual ESCALATE participants receive a URL and a Unique ID Code, which they may use to take the ESCALATE Survey at all points. The surveys are completed in Qualtrics and may be accessed by any mobile device or computer, including smart phone. • For each ESCALATE component, the survey is collected at 3 time points: pre/post ESCALATE program participation and 3 months following participation.
Focus Groups			
Individual Level ***Analysis: Dedoose***	• Focus groups are a secondary method of data collection for individual participants in ESCALATE Training (not TA or LCs). Each year, TRX will conduct focus groups with trainees following ESCALATE training. • Question guides will explore participant experiences with implementing the training in their work and personal lives at the time of the conclusion of the training program, particularly in light of their own self-assessments of capacities following Training.	Analysis of focus groups will enable the exploration of: • ***Effectiveness*** of the ESCALATE Training curriculum in providing anti-HIV stigma practices and strategies that can be implemented at RWHAP agencies. • ***Adoption*** of anti-HIV stigma practices or strategies by trainees at their home organizations and communities • ***Implementation*** costs, challenges, and supports encountered after Training,	• Focus groups will be facilitated by TRX evaluation staff over Zoom.com. The groups will be audio-recorded and transcribed for analysis in Dedoose. • At least three focus groups will be conducted annually, for a total of 12 across the four years of program implementation.
ESCALATE Organizational Self-Assessment (EOSA)			
Organizational Level ***Analysis: Stata SE16***	The EOSA is the primary source of organizational change data for RWHAP-funded organizations (Parts A-D) participating in any ESCALATE component (Training, TA, and LCs). The EOSA consists of questions designed to measure the extent to which organizations have identified HIV stigma and other stigmas as areas of concern and the organization's level of engagement in the development and implementation of formal policies to address HIV stigma and other stigmas.	The EOSA will indicate: • Extent of ***adoption*** of anti-HIV stigma practices and strategies in organizations receiving TA or participating in LCs. • ***Maintenance*** of anti-HIV stigma practices and strategies after program participation has ended.	• Collected by TRX evaluation team over the ESCALATE Data Platform. • The EOSA is powered by Qualtrics. Individual ESCALATE participants take the EOSA as part of the ESSAT at all time points. • For organizations with 10 or more participants in ESCALATE activities, the Evaluation team will conduct a Facilitated EOSA process that will provide a baseline score that an organization can use to develop a stigma-reduction strategy.
Case Studies			
Organizational Level ***Analysis: RE-AIM protocol created for ESCALATE Evaluation***	• Case studies document organizational participation and change in ESCALATE. Starting in year 2, eight organizational case studies will be produced annually (four TA participants, four LC participants, 24 case studies total). • Case studies will be chosen to reflect exemplary cases of positive change toward reducing or eliminating stigma, challenges and *(continued next page)*	• Each case study will be conducted with the same case study protocol designed to explore RE-AIM Framework elements and to provide input for annual assessment of TA and LC ***effectiveness*** and impact on organizations *(continued next page)*	• The Evaluation team will collect documents, interview key informants, and collect other observational data with the organizations and clients involved in the cases. • Case study data will be supplemented with EOSA and ESCALATE survey results for the organizations and individuals *(continued next page)*

Data Table: Case studies, continued

	adaptations that can provide important models of "best practices" for anti-HIV stigma programming, and the impact of HIV stigma-reduction policies on clients seeking services at RWHAP agencies. • Case studies will be utilized to identify best practices and strategies for reducing HIV stigma and developing an environment of cultural humility at RWHAP agencies. These practices will be submitted to the Target HIV Best Practices Compilation for dissemination.	and to adapt TA and LC methods when appropriate. • Case studies will document ***adoption*** of anti-HIV stigma practices or strategies participants organization; ***implementation*** costs, challenges, and supports; and the potential for ***maintenance*** of practices over time.	participating involved in the specific TA or LC process. • Annual reporting of the case studies will be utilized with Abt and NORC to identify specific challenges encountered in implementation of practices and strategies and how this learning can be used to adapt ESCALATE training to enhance the effectiveness and impact of the program at both the individual and organizational levels.
Documentation of Implementation Science and RE-AIM Components			
RWHAP System level Analysis: Dedoose	• Documenting the implementation of ESCALATE's components will feed a 3-tiered process of feedback loops: a) Monthly evaluation meetings between evaluators and the partners for each component (NMAC for Training, Abt for TA, and NORC for LCs) to review documentation, track site calls and implementation notes, and document core program components. b) Quarterly review of monthly reporting and meetings, barriers and facilitators to implementation of program components, deviations from program models, and review or follow-up of adaptive actions to address challenges or deviations. c) Semi-annual review meetings to examine implementation for the program year, evaluate adaptive and corrective actions, fidelity to model, results of the current program year, and adaptive actions to be taken in the coming year, to repeat the monthly/quarterly/annual reporting and feedback cycle. • With TA and LCs, evaluation will concentrate on change at the organizational level and efforts at evaluating how organizational anti-HIV stigma efforts are reflected in changes to the client experience of cultural humility. While the ESCALATE Survey and EOSA can establish the reach and effectiveness of ESCALATE, the case studies will enable the evaluation to drill down into the potential for system-level innovation in addressing HIV stigma across the RWHAP communities. a) Case study selection and review: TA and LC leadership will designate appropriate case studies, and monthly and quarterly meetings will review documentation of the cases according to ESCALATE protocols. b) Case study documentation will also include key informant interviews by evaluators of TA and LC facilitation teams and agency participants. Evaluators and TA and LC facilitators will work together to obtain client-level consumer satisfaction data from participating organizations to assess clients experience and change.	• The document review protocols will involve completion of RE-AIM Framework protocols for implementation, fidelity/deviation, adaptive/corrective processes, organizational learning, and client experience at RWHAP agencies participating in ESCALATE. • Protocols will document specific challenges, deviations, facilitators, and adaptation for each element of RE-AIM: ***reach, effectiveness, adoption, implementation,*** and ***maintenance***, with progress tracking across time to analyze how program activities are meeting goals in each RE-AIM element. • Semiannual feedback cycles will take place: a) After annual reporting (December) to examine program year trends, challenges, facilitators, adaptations, and program changes—and to recommend adaptive processes and changes for the coming program year. b) Six months after the annual report (May-June) to review implementation of annual review changes and goals and utilize evaluation data to support program implementation.	• Documents will be loaded into Dedoose each month for mixed methods analysis to be provided in the semiannual feedback sessions and annual reports. • The Evaluation team will work with NMAC, NORC, and Abt to identify practices to be proposed to the Target HIV Best Practices Compilation project, as proposals/abstracts for conferences, and as joint projects in peer-reviewed evaluation manuscripts. • The Evaluation team will meet monthly with each ESCALATE partner (NMAC, Abt, NORC) to collect program documents and develop and improve protocols for documentation across the program's four years of implementation. • During quarterly meetings, the Evaluation team will audit program documentation by partners to ensure that all materials in the Documentation Review Protocol are being collected and submitted to evaluators, for review and planning. • Document review and feedback sessions are another source of best practices to be submitted to the Target HIV Best Practices Compilation and to be developed into other presentations or HRSA/HAB Webinars for dissemination.

Data Table, continued

Learning Collaborative: Stigma Program Description			
Organizational Level	Stigma programs are designed by participants with NORC support to guide participation and home implementation.	Describes the anti-HIV stigma program that the organization is ***adopting/has adopted*** and intends to ***implement*** or is ***already implementing***, and describes the team, the population of interest, the stigma focus, goals, objectives, resources, timeline and stage of implementation.	• Collected by the Evaluation team over the ESCALATE Data Platform (powered by Qualtrics). • Data compiled by NORC during the LC implementation. Stigma programs developed by participants with support of the LC and NORC.
Learning Collaborative: PDSA Cycle Data			
Organizational Level	NORC will adapt PDSA processes for participants to implement and improve programs throughout the LC, share data and results, share learning, and develop common best practices. LC best practices will be compiled by the Evaluation team and the LC team for submission to the Target HIV Best Practices Compilation and to be developed into other presentations or HRSA/HAB Webinars for dissemination.	The PDSA cycles involve improving ***implementation*** through iterative cycles of PDSA processes in which real-time evaluation data will help organizations deepen their commitments to anti-HIV stigma programs. Review of this data over time will provide insights into the ***effectiveness*** of the LC and assess the potential for ***maintenance*** of anti-stigma programs over time.	• Collected by the Evaluation team over the ESCALATE Data Platform (powered by Qualtrics). • Data compiled by the LC team at iterative intervals through the LCs, with formal protocols to be developed. Data will be presented back to participants via an LC newsletter and discussed during LC Learning Sessions to foster benchmarking and ongoing improvement.
Learning Collaborative: Digital Stories			
Organizational Level	The LC team will develop digital storytelling protocols for LC participants. The digital storytelling process will be utilized to showcase LC participants' programs and results for dissemination throughout the RWHAP communities.	The digital stories will carry anti-stigma programming in the LCs from ***adoption*** through ***implementation*** and ***maintenance***, and ultimately will describe the ***reach*** and ***effectiveness*** of the LCs.	• Data collected and compiled by NORC at iterative intervals through the LCs, with formal protocols to be developed.

Appendix C: Feedback Plan and Timeline Table, Annual cycle

Months	Type of Review	Goals, tasks, and feedback
January, February	Monthly	Main goals: Documentation and troubleshooting data collection • Data collection: documentation, notes and minutes of site calls, other meeting implementation notes, documentation of core program components, collection of tracking data for fidelity to model and participants served. • Troubleshooting data collection and ensuring that all needed program documentation is being collected. • Ensuring that participant data collection in the ESCALATE Survey and Self-Assessment Tool (ESSAT) is being submitted as expected. • Developing Focus Groups and case studies with the appropriate ESCALATE partners.
March	Quarterly	Main goals: Assessing progress on implementation progress to goals; troubleshooting data collection, identifying supports and facilitators to improve implementation and adaptations of ESCALATE activities.
April, May	Monthly	Main goals: Documentation and troubleshooting data collection (as noted in January/ February)
June	Semiannual/ mid-year	Main goal: review progress on annual goals, document achievements, triage challenges, and adapt strategies to achieve goals.
July, August	Monthly	Main goals: Documentation and troubleshooting data collection (as noted in January/ February)
September	Quarterly	Main goals: Assessing progress on implementation progress to goals; troubleshooting data collection
October, November	Monthly	Main goals: Documentation and troubleshooting data collection (as noted in January/ February)
December	Semiannual/ full year	Main goals: Identify and set annual goals for each component of ESCALATE (including confirmation of existing goals and adoption of new or adaptive goals based on the previous year's program activities). • Build adaptive processes based on triage of challenges from the previous year. • Review annual report and adjust program goals and expectations by incorporating feedback on the extent to which the previous program accomplished its goals, challenges that emerged, adaptations, fidelity to program model, and lessons learned in implementation.

Note: This table is tracked to calendar years. HRSA program years run September 1 through August 31, with an anticipated annual report date of November 30. The timeline may be reset by HRSA adhere to different reports timing, and the three-tier approach to documentation and feedback will be adjusted accordingly.