Julie Hook: Good afternoon and welcome to this webinar, Building and Sustaining the HIV Workforce. Ryan White's, Ryan White, Rhode Island's Ryan White HIV/AIDS Program Goes to College. My name is Julie Hook from the Integrated HIV AIDS Planning Technical Assistance Center and I want to thank everyone for taking the time to be on today's Webinar. During today's Webinar, folks from JSI in Rhode Island will describe the current state of HIV workforce capacity in the United States and work that Rhode Island and others are doing to build and sustain their HIV workforce. The slides are available now for download on IHAP TAC tech page on the target HIV website and the transcript and recording will also be made available on our webpage early next week.

Julie Hook: The integrated HIV AIDS Planning Technical Assistance Center or the IHAP TAC is a partnership between JSI, Health HIV and [inaudible 00:00:49] and it's funded by the HRSA HIV/AIDS bureau. As a reminder we're three year cooperative agreement to support Ryan White Hiv AIDS program parts A and B recipients and the respect of planning bodies with the overall integrated planning efforts and the implementation and monitoring of their integrated HIV prevention and care plans. We provide both national and targeted technical assistance and training activities. We provide support in the following areas, integrating HIV prevention and care at all levels, but does help with integrating planning bodies. Integration of care and prevention programs within health departments. Strategies for implementing integrated plan activities. Publicizing and disseminating progress of integrated plan activities to stakeholders such as communicating progress to planning councils and bodies. Identifying roles and responsibilities for integrated planned activity implementation, monitoring, improving their integrated plan activities and helping with collaboration across jurisdictions.

Julie Hook: We'll be answering questions at the end of the call. We'll answer as many as time permits, so if you have questions during the call, please chat them into the chat feature. I also want us to mention that after the Webinar ends, an evaluation will pop up immediately. And hopefully you'll fill this out as it helps us to improve and inform future webinars and training. We hope that after today you'll be able to describe the current HIV workforce capacity in the US, describe the purpose of the human resources inventory. Identify at least one way jurisdictions can build and sustain their HIV workforce. So I'd like to now introduce our speakers. First we'll have Stewart Landers who is the principal investigator of the IHAP TAC and prior to that was the Co Pi, of the [inaudible 00:02:27] Center. He has over 30 years of experience in public health practice, HIV/AIDS and has expertise in community and consumer engagement working with planning bodies and needs assessment.

Julie Hook: He collaborated with the state of New Hampshire on the development of their integrated HIV prevention and care plan as conducted comprehensive planning and HIV prevention and care needs assessments for several part A and part B jurisdictions. Amy Black has over 15 years of experience in health equity, health care policy, data analysis, sexual health and program evaluation. Since 2017 she

has served as the Project Director of the Rhode Island Ryan White Technical Assistance Project for people living with HIV and AIDS. And this capacity, Dr. Black is supporting the implementation of the integration of behavioral and physical health into the HIV system of care with an emphasis on identifying strategies and best practices to better achieve such integration. We also have, we're very excited also to have Tonya Glantz, who is the Director of the Institute for Education and Health Care at Rhode Island College. She has more than 25 years of experience working with social service, higher education correctional and community based organizations. Professional research interests revolve and exploring and implementing empowering interventions that promote understanding and productive relationships between vulnerable populations and service organizations.

Julie Hook: Dr. Glantz is a lead project investigator for the RIC-COEXIST grant a funding initiative addressing HIV/AIDS awareness and prevention through workforce development and care continuum expansion. So now that you've heard a little bit about us, we want to hear a little bit about you. Just want to hear from those on the Webinar, whether or not you've participated in a IHAP TAC Webinar before. I think we can go ahead and close the poll. It looks like some of you ... So it's a pretty good split about just over a third of you have been on before. So welcome back and about two thirds of you have not been on before. So welcome. We're glad to have you. Also, we want to hear from you about whether or not, how would you describe your experience or process for developing the workforce inventory section of the integrated HIV prevention and care plan? Very easy, easy, neither difficult or difficult, difficult or very difficult. I also realize there could be a non-applicable choice here as well, so you can chat that into the chat feature if this was applicable for you.

Julie Hook: People want another minute or so. I think looking at the responses it looks like about 60% of you felt like it was not easy or difficult. About 20% thought it was difficult and about 18% with difficult. So hopefully we can shed some light today with some experience in resources. So thanks for joining. And now I would like to hand off over to Stewart Landers.

Stewart Landers: Thank you Julie. So I'm going to provide a little bit of an overview of the workforce capacity and start by giving a little bit of a background of how we've gotten to focus today on workforce capacity.

Stewart Landers: As many people are familiar with the national HIV/AIDS strategy, we often look at the first three goals, but a very important goal is the fourth one, to achieve a more coordinated national response to the HIV epidemic. Specifically by way of increasing coordination of HIV programs across the federal government and between federal agencies and state territorial, tribal and local governments. However, we also now have the current administration's and the HIV epidemic plan, which is yet another effort to further coordinate and target those resources. Next slide. So part of the idea to achieve this higher coordination was CDC and HRSA working together to introduce the integrated HIV prevention and

care plan guidance. Including the statewide coordinated statement of need released in 2015 to help create integrated HIV prevention and care plans for the time period 2017 to 2021.

Stewart Landers: The goals of the guidance are to further reduce reporting burden and duplicated efforts, to streamline the work of health department staff and HIV planning groups and to promote collaboration and coordination in the use of data. Integrated plans are considered living documents which serve as a road map to guide jurisdictions, HIV prevention and care service planning throughout the year. And also support jurisdictions to better leverage resources and improve efficiency in coordination of HIV prevention and care service delivery. Next slide. The human resources inventory is a tool included in the integrated prevention and care plan to help identify available human resources to meet HIV prevention, care and treatment needs of its population as well as any associated resource gaps. And the three bullets describe what the guidance requires jurisdictions to do next. Next slide. US workforce faces capacity challenges to effectively treat people living with HIV. The demand for HIV and primary health care services in particular continues to increase as people living with HIV are living longer therefore creating higher prevalence overall of people with HIV in most jurisdictions.

Stewart Landers: Exacerbating the workforce demands that many experienced professionals, including many, many HIV practitioners are retiring from practice and many younger providers maybe choosing medical fields outside of HIV and primary health care. Next slide. So all of the information that I have going forward has citations and uh, we can provide them, but I'm not going to name all of them. Some of them are on the slides, but not on all of them. So 30% of experienced HIV specialists will retire by 2020 according to a report of the American Academy of HIV medicine. And there are also a higher rates of turnover projected for many providers at Ryan White HIV/AIDS program funded facilities compared to other practices. Next slide. So the first statement does come from HRSA's AETC needs assessment guidance and indicates that there were many providers who are physicians and non physicians spent nearly twice as much of their time providing HIV care.

Stewart Landers: But access to HIV services has increased under the Affordable Care Act because more people living with HIV have access to health insurance and therefore to private physicians and safety net clinics that they may not have necessarily been able to access so easily before. Next slide. In terms of the types of providers on the clinical side, we're talking about primarily physicians, physician assistants, nurse practitioners, registered nurses, dental providers and clinical pharmacists. On the non-clinical side you have social workers, psychologists, case managers, public health providers who may run many of the public health programs and services available to people living with HIV and AIDS, non-medical services, community health workers and other allied health professionals. One of the important findings has been that there is a mismatch in the demographic characteristics of patients versus those of providers. So, for example well, 45%

of black non-Hispanics accounted for the highest share of visits to providers. Only 8% of the providers themselves identified as black, non-Hispanic.

Stewart Landers: Also, as the Latino Latinx Hispanic population is experiencing increases in the prevalence of people with HIV, especially MSM, the services that are more culturally and linguistically aware of that Latino, Latinx Hispanic community will be necessary. And sometimes language barriers can cause very significant problems for people trying to access both clinical and nonclinical services and can lead to problems such as HIV medication adherence. Next slide please. That's like in terms of the geographical distribution, the largest demand for HIV and AIDS services is in the South and Northeast. And while the Northeast has a high need for services, the Southern region faces more barriers to care and has a somewhat smaller percentage of the provider population than they do of the client population. And in addition, fewer people living with HIV in the South are aware of their infection than in any other region, excuse me. So it may be that the patient percentage reflected here is an underestimate of the demand for providers in the south equipped to care for HIV patients.

Stewart Landers: Similarly, also a challenge for the South is that they have higher HIV diagnosis rates in suburban and rural areas as compared to the other regions in the country. Which provides some unique challenges to both HIV prevention efforts and potentially access to clinical sites with specific providers for HIV. Next slide please. So in Rhode Island of coEXIST partners have indicated that they need more access to behavioral health providers and to particularly those who can assist with the health issues facing drug users, including harm reduction approaches and that will offer obviously affect many HIV clients. And the needs assessments identified a key barrier to care is access to mental health services substance use treatment. Next slide. In addition, people living with HIV have increasingly complex and demanding needs. HRSA has projected that the number of HIV related visits would increase by almost 14% from 2010 to 2015, while the number of HIV clinicians would drop by 5.5% in the same period.

Stewart Landers: And there is, limited HIV specific training opportunities for physicians and advanced practitioners. In addition, as the cohort of people living with HIV ages, there needs do become more complex as HIV we've learned interacts with the normal aging process in a variety of ways that needs to be monitored closely. Next slide. And then when the strategy has been updated to 2020 it prioritizes testing and linkage to care treatment adherence as well as treatment as prevention and those will all require yet additional workforce training to take place. Next slide. Okay. Strategies for increasing workforce. We're going to hear more about this from the presenters from Rhode Island, but we just wanted to mention that there is increasing capacity at federally qualified health centers for their care clinicians to provide HIV care. We're sort of shifting people living with HIV who have achieved viral suppression to health center providers.

Stewart Landers: We're integrating HIV care more and more into primary care where possible. And we're training for PAs and nurse practitioners or clinical staff to really work

at where we can say at the top of their license to really provide the best and most effective care they can. We're also looking at strategies to share the care and workflow redesign that there's patients the panel of patients is assigned to a care team rather than a single provider and in that way implement more team based care approaches. Co-management is yet another strategy patients continue to be assigned both a primary care provider and an HIV specialist. However, some with less complicated HIV cases can be assigned only to a primary care provider but have access to an HIV specialist for consultations as needed. We can use community health workers to increase access to care, provide support for navigation through the healthcare system. Management of side effects, cultural awareness, and again, as I mentioned, have providers work at the top of their license

Stewart Landers: Next slide. A key resource available to help with workforce capacity are the AIDS education and training centers. Their mission is to increase the number of healthcare professionals who are educated to counsel, diagnose, treat, excuse me, and medically manage people living with HIV. And to help prevent high risk behaviors that lead to HIV transmission. They offer free expert advice on a range of topics. They have clinical reference guides and often provide both online or live training courses as well as training materials. With that, I'd like to turn it over to Amy Black. You're in good hands. Thank you.

Amy Black: Thanks Stewart. So I'm going to spend a little bit of time talking about the concept of CoEXIST and briefly what we were trying to accomplish and then I'd like to spend most of that time, give most of my time to Tonya so that she can talk in more detail about the workforce development piece. Okay. So Rhode Island CoEXIST was formed through the Ryan White Program in Rhode Island and basically the funding came from a mix, but really it was oh we have some, uh, more than we expected rebate funds. And there had been a need identified through a consumer needs assessment that JSI conducted, that there was a gap in treatment availability for substance use and mental health issues. So the state decided to start this initiative around CoEXIST. So CoEXIST, the bulls of coexist really were to address sort of brick and mortar at the existing aid service organizations as well as innovative ways to be more out in the community providing healthcare through mobile units. That would focus on the integration of physical and behavioral health, sexual health through the model of using intensive case management teams that are teams that were made up of multidisciplinary providers from case managers, nurses, psychologists, social workers.

Amy Black: And we also had a dental initiative and they would use this funding to not only expand their treatment teams but have workforce development through Rhode Island College as Tonya, will talk about as well as ways in which we could expand into the community through mobile units that would provide care and testing and address some of the social determinants of health. So a key initiative goal of CoEXIST was to increase the number of available housing for people living with HIV. A key criteria there however, was that there were different eligibility in

terms of income, but consumers were required to agree to the intensive case management teams.

Amy Black: So just I wouldn't want to go into too much detail here, but in addition to the consumer needs assessment, conceptually CoEXIST was based off of The Triple Aim framework in health system transformation, which is part of the larger Rhode Island's healthcare system transformation initiatives going on. So how we're doing that is sort of prioritizing the HIV system of care, the needs and the gaps with this interdisciplinary approach. But we also focus and have been focusing on increasing the patient self efficacy and focusing on how we say, meeting the patient where they're at in terms of taking a trauma informed approach and harm reduction.

Amy Black: So this is the list of ... These may not mean much to everyone here, but what this is to show that these are our funded agencies. That's a mix of the usual suspects, as you would say, the aid service organizations. But we brought in a public, the Rhode Island Public Health Institute, two of the Rhode Island College and University of Rhode Island. And what was new here too is that we partnered with a new clinic, Clinica Esperanza, which is a free clinic in providence serving primarily Latino and immigrant communities. We also expanded to involve the Department of Behavioral Health, which was new in the HIV world, if you will. And a renewed connection with the Rhode Island Department of Corrections.

Amy Black: So here is just the concept of CoEXIST. It would take much more time than I have to go into all of these details. But we took the different tasks and the work that our partners were doing and tried to put them into concepts of evaluation domain so that we can monitor our progress. And you'll see here that they either represent HRSA service categories, which are the first three or HRSA requirements specific grant related focus areas or both. What we're going to talk about here is the highlighted number four. You can read this later. I don't need to go through all of this, but what we tried to do, and this is just some suggestions for how we talked about measuring success right now while some of this work is still going on that consistent funding for all of these initiatives are still uncertain.

Amy Black: But what we've done is taken the work that people were doing and trying to put it into measurable objectives. Particularly of interest is number one around how do we define integration of behavioral health. People define it in many ways. For us, we were trying to look at integrating primary care and behavioral health into HIV care and that could be defined as being of agencies being co located. For us a lot of that was through the intensive case management teams and some of the work that Rhode Island College has done was sort of taking multidisciplinary students and building a team there. One of the ways that we started to measure initially, which ended up being much more robust around workforce development was simply the creation of the curriculum certifications

for say HIV testing and case management and measuring student and provider teams, participation in satisfaction.

Amy Black: Again, here we started to, as you can see not all of these were built out yet. But focusing on in a long term basis. Are we addressing through increasing the workforce through having a more diverse and multidisciplinary workforce, are we addressing the social determinants of health? We all know what they are for people living with HIV, but are we actually starting to make progress and shifting patient outcomes here? Okay. So one of the areas that was interesting for any sort of what we found for this large of a project, a statewide project that was beyond just the actual tasks, whether it's workforce development or intensive case management teams or EIS, Early Intervention Services, is that they all worked together. So it was important for if the system of care and the continuum of care is one interrelated thing than the people that we are working with, we were trying to measure how they're working together.

Amy Black: When you're bringing in new people, whether that's Rhode Island college or a primary care organization that hasn't to date been used to working within the HIV system of care. We wanted to measure how people were talking to each other. So this is really we found it to be more important than initially we had thought. So we increased the training opportunities for the funding agencies and created ongoing brown bag sessions to talk about best practices. Not only in case management, but we created a behavioral health work group as we were seeing more trends in say meth use among MSM. Is we're realizing that we didn't necessarily have the resources that we needed to address that even though we had an increased number of providers through this project. We realized that we hadn't, that mess sort of was quiet for a while and there was an increased behavior around meth among MSMs.

Amy Black: And finally we saw an increase of referrals in collaboration among agencies, sort of ongoing case conferences to share successes and discuss and solve issues. And this is something that Tonya, will talk about that as each semester of new students came along they were able to have ongoing conversations with agents saying, "What is it that you actually need from our students and how are your clients experiencing students?" And on the student side saying, "What are your frustrations? What are the challenges? What do you need in order to actually be a part of this workforce?" Sp with that, I'm going to kick it over to Tonya to talk about the training program and the workforce development through Rhode Island College.

Tonya Glantz: Thanks so much, Amy.

Amy Black: You're welcome.

Tonya Glantz: Hello everyone. I'm really excited to be able to share with you the project that we have been going on this incredible journey was over the last two years. And I think that we've been really fortunate because of what I'm about to share with

you hasn't had to be silo-ed in either a care continuum augmentation focus or just workforce development. We've really been able to embrace the two together. And so, I wanted to start off just a little bit sharing the purpose of RIC-CoEXIST. Well, our director, Dr. Marion Raimondo is very active in HIV community here in Rhode Island. She leads their quality measures work. It was actually the first time for Rhode Island College to be a partner at this table. And it has been very transformative for us, for our students and for our community partners. And a lot of really strong relationships have emerged as a result of this.

Tonya Glantz: And I think that they're both directly related to the fact that we work together across teams to build this multidisciplinary response to capacity building and partnerships where both workforce development and augmentation of the HIV care continuum was the focus. And so I'm going to share with you today just a make overview of what we accomplished. You can see that in terms of the workforce capacity, we really tackled it in a tiered context. One, we recognize that there was an existing work force that needed to be supported and really trying to use some of the quality data that was created and gathered in partnership with that Raimondo and also to build direct partnerships. The same ones that Amy was alluding to in her part of the presentation.

Tonya Glantz: So we talked about and thought very deeply about who was already in the workforce. And then we recognize all of those concerns that Stewart has raised at the beginning of this discussion today, that this is an aging workforce, that there are challenges related to burnout and income and the need for the workforce to be more representative of our client population. And so we really started to look carefully at what we could do as a higher ed partner to really start to get students focused on and excited about potential careers in this area. And we accomplished that in two ways. We created a course that was launched this past fall and is repeating again this spring. And then we also created this very dynamic experiential interdisciplinary learning opportunity for students to receive training and then to be co located in the community. And it was through that co-location of students and the creation of these inter-professional teams that we were able to really very dynamically move toward augmenting the care continuum. And I'm going to talk a little bit more about that.

Tonya Glantz: One of the real opportunities here was bringing an issue that many of us have been aware of and grew up with and have had this concern and passion for. But this younger generation has not been exposed to HIV and AIDS the way many of us have. And so the opportunity to find students in different majors was really, really important. And so we started to think about those pieces. We started to think about the community partners that we would need to form relationships with. And then most importantly, we wanted to make sure that what we did was authentic and really met the needs of the consumer population. And so we really sought to create this fit. And as we looked at the consumer population, we had the opportunity to work both with folks who are living with HIV as well as the early intervention and high risk negative population.

Tonya Glantz: And so our students had the opportunity to really experience the prevention end as well as the dynamic work that gets done once people are diagnosed with HIV. And all of the different supports that can be provided to really promote people's personal power and their physical and mental health. When we started to look at our teams, we had the luxury. Amy's already shared with you, the different community partners that we've worked with. But we really look to see which sites really wanted and could accommodate two teams. And so we were very fortunate to work with the age care ocean state, community chair alliance who started a brand new Transitional Housing Program. Project Level Renew has been a fabulous partner. We also worked our first year in men's and women's intake at our correctional facility here in the state.

Tonya Glantz: And it was the first time in many, many years that we were actively being able to discuss and assess for HIV within the pre-sentenced population. And then on our own campus, we had one student who was really an inspiration. His name is Anthony Masselli. And he challenged me early on in the development of this project when I was thinking about sites and he said, "What about Rhode Island College?" And I said, "Oh, I hadn't really thought of that." And he said, "Well, you should, these are college students. They don't have access into inflammation. They're at a high risk because of these different factors. And I think we need a team here." And it's to Anthony's credit that we actually created a peer education team that worked very carefully with our health service department as well as our AIDS service organizations to create testing opportunities and educational opportunities on campus.

Tonya Glantz: And so those partners made it possible for us to start to really think about which academic disciplines could potentially populate these teams. And so over the last two years, our student disciplines have kind of met a wide array from I would say majors that are traditionally associated with this field such as nursing and social work. And we really looked outside of the box. We had wonderful students from community health and wellness who are really great health educators and have played a critical role. We had one young man who was a fine art major who now works for one of the ASOs and he does their communication blog and some of their social media. So he's merged his artistic skills with the critical needs in that community. We had students from youth development and we also had the opportunity in our first year to integrate some community health workers.

Tonya Glantz: This year was our first year partnering with the Alpert Medical School at Brown University. And we had two third year medical students who were really nice additions to our teams. And so as we looked at these three core stakeholders, we operated with a lot of transparency and we asked everybody to come together and inform what it was that they needed support with, how could support our students. And really recognizing that this was a very egalitarian relationship. That we wanted everybody to be having their needs met with it. Because this was an opportunity to really look at what makes a difference, I did want to just very briefly share with you some of the things that we've been

doing over the last two years to really assess the impact that our students have had both at the workforce development and the care continuum augmentation levels. And so this slide that you're looking at right now really shows you how we're looking at our student populations with regard to their own preparation, what their knowledge was prior to and after participating in this process.

Tonya Glantz: We monitored their ongoing development with tri-annual meeting surveys to really get a sense from them and the community partners how things are progressing. We've engaged in clients, in sight based satisfaction surveys. And we've been looking very, very carefully at the type of work our students are doing on site. I have one young man who is a healthcare administration major and he's been on my capacity building team and really looking at how can we continue to provide care continuum augmentation going forward. And he just entered, I think our 140 something client contact data. And that's really what's giving us insight into what the different sites needs. Each site is a little bit different. And so the work that students engage in meets that need. But overall we've been able to track the number of individuals either through outreach for our EIS population or through direct care to people who are living with HIV.

Tonya Glantz: And in my conversations and some of the satisfaction surveys from sites, we've heard that our students have played a critical role in expanding resources that don't typically exist, such as helping people with resumes, looking at some of the legal challenges that people are having. Really helping to ease people's acclimation into transitional housing or into the beginning of their HIV care. And so my colleagues in the field said, "You know, it's not that we don't want to do these things. We don't always have the luxury. And so we've seen some initial impacts here, and we've also seen the infusion of behavioral health focuses and services because of what our students are doing. And so these data gathering tools are really helping us look to see what we're doing, what we can do better and potentially how we can keep this type of a process going forward.

Tonya Glantz: Okay. Now for the good stuff. I was really fortunate in December to attend the Ryan White Conference and I spent most of my time in the workforce development offerings because I was really curious to know what my colleagues and other states were doing in another programs. And I was really pleased that what we were doing paralleled some really impressive work that's going on. And also, shared some of the challenges in terms of funding and the struggles between what's needed in the field versus how much time students have in those types of things. But one of the things that I think across the board, everyone agreed to was the importance of preparation. And another factor was the critical role of inter-professional education. And so we started for our co-location of student teams.

Tonya Glantz: We started all of our students with required training 32 hours of intensive pre-placement training. We did not allow any students to go into the field without having this training. And this we included, we had actors come in and do role plays and really had our supervisors assess what their skill level was at the

beginning where they needed some support. In addition to that, because we couldn't accommodate all the students in the IPM integrated case management team process, we created health care administration course called exploring HIV health issues and career opportunities to serve as learning. And while I'm students there weren't doing direct service with this community, they were doing site observations, identifying areas of need and really doing dynamic problem solving that is exposing them to doing this work as well. And then in terms of kind of taking that to the next level, we also continued to pay attention to the needs of the existing workforce to the offerings that you can see listed here.

Tonya Glantz: We're excited to be launching the 45 hour certificate program, hopefully by mid May. Here you see a picture of our wonderful student teams and some of the different activities that they engaged in. And over the last two years we have had within our student teams, we've had about 70 students and this doesn't include the students who have taken the healthcare administration course. And so with the students, one of the things that we've been doing is follow-up interviews with them and we're finding that 35% of them are pursuing careers or study and fields related to HIV. And of this 35%, 30, 35% of them were actually hired following their experiential learning opportunities. And so we have received some really positive feedback from the students that it expanded their awareness of an area of practice that they had never considered. And many of them recommended the experience to other friends and we were getting lots of emails and then people just showing up in the office asking how they could get involved. And it was unanimous that all of our students would recommend this process going forward to other people.

Tonya Glantz: This just a kind of bird's eye view of how we augmented students training throughout the year. And often this training was cosponsored with community partners. So students actually were in training with professionals in the field. So there was some really rich learning that was going on. And one of the other things that we had the benefit of doing that really drove our process was a partnership with our Ryan White cab at the Miriam Hospital. Our cab partners came and they trained our students. They did panel discussions. They work together with our students to put on consumer conferences. We actually have our second one planned for April 20th, which is next weekend. And a real friendship emerged from these relationships that I think really humbled our students and played a critical role in keeping our work real. And so we really valued that I'm authentic partnership that only the true experts in this field, people who are living with HIV can really bring to the table.

Tonya Glantz: All right. So I'm going to move a little bit away from the workforce development piece and really talk a little bit about what our students were accomplishing. And I see I'm, I'm moving towards the latter part of my time. But I want to just emphasize the areas that our students played a critical role and you can think about them very much in reference to the hearse and service categories that Amy mentioned. That our students were co located to impact outreach,

engagement and retention to really play a critical role in providing links to social support and psycho social support was a strong emphasis on social determinants of health. Our students were also engaged with the intention of increasing behavioral health support. And I think some of the preliminary data from this funding process is showing that more clients are making themselves aware of and accessing behavioral health support than previously.

Tonya Glantz: And then we also wanted to make sure that we recognize the obvious issues of oppression and disenfranchisement that accompany this population. And so making sure that our students were aware of those social and political issues and intentionally outreaching and engaging people from these populations. The students were guided in their training and their practice model by the evidence based practices that you see here. Our most recent data from the students we see motivational interviewing tends to be the area and strength based practice really are driving their interactions with consumers and they're finding ways to transfer the learning from training into the direct practice with consumers which has been really exciting to me. Since the start of our program we have been really fine tuning our data collection methods. And so I wanted to share with you a little bit of our activity from this year.

Tonya Glantz: So you can see I'm at the time that this presentation was submitted, we had 87 client contact forms that had been submitted and the predominant level of contact was face to face direct interactions with consumers, which was a critical place that our students augmented services in our AIDS organizations because there were limits. Case loads are high, they need more people to do more outreach and our students were really able to expand that. Also you can see that education and training for the most part, it was one on one really providing critical information to consumers about different issues, whether it be about their treatments, seeking supports for social determinants of health, housing, food. And then also really excited to see that we brought a significant amount of attention to providing clinical and behavioral health support. Mentioned where our students focus is, we all know in this field how critical motivational interviewing is.

Tonya Glantz: It's critical in all fields when we're dealing with a population and trying to look at different change. But also the opportunity to share information was one that students really actively pursued. When we think about the areas of needs that are being met in these communities, it's not going to be a surprise to anyone listening to this webinar. But you can see here it's all of those areas of needs that have been existed that continue to exist. And you can see here where the greatest emphasis was based on what the consumer presented with meeting. We also focused on decreasing consumer isolation either through navigating other supports, referring people to support groups, private, whoever had a really dynamic women's support group that our students actively recruited and connected women to. And then also really helping people to see if their own power and to really get the resources and help that they needed to be able to function productively in a daily basis.

Tonya Glantz: This is just a little information about how we worked with our cab and the community work with our students to do a conference, which I think is important. I think failing to include consumers as a critical leader and informing this process really would have demeaned it. And so I'm really proud to say that they were drivers of this process. I want to just end just sharing with you some of the impacts that we heard overall. I mean this is if you had to synthesize down what we heard from consumers and students, these are the themes that really emerged. And I've included in the presentation specific quotes that were provided. But empowerment was really critical for consumers. And we heard from a number of them just how exciting it was to be able to help shape the future workforce.

Tonya Glantz: Also, being able to come to Rhode Island College and participate in activities here was really important. And I think build a greater sense of community. And then on the student end it really exposed a new generation of prospective employees to work that none of them, none of this 70 students that came in had ever considered. And also gave them really critical learning which learning real learning experiences about working with a vulnerable population and the need to be culturally responsive and to be informed and to really be led by the true needs to meet people where they are. And as an educator, as a researcher, this here really speaks to my heart in terms of our success with this process. You can at your leisure, I hope that you will look through the different slides that share the actual quotes, and I'm just clicking through them here so that you'll know where they are. Just so that you get a sense of how folks were impacted by this process. And with that I'm going to stop talking and turn it over to my colleagues. Thank you so much.

Julie Hook: Great. Thanks so much Tonya and just a reminder for folks if they want to take a look at that consumer feedback that you provided. You can go ahead and the slides are already available for our website. You can take a look at some of those the quotes that Tonya was talking about. So if you have any questions for any of our presenters, please chat them into the chat box. And just as a reminder while you for questions to come in, please note that immediately after the Webinar ends, a evaluation will pop up, we'd love to do to build this out as it helps us plan and develop additional webinars and resources. So Tonya and Amy, there was one question that came in, which was if you could share some more specific information on how the behavioral health workers played a key role on the intensive case management teams.

Tonya Glantz: Sure. I can tell you. So we had your traditional social work students graduate social work students doing things like depression and anxiety scales and working on behavior change. In addition to that, all of our students received trauma informed training. And so it was impactful on the behavioral health level. Students working with consumers around their struggles with addiction, different struggles with family system issues and helping to connect them to resources. And then we actually had, last year, one second year MSW student who started to work as a clinician and he actually subsequently was hired and is

completing his second year of employment there. And so depending upon the resources at the site, we responded to the need of the organization and created student teams that met those needs. If they needed social workers then they got social workers. If they had social workers and they needed some other students to support some of those behavioral health conversations and assisting with bringing people to appointments, we provided that kind of helps. So it really I would say it's a continuum of support all the way up to clinical intervention. I hope that answers your question, Kevin.

Amy Black: And I would just add quickly, I inadvertently responded, just to Kevin. This is Amy. Just in general those who are already working in the field, the non student members of the ICM teams. The providers from the behavioral health world were sort of critical to the teams. They really were the leaders of the teams that they would run the daily meetings. The first thing in the morning they would have their meeting saying, "Okay, let's run through all of our cases and see what people need." And that not a unique to Rhode Island, not really it was less about treating the HIV and more about getting ... There was a much more neat around substance use treatment and mental health treatments as they all like to tell me like the HIV is not actually the issue. We can treat that. So the teams were heavily loaded with behavioral health specialists. And as I said in my example that when there was a particular need or a challenge that folks could not meet, that's when we would have the case conferences around sort of behavioral health. And what are the gaps and what do we need to do to get treatment for say increased messages?

Julie Hook: Great. Thanks Amy and Tonya-

Tonya Glantz: And if I could respond to Kevin's question about is it 87 clients or encounters? At this point we have had I think 143 client contacts sheets submitted. And depending upon the location of our students. So our students working at places like Community Carolina about copy Providence, which is transitional housing and the aged care ocean state, which has case management and a housing program, those will be multiple contexts for one client. So we see longer term relationships there. Our folks working at Rhode Island College and a project level renew. The majority of their work has been outreach. And so while they might see someone maybe two or three times and help connect them to services, they're not having the same long term relationship. And we're just at the point as our semester is coming to an end where we're going to be diving into those data and really being able to answer that specific question. How many unique client and how many clients did we serve multiple times and what was the impact of those multiple encounters?

Tonya Glantz: So if you want to send me your contact information, Kevin. I'd be happy to share our data once we were done with it.

Julie Hook: Great. Thanks so much. So as I mentioned you could access all of our archives and upcoming webinars on our website on Target HIV. We have another one

coming up at the end of the month on April 25th on integrated planning activities for prevention and care. And attendees will learn about a different, various models of collaboration or integration that jurisdictions can pursue as well as the benefits and potential challenges associated with integrated planning activities. The webinar will feature guest presenters from Memphis, Tennessee and San Francisco who'll detail their jurisdictions efforts, integrate planning body activities of resident care. And we also have another one coming up with the dates still to be determined that will address the challenges and promising practices of leveraging HIV prevention and care programs to include Hepatitis C services within health departments.

Julie Hook: So please visit our website to check out our resources and our archive and upcoming webinars or to join our list serve. We also have an online resource guide available on the website intended to support a part A and part B recipients in their respective planning bodies with implementation and monitoring of the integrated HIV prevention and care plan. Included in this guide are resources, tools and tips to support the process of integrating HIV planning and implementation efforts across prevention care and treatment delivery services. And soon we will have a couple, we'll be launching two new sections very soon. One along integrating prevention and care within health departments as well as tools and resources support part A and part B recipients around resource allocation activities. So like I said, if you have any questions stemming from this presentation or would like to obtain more information, request TA or share your experiences with integrated planning please contact us. Our email address is here and we thank you for listening in today. Have a great afternoon.