VIRTUAL
2020 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

HRSA's HIV/AIDS Bureau's Innovative Interventions Addressing Sexually Transmitted Infections: Two Diverse Initiatives

Disclosures

None of today's presenters have relevant financial or non-financial interests to disclose.

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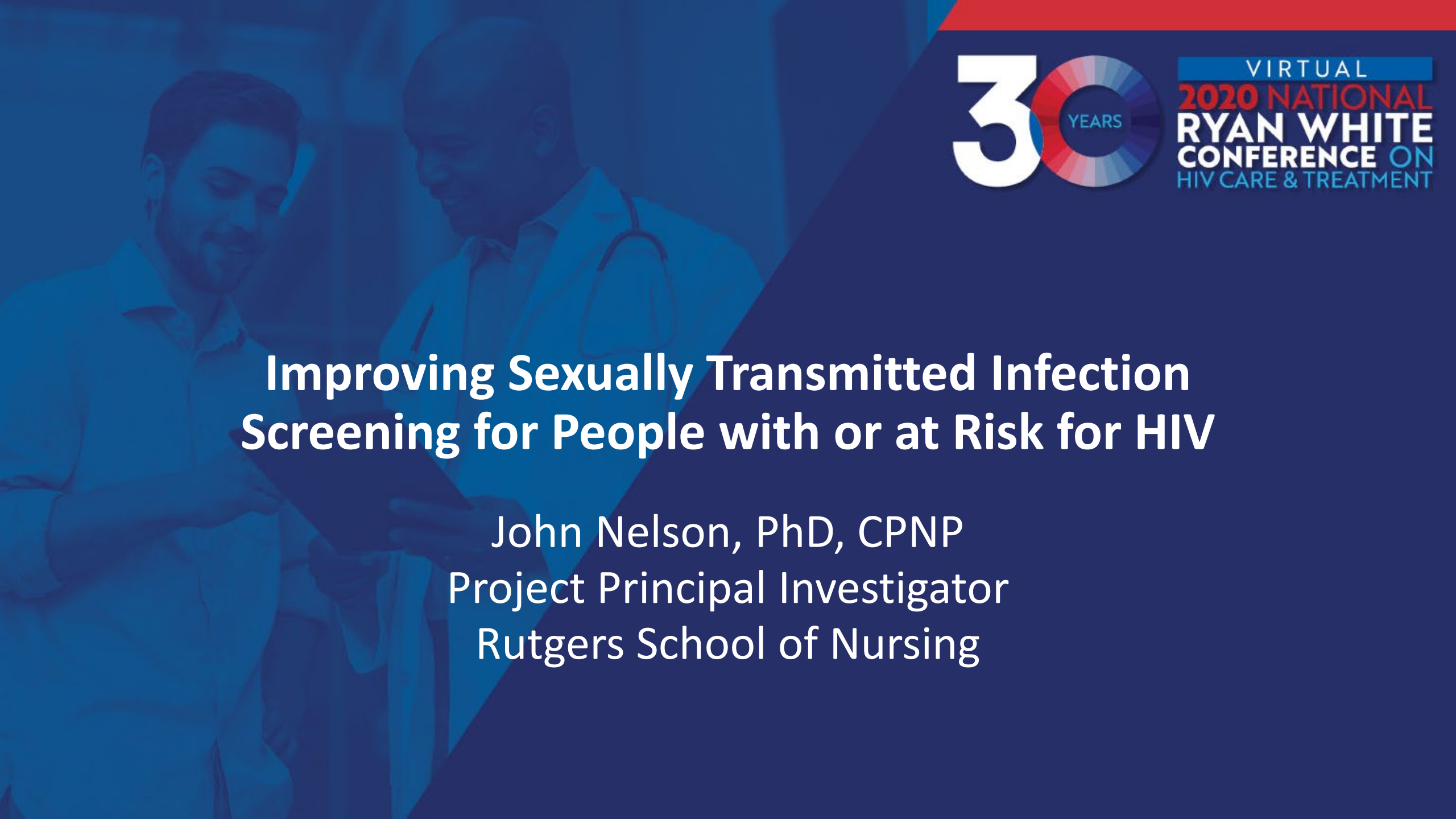
Commercial support was not received for this activity.

Learning Outcomes

At the conclusion of this activity, participants will be able to:

1. Describe the system level interventions being implemented to increase STI screening and treatment across jurisdictions;
2. Describe how matched STI (chlamydia, gonorrhea, and/or syphilis) and HIV surveillance data be can be used to improve the capacity of RWHAP clinics to prioritize resources for linking and re-engaging people with HIV into care; and
3. Understand where to locate additional resources related to these projects for possible replication.



VIRTUAL 2020 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

30 YEARS

Improving Sexually Transmitted Infection Screening for People with or at Risk for HIV

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Disclaimer

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Introduction & Background

- While the rates of HIV diagnosis have decreased from 2012 to 2016, bacterial STI rates have seen consistent growth.[1,4]
  - Compared to 2017, 2018 CDC nationwide reporting shows a 2.9% increase in the rate of CT infection, a 5.0% increase in the rate of GC infection, and a 14.9% increase in the rate of syphilis infection.[1]
- In addition to increasing the risk of HIV transmission from a non-virally suppressed person, STIs are a continuing public health concern because of other associated morbidities and mortalities.

Introduction & Background Continued

- Another concern has been the increasing rates of antimicrobial resistant strains of gonorrhea.[3]

- Despite national recommendations on screening and treating STIs in people with HIV or at risk for HIV, gaps exist in the regular screening, treatment, and prevention of STIs among people with HIV.[2]

  - According to the CDC Medical Monitoring Project, only 37% of people with HIV reported being tested for GC, CT, and syphilis in 2017.[8]

- Although evidence-based interventions are known to improve STI care, these interventions have not been evaluated in RWHAP clinics.

Barriers to ongoing STI screening, testing, and treatment

- Improving efforts to address barriers associated with providing STI care in HIV care clinics is an integral step towards reducing STI rates nationwide.

- The barriers to ongoing STI screening, testing, and treatment are multiple, and exist across **institutional, community, provider, and patient levels**.

- Despite interventions such as "Ask, Screen, Intervene," an HIV/STI transmission prevention intervention for providers to use with people with HIV,[5] gaps exist in the clinical integration of CDC recommendations for STI testing and treatment for at risk populations in and outside of HIV care.[6,7]

Jurisdictions

- 3 U.S. Jurisdictions with higher than national HIV incidences were selected for this project, and each has a jurisdiction convener:

  - Florida (University of Florida, Gainesville)
  - Louisiana (Louisiana State University Health Science Center, New Orleans)
  - Washington, D.C. (Howard University)

Clinical Demonstration Sites

- Within each jurisdiction, 3 RWHAP-funded clinical demonstration sites were selected:
  - **Florida** (Alachua County, Bay County, & Orange County Florida Department of Health clinics)
  - **Louisiana** (CareSouth Health Center, Shreveport Louisiana State University Health Science Center ID clinic, & Southwest Louisiana AIDS Council [SLAC] clinic)
  - **Washington, D.C.** (Andromeda Transcultural Health clinic, Family and Medical Counseling Services Health Center, & Howard University Comprehensive Care Clinic)

Project Objectives

- To conduct a baseline needs assessment (BNA) of the 9 clinical demonstration sites
- Based on the BNA results, select evidence-based interventions for the clinical demonstration sites to implement for the purpose of improving routine screening of bacterial STIs among patients with and/or at-risk of HIV
- Construct implementation protocols and a multisite evaluation plan for measuring the processes and outcomes involved with intervention implementation
- Identify challenges and successes to routine bacterial STI screening, testing, and treatment interventions among the 9 clinical sites

Methods

- BNA evaluation of the 9 clinical demonstration sites was completed in year 1 of the project
- Quantitative data were collected via 6 surveys completed by designated change champions and clinic staff at each clinical demonstration site
- Qualitative data were collected via interviews with clinic staff at each clinical demonstration site
- Interview transcripts were thematically analyzed, and resultant themes were investigated with quantitative survey data to provide evidence for intervention selection and evaluation plan methods.

BASELINE Needs Assessment Findings

Baseline Needs Assessment Overview

Assessment Tool	Purpose
Pre-Intervention Data Survey (2016 - 2017)	Gather aggregate clinical data from 2016, & 2017 related to STI screening & diagnosis.
Pre-Intervention Costs (2017)	Estimate the total annual and average cost per client for the following pre-SPNS STI project annual aggregate sexually transmitted infection (gonorrhea, chlamydia, and syphilis only) prevention, screening, and treatment cost(s) for your Ryan White HIV/AIDS Program-funded primary care HIV clinic for Calendar Year 2017.
Clinical Team Member Process, Attitudes & Beliefs Survey	Assess clinical processes, and provider attitudes & beliefs related to screening, diagnosis, treatment & follow-up.
STI Screening Readiness Checklist	Assess clinical capacity to implement interventions to improve STI screening & treatment.
Clinical Team Member Interview	Qualitatively assess provider feedback on clinical experiences (barriers, challenges, training, policies & procedures) related to STI screening & treatment.
Clinic Workflow Operations Checklist	Observe routine clinical functions & flow.

Results - Aggregate, Jurisdictional, and Clinic Level

1a) Pre-Intervention Data Survey (2016 - 2017)

1b) Pre-Intervention Costs (2017)

2) Clinical Team Member Process, Attitudes & Beliefs Survey

3) STI Screening Readiness Checklist

4) Clinical Team Member Interview

5) Clinic Workflow Operations Checklist

Pre-Intervention Data Survey (2016 - 2017)

Pre-Intervention Data Survey (2017)

Jurisdiction	People with HIV	Individuals at-risk of HIV	MSM with HIV	Adolescents/ Young Adults	Pregnant individuals with HIV	Transgender Women with HIV
Florida	2600	0	757	128	58	31
Lousiana	2007	1500	277	287	71	6
DC	731	90	85	70	2	4
Overall Total	**5338**	**1679**	**1119**	**485**	**131**	**41**

Clinical Team Member Process, Attitudes & Beliefs Survey

Sample Size (*n*) = 27: Change Champions, Clinical Prescribers, and Clinical non-Prescribers

Sexual History Taking

- 44% conduct a consistent, comprehensive sexual history on intake
- 74% conduct follow-up sexual histories at acute care visits when symptomatic for an STI

STI Testing

- Among sexually active adolescents and adults living with HIV
  - 67% test for STIs on at least an annual basis
  - 18% test for STIs every 3-4 months
  - 78% test for STIs if symptomatic for an STI
  - 59% of patients self-collect NAAT or culture specimens for GC and CT

STI Treatment

- 52% and 48% of patients are brought back into clinic for a positive STI test result after being tested within 1-3 days and 4-10 days, respectively.

Clinical Barriers to STI Testing and Treatment

The top four intervenable barriers include the following:

- Patient refuses to have provider do NAAT swabbing (oral, anal, and/or genital)
- Patient refuses to provide urine for NAAT
- Provider discomfort with sexual history taking and specimen collection process
- Supplies for STI testing are not easily accessible in exam rooms

Non-Clinical Barriers to STI Testing and Treatment

- 25% and 26% of respondents rated their clinics as less than friendly to LGBTQ individuals and adolescent/young adults, respectively
- 37% of respondents rated their clinics as less than culturally competent for both LGBTQ individuals and adolescent/young adults

Clinical and Non-Clinical Provider Attitudes and Beliefs

- 29% of respondents reported:
  - if a patient has gonorrhea or chlamydia in their throat or rectum, they most likely will also have it in their urine
  - routine STI testing should be done in STD clinics or by the primary care provider, and not HIV specialists
- 26% of respondents reported that people with an STI could have avoided getting infected if they had wanted to

Training Topic	Percentage Reporting No Training or Training Not Applicable Over the Past Year
Adolescent/Young Adult Care	56%
Sexual History	48%
LGB or MSM Health	41%
Transgender Care	41%
Caring for Pregnant people with HIV	41%
Sexual Health	30%
STI Testing and Treatment	26%

*Clinical Team Members include MDs, NPs, RNs, PAs, and DOs

There was a 100% response rate from 27 Change Champions, Clinical Prescribers, and/or Clinical non-Prescribers

STI Screening Readiness Checklist

STI Screening Readiness Checklist

Percentage	Question
100%	Your clinic has the capacity to increase CT, GC, and syphilis testing. Your clinic has the supplies needed for CT, GC, and syphilis testing. Your clinic is working to reduce identified barriers related to STI testing, diagnosis, treatment, and follow-up.
78%	Your clinic has a way to systematically monitor STI testing, diagnosis, treatment, and follow-up data for clinic population(s).
44%	Your clinic has a process in use to evaluate patient care satisfaction and/or experiences regarding STI testing and treatment.
33%	Your clinic has policies and procedures in place regarding staff member(s) responsibility for prevention of HIV (for HIV-uninfected patients), CT, GC, and syphilis.

Clinical Team Member Interview

Clinical Team Member Interview – Barriers

- Provider comfort/stigma
- Transportation
- Housing
- Labs and medications on site
- Patient care/coordination/communication

Clinical Team Member Interviews – Recommendations

- Increase screening frequency
- Patient transportation aid/assistance with needs
- Stock exam rooms with necessary supplies
- Improve clinical team communication regarding patient care

Clinic Workflow Operations Checklist

Clinic Workflow Operations Checklist - Aggregate

Clinical Team and Clinical non-Prescriber at each of the 9 clinical demonstration sites

STI Prevention, Screening, Testing, Diagnosis, and Treatment

- 100% of providers conduct a sexual history
- 100% of patients are asked to provide urine for chlamydia/gonorrhea NAAT
- 67% of patients self-collect swab(s) for chlamydia/gonorrhea NAAT
- 89% of providers
  - collect or request an oropharyngeal swab chlamydia/gonorrhea NAAT; and
  - collect or request a rectal swab chlamydia/gonorrhea NAAT
- 56% of providers collect a genital swab chlamydia/gonorrhea NAAT
- 78% of providers discuss HIV testing, if needed

Clinic Workflow Operations Checklist – Aggregate (2)

- 78% of Nurses/MAs conduct rapid point-of-care tests (pregnancy, HIV, syphilis, GC/CT)
- 89% of clinics have a policy for patient satisfaction assessment (electronic survey after visit, annual assessment done, quarterly assessment done)

Non-Clinical Barriers to and Support for STI Testing and Treatment

- 44% of clinic waiting rooms have visible indications of LGBT support (rainbow flag, designated safe space sticker, images or same-sex couples on educational materials, images of transgender affirming information)
- 56% of clinic waiting rooms have visible indicators of adolescent/young adult support and friendliness (images of adolescent/young adults on pictures, pamphlets)

Limitations

1) Only 3 clinical team members representing the comprehensive feedback of all clinical team members at each clinic were asked to complete 3 assessment tools (3, 4, and 6). Therefore, not all clinical team members were individually surveyed.
2) The needs assessment did not include patient level data.
3) The cost analysis for most clinics was incomplete due to infrequently recorded cost and patient visit data as STI related care was provided within the context of HIV care.
4) EHRs varied among clinics which limited the ability to record comparable clinical and demographic EMR data across all clinics.

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VIRTUAL 2020 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Innovative Interventions Addressing Sexually Transmitted Infections: HRSA-18-040

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Sexually Transmitted Infections (STIs)

- Increase the risk of both HIV transmission and acquisition
- Public health concern
  - STIs can result in infertility, chronic inflammation & pain, congenital anomalies, and neurocognitive disease
  - Increasing rates of antimicrobial-resistant strains of gonorrhea
- Gaps continue to exist in regular screening, testing, treatment, and prevention of STIs among people with HIV
- Due to successes in HIV treatment (U=U) and prevention (PrEP) condom use has decreased
- It is critical to identify STIs early, treat as per Centers for Disease Control and Prevention (CDC) guidelines, and follow-up to make sure the treatment was effective and reinfection has not occurred

Improving Sexually Transmitted Infection (STI) Testing and Treatment among People with HIV or at Risk for HIV: 1

Implement evidence-based interventions to improve screening and treatment of common bacterial STIs (gonorrhea, chlamydia and syphilis) among low-income people with or at-risk for HIV who are served by Ryan White program clinics

Interventions need to be:

1. Acceptable to patients and providers
2. Cost-effective
3. Easy to implement
4. Easy to utilize
5. Sustainable

Interventions chosen from the following categories:

- Training
- Clinical
- Non-Clinical
- Systems Level

Improving Sexually Transmitted Infection (STI) Testing and Treatment among People with HIV or at Risk for HIV: 3

1. Provider Training (Training)
2. Audio Computer-Assisted Self-Interview (ACASI) – for administration of sexual history survey (Non-clinical)
3. Patient Self-Collected Nucleic Acid Amplification Test (NAAT) Specimens (Clinical)
4. LGBTQ Welcoming Clinic Space (Non-clinical)

Florida Clinical Demonstration Sites

1. Alachua County Health Department
   - ~500 patients
2. Bay County Health Department
   - ~150 patients
3. Orange County Health Department
   - ~1800 patients

Provider Training: 1

- Need and frequency of bacterial STI testing should be based on a clients' risk factors, which requires complete sexual health histories
- Studies have found that sexual health histories as part of routine care are not commonly taken, and even when performed miss essential components
- Barriers include:
  - Lack of provider training on administering sexual health histories
  - Lack of provider comfort discussion sexual health histories
  - Lack of culturally competent care

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Provider Training: 2

Quarterly trainings including three, one-hour virtual trainings and one, three-hour in-person training for the nine clinical demonstration sites by the National Network of STD Clinical Prevention Training Center's jurisdictional prevention training centers (PTCs):

- Johns Hopkins PTC – Washington, D.C.
- Sylvie Ratelle PTC - Florida
- Denver PTC - Louisiana

Provider Training: 3

Target Audience:

- Change Champions
- Clinical prescribers (e.g., MD, DO, NP, PA)
- Clinical non-prescribers (e.g., RN, SW, MA)
- Administrators
- Support staff (e.g., front desk registrar, patient navigator)

Training Topics

- Epidemiology, Diagnosis, and Treatment
- Taking a Comprehensive Sexual History
- Culturally Responsive Care to Reduce Stigma
- Success Stories on Improving STI Care

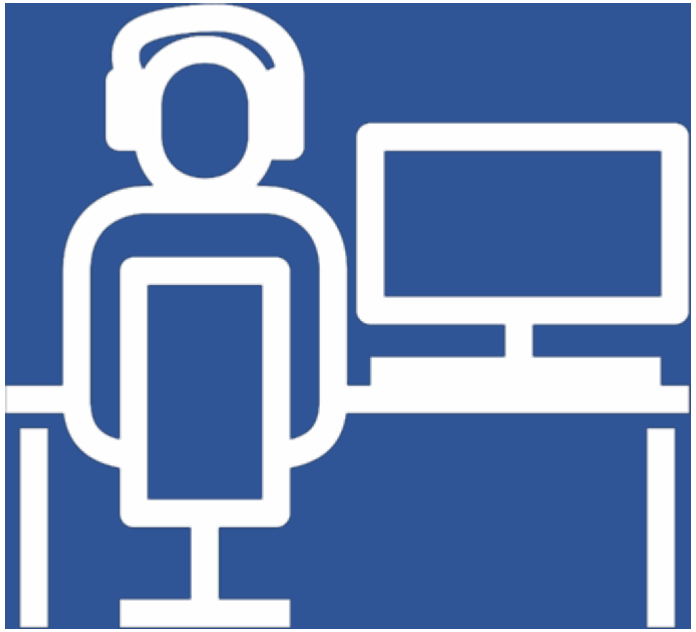
Audio Computer-Assisted Self-Interview (ACASI): 1

Use of ACASI for STI risk assessment has been associated with:

- Identifying high-risk behaviors
- Less time spent by provider taking a sexual health history
- High acceptability when used by patients

Potential barriers include:

- Computer literacy
- Implementation expense
- Export of data to EMR when used for clinical care



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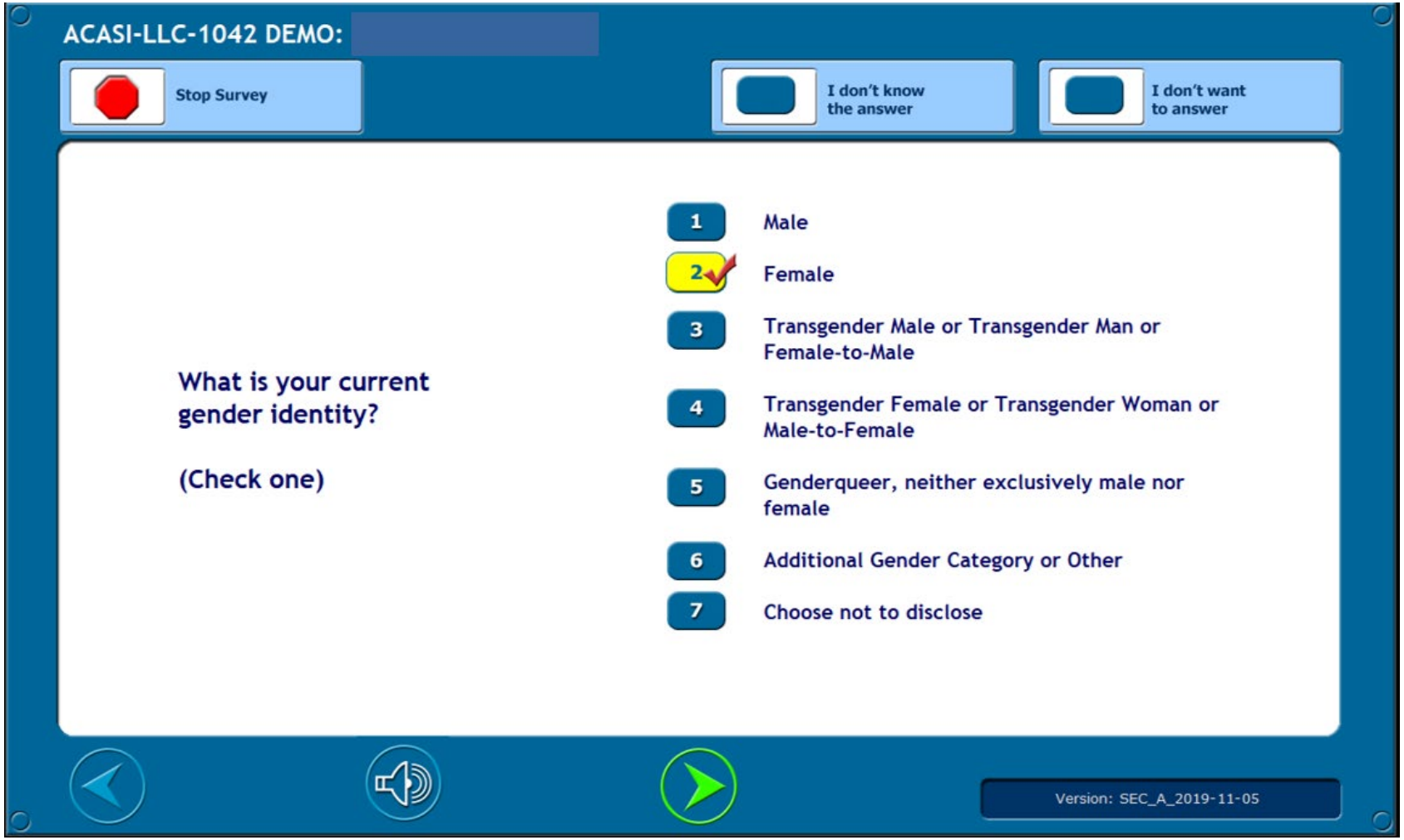
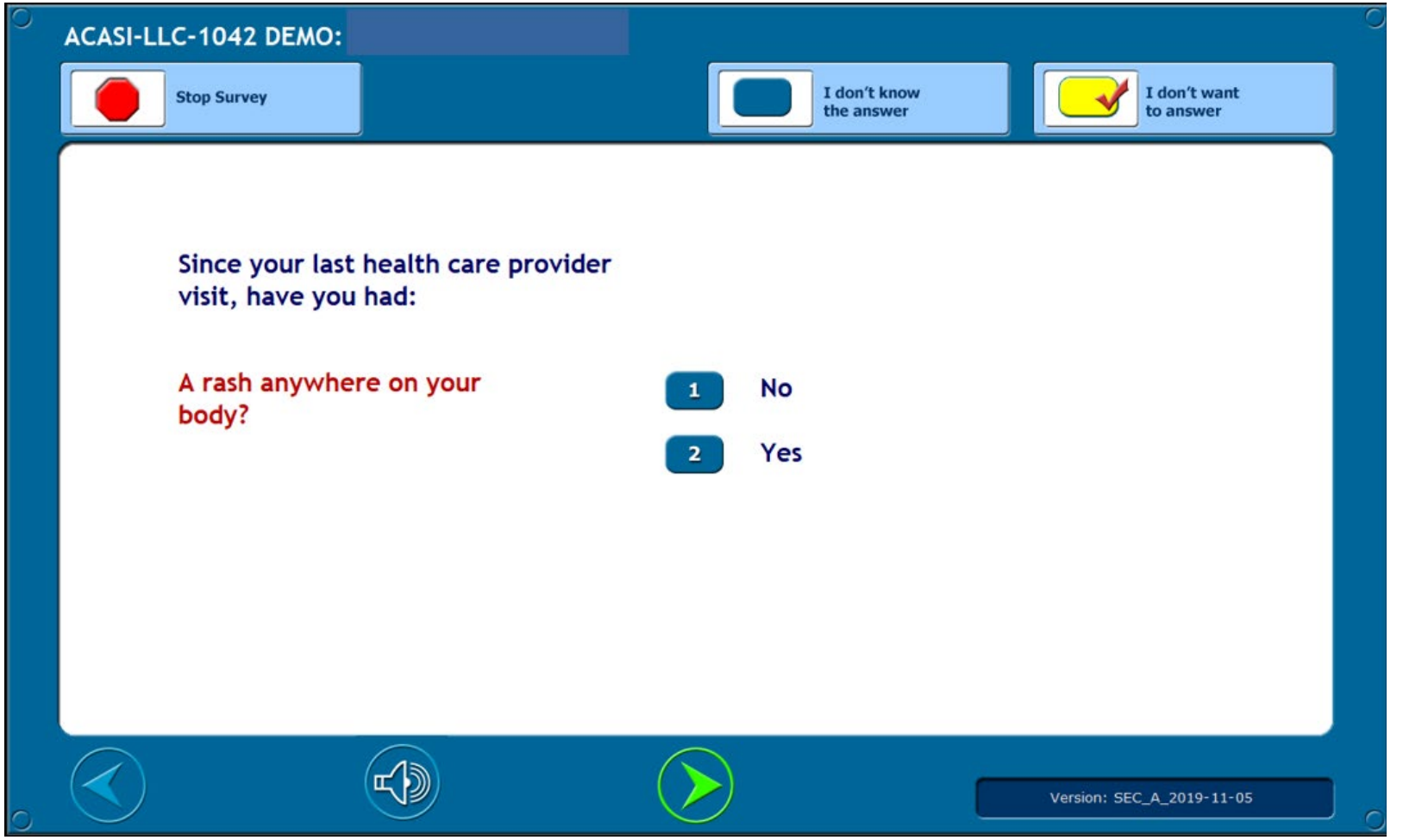
Audio Computer-Assisted Self-Interview (ACASI): 2

- The ACASI sexual history survey will be offered to all patients as part of routine clinical care at each clinic visit
  - Provided in written/spoken in patient's preferred language: English, Amharic, Spanish or Haitian Creole
- Evaluation data will only be collected on patients providing informed consent
- Assessments of satisfaction will be performed quarterly
  - ACASI based patient survey to evaluate satisfaction and challenges with the interventions
  - Clinical care team survey will be administered to prescribing and non-prescribing clinical team members to evaluate the acceptability of the interventions

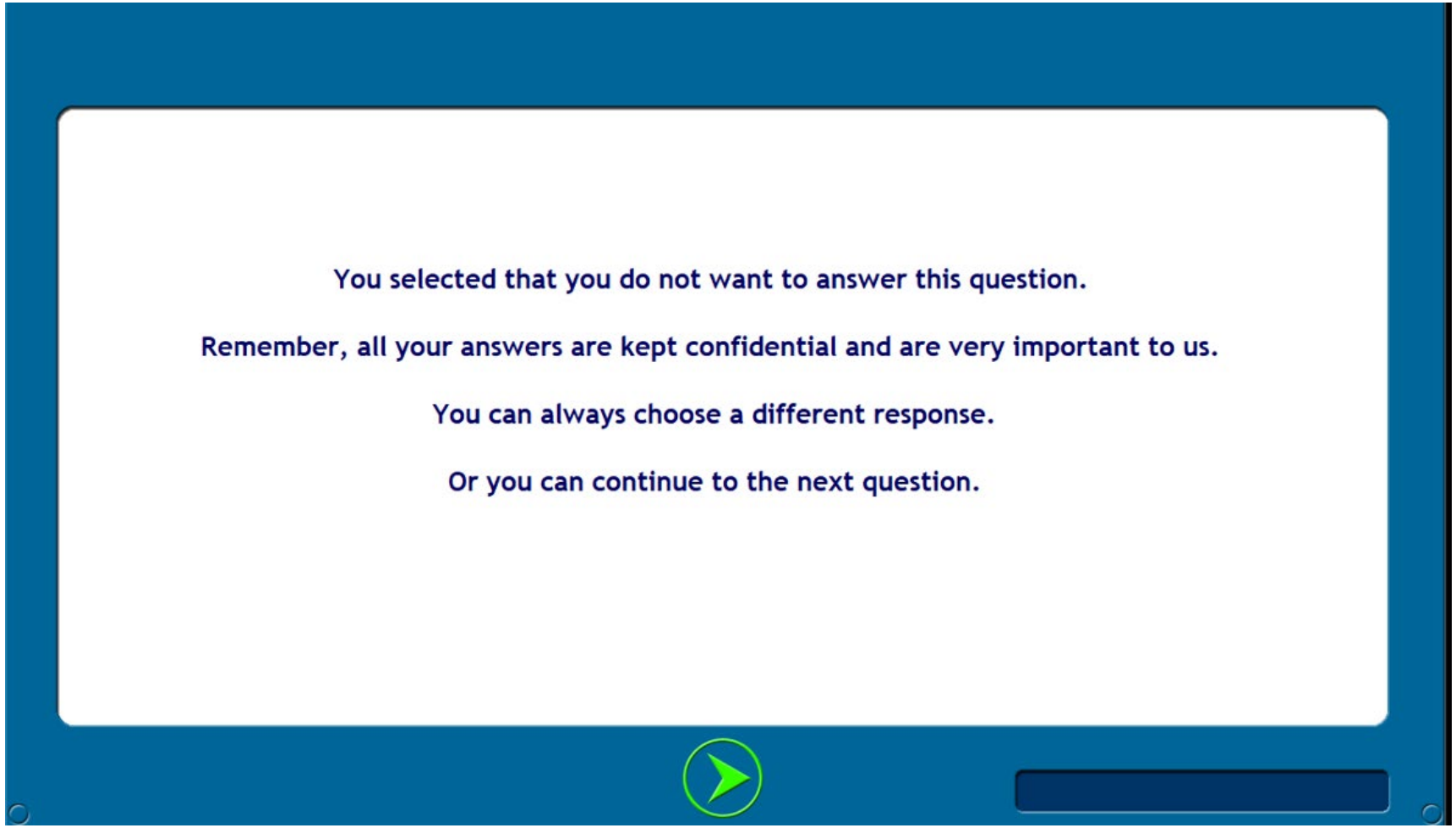
ACASI Sample Question 1



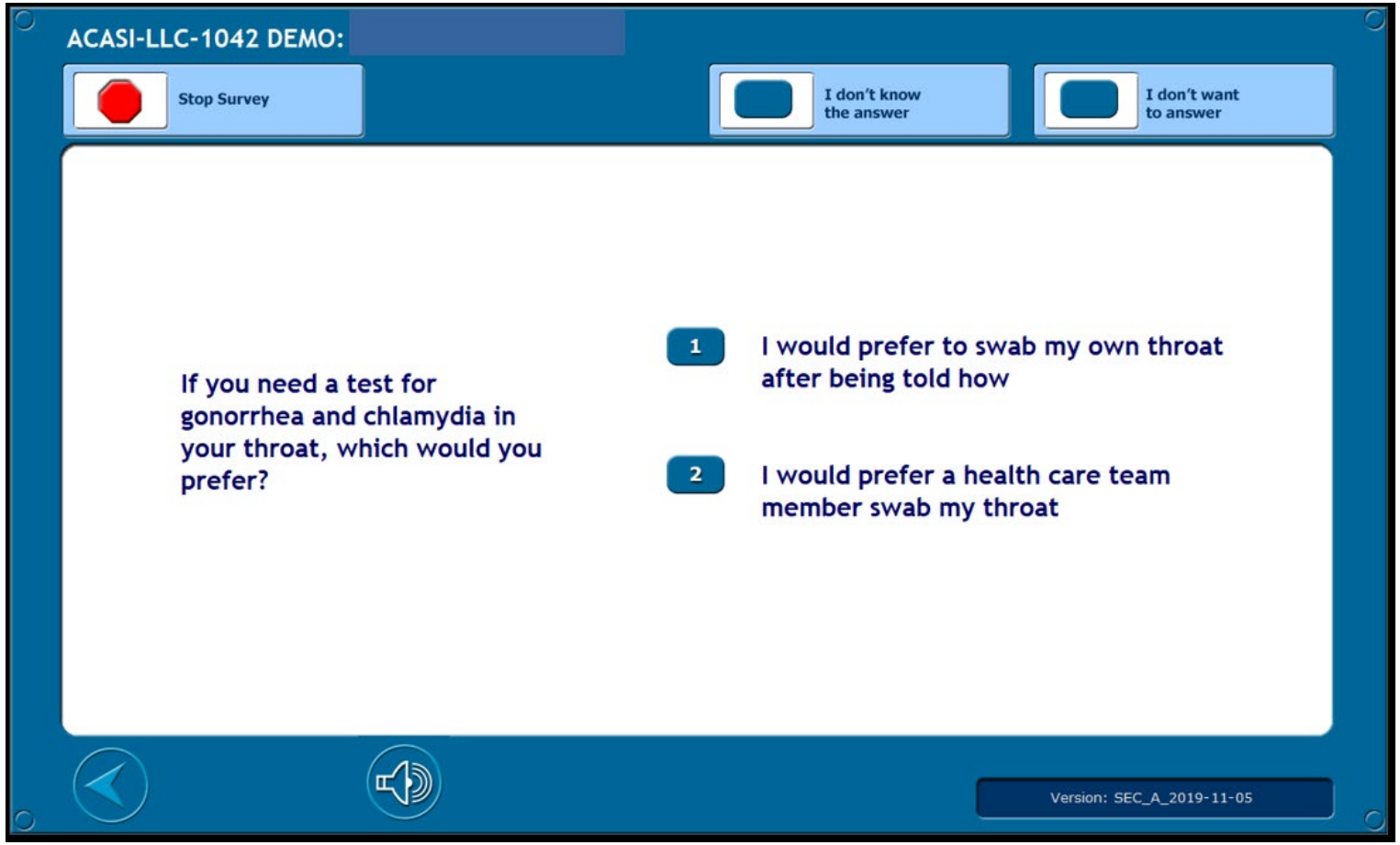
ACASI Sample Question 2



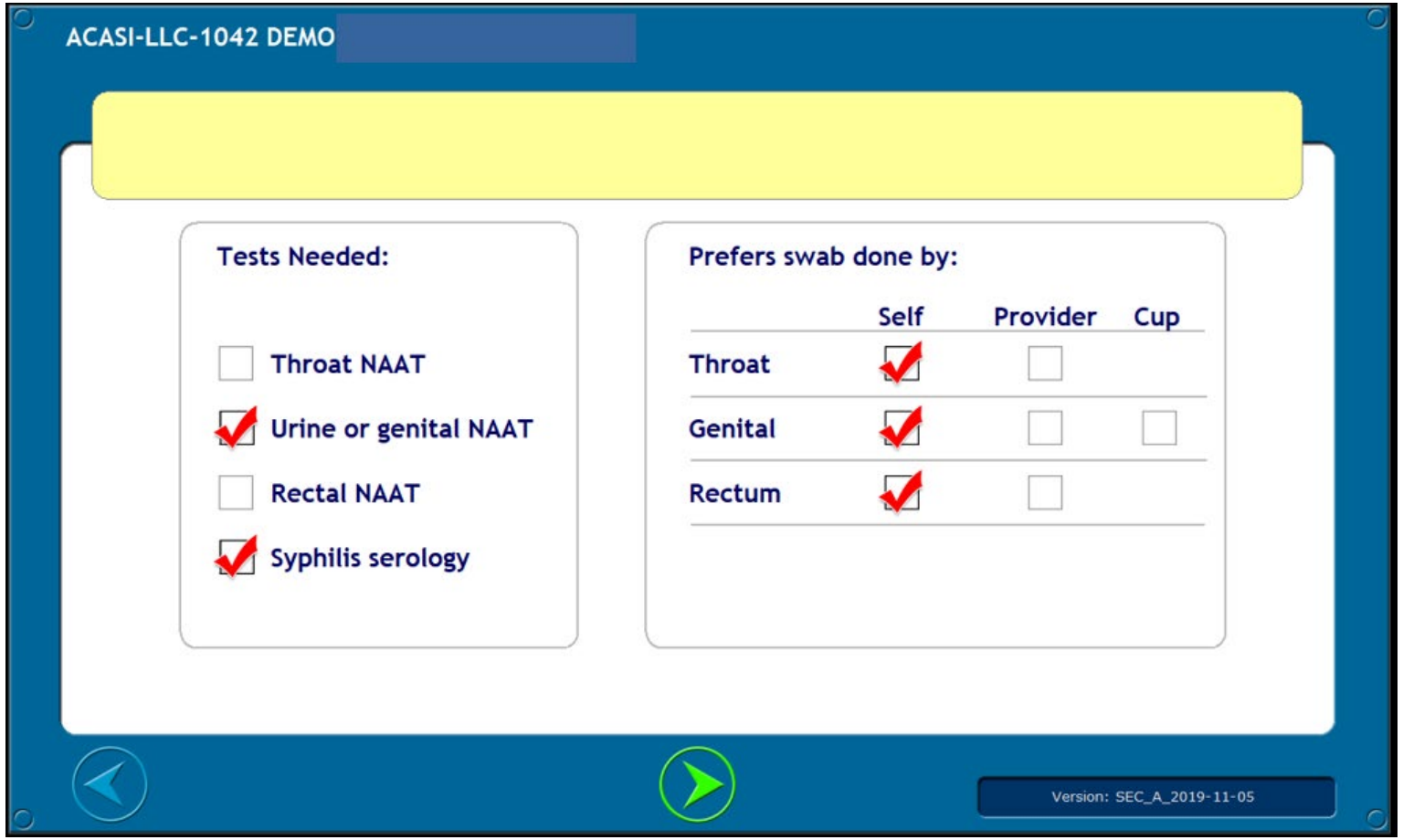
ACASI Sample Response 1



ACASI Sample Question 3

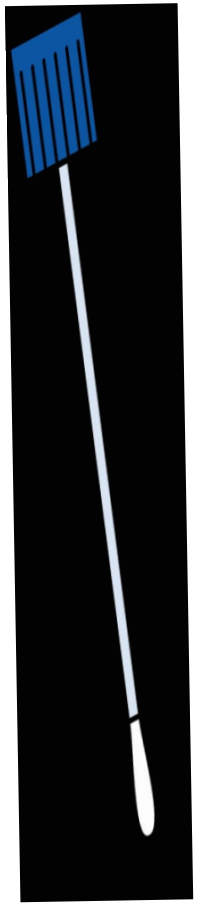


ACASI Sample Response 2



Patient Self-Collected Nucleic Acid Amplification Test (NAAT): 1

- Patient self-collection has been shown to be equally effective to provider-collection in clinical and non-clinical settings for the following specimens:
  - Vaginal swabs
  - Rectal swabs
  - Pharyngeal swabs
  - Urine samples
- Acceptability by patients, especially those at high-risk for STIs (i.e., men who have sex with men) is high



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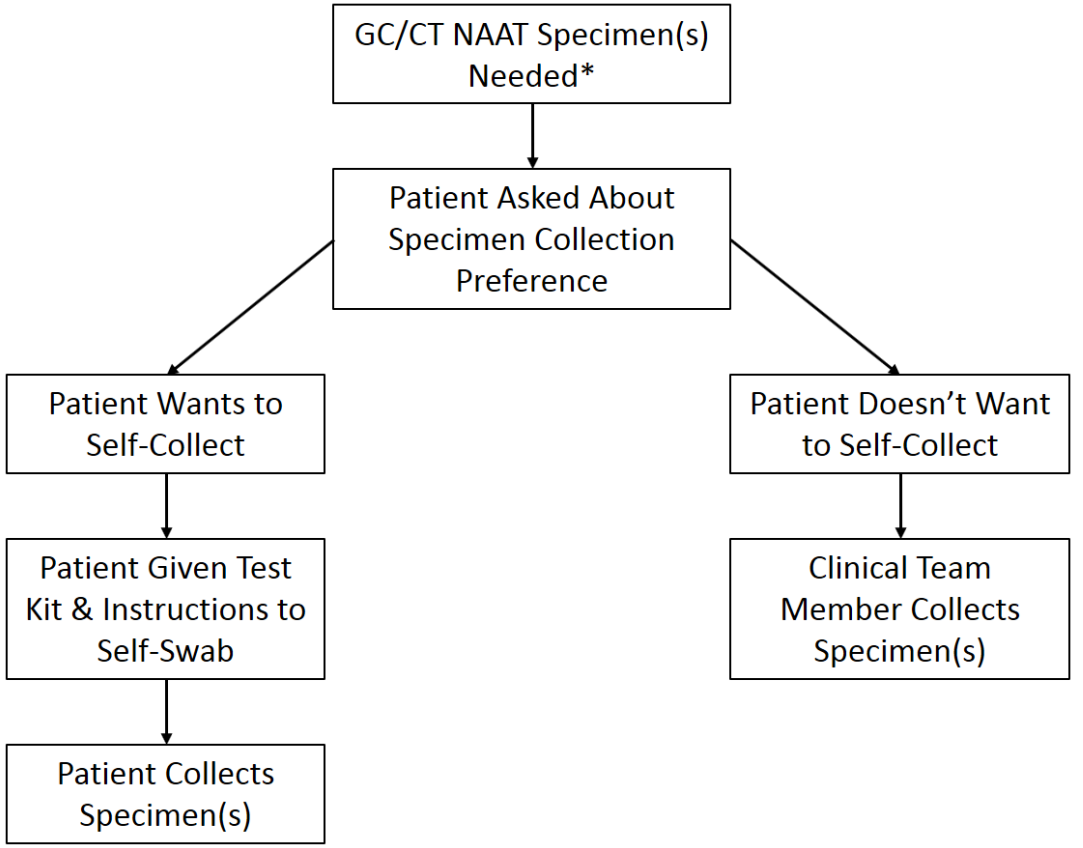
Patient Self-Collected Nucleic Acid Amplification Test (NAAT): 2

The GC/CT NAAT specimen options include:

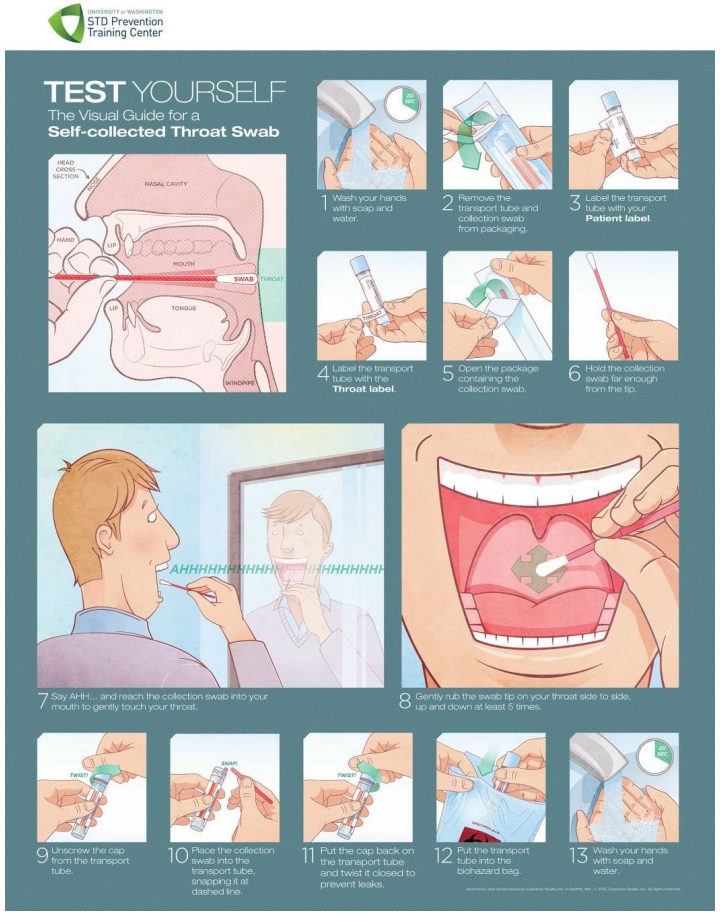
- Urine (for urethral/genital) GC/CT detection
- Urethral swab (for patients with penis and not able to urinate or not wanting to provide urine)
- Vaginal or cervical swab (for patients with vagina and not able to urinate or not wanting to provide urine)
- Pharyngeal/throat swab
- Rectal swab



*All GC/CT NAAT specimen(s) for all clinic patients

Patient Self-Collected Nucleic Acid Amplification Test (NAAT): Patient Education

- "Test Yourself" posters will be used for patient education and will be posted in bathrooms where self-collection occurs



Poster courtesy of the University of Washington Prevention Training Center (http://uwptc.org/)

LGBTQ Welcoming Clinic Space: 1

- Creating welcoming spaces has been shown to be particularly important for two populations that have high rates of STIs
  - Youth
  - Lesbian, gay, bisexual, transgender and queer (LGBTQ) populations
- The Joint Commission (2011) lists creating welcoming environments as an essential step in providing effective care for the LGBTQ community
- Baseline needs assessment findings showed that all nine clinical demonstration sites had the capacity and readiness to implement at least 10 of 12 identified indicators of sexual and gender minority "welcoming" clinic spaces

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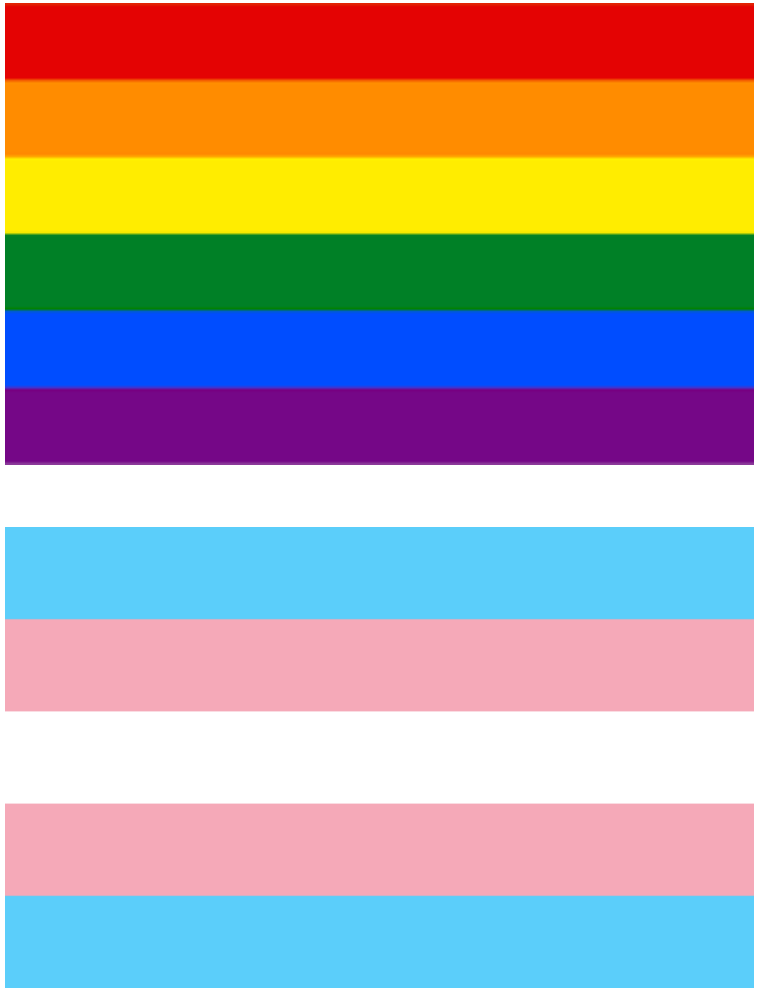
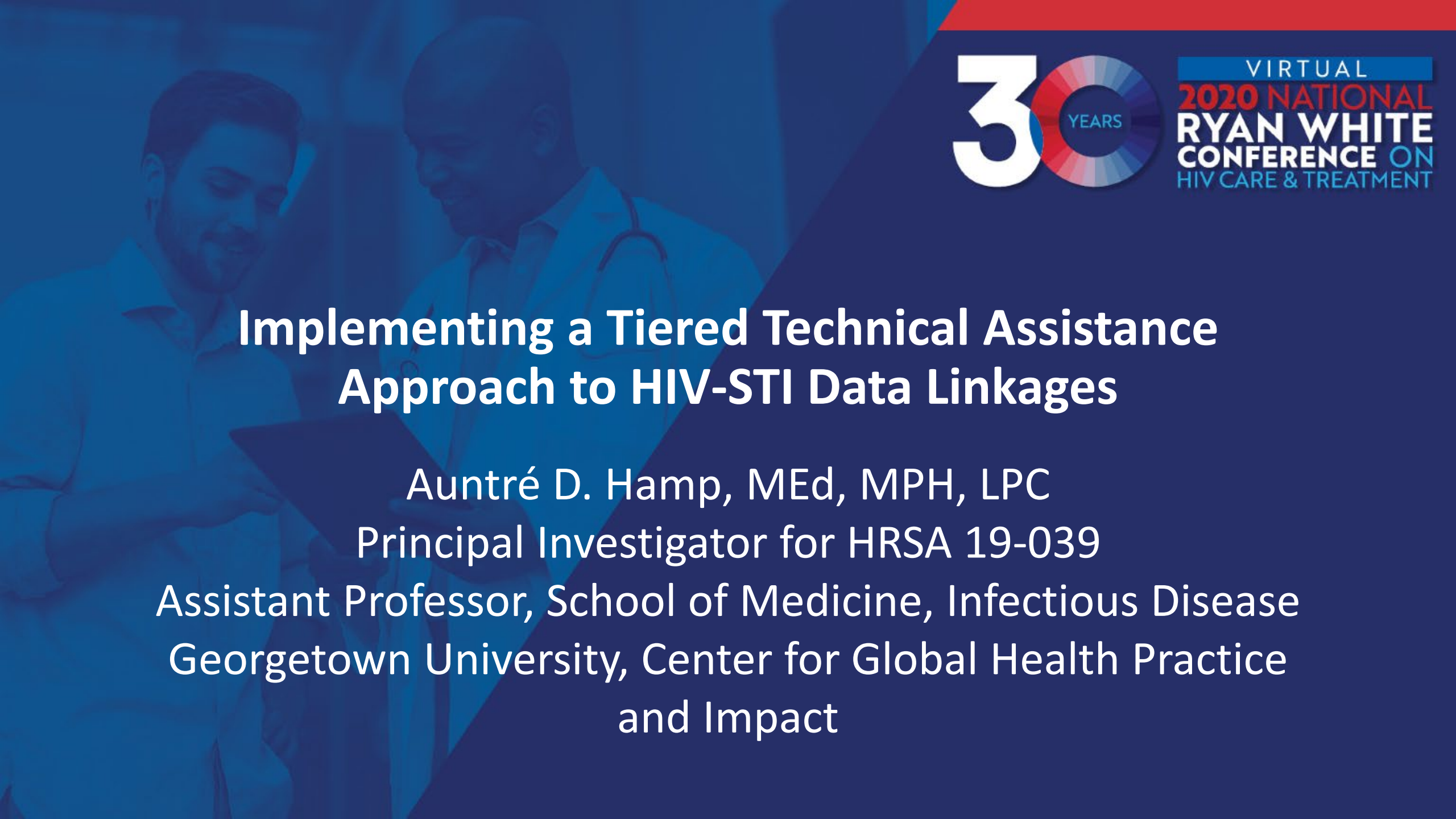
LGBTQ Welcoming Clinic Space: 2

1. Gender-neutral bathroom(s)
2. Visible gender and sexual minority inclusiveness in waiting room materials (magazines, posters, fliers)
3. Gender and sexual minority inclusive educational materials (gender diverse persons and same-gender couples)
4. A gender identity, gender expression, and sexual orientation nondiscrimination policy clearly displayed
5. History taking includes current gender identity and sex at birth inclusive of non-binary identities
6. Clinic registration/intake form has a question for client preferred name and pronoun (in addition to legal name)

LGBTQ Welcoming Clinic Space: 3

7. Display materials for community-based affiliations with sexual/gender minority supportive organizations
8. Community advisory board sexual and gender minority members
9. All staff training on gender identity diversity and sexual orientation
10. LGBTQ flag (red, orange, yellow, green, blue, purple) in waiting room
11. Transgender flag (blue, pink, white, pink, blue) or symbol in waiting room
12. Acknowledgement of LGBTQ awareness and recognition days/events (e.g., Transgender Day of Remembrance, LGBTQ Pride)





VIRTUAL 2020 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Implementing a Tiered Technical Assistance Approach to HIV-STI Data Linkages

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The content in this presentation is solely the responsibility of the authors and does not necessarily represent the official views of any governmental agency or Georgetown University.

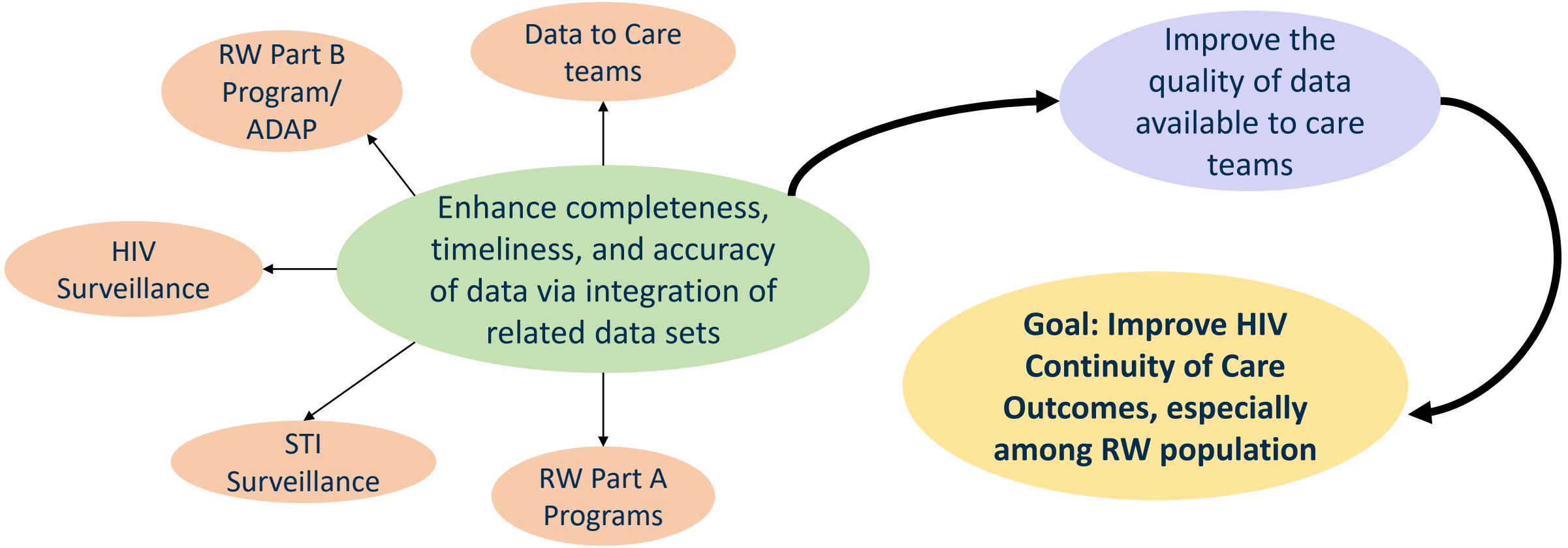
Learning Outcomes

At the conclusion of this activity, participants will be able to:

1. Summarize the various components involved in implementing a Technical Assistance program aimed at linking HIV/STI data sources to improve health outcomes
2. Integrate TA implementation processes outlined, in order to engage internal and external data owners in mutually beneficial data sharing
3. Describe the potential barriers to TA implementation

Overview of HRSA 19-039

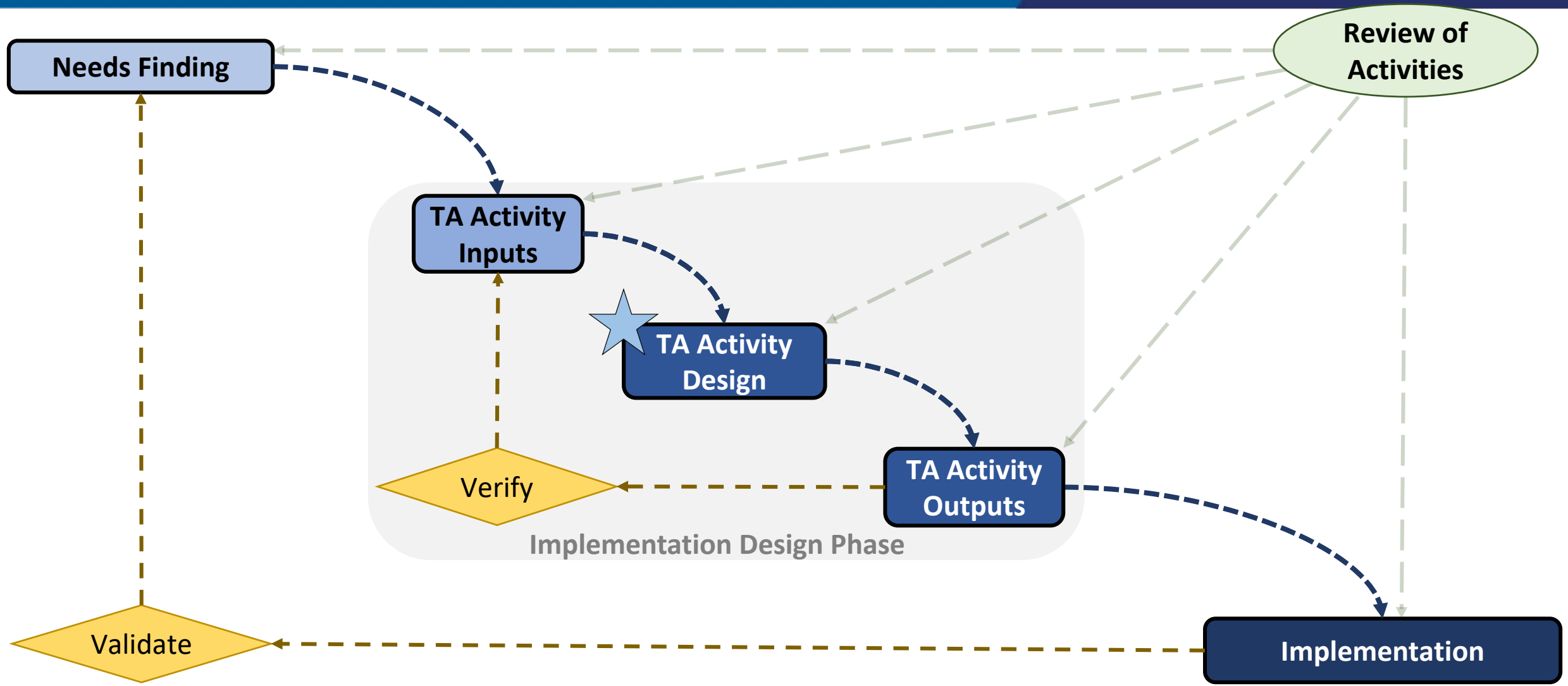
Georgetown University serves as the Technical Assistance Provider



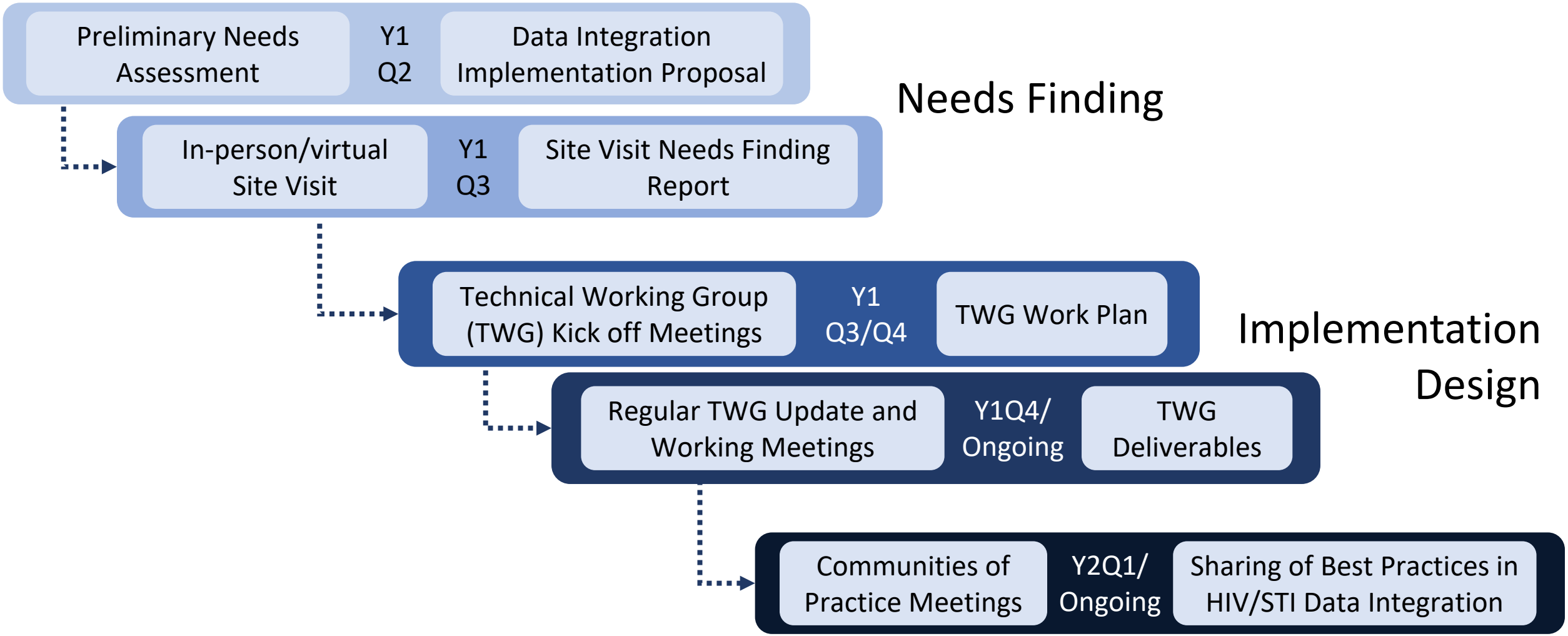
External Evaluation

- Georgetown University has supported Abt Associates in their external evaluation of the HRSA 19-039 project
  - Areas of collaboration included:
    - Examining and providing feedback on evaluation measures based on TA activities
    - Conducting routine TAP/external evaluator meetings (bi-monthly)
    - Engaging/involving the external evaluator in ongoing administrative and TA Working Group meetings
    - Coordinating communication efforts between the TAP, jurisdictions and external evaluator

Technical Assistance Design Plan



Technical Assistance Activities Timeline



Needs Finding: TA Focus Areas per Jurisdiction

AL DOH Focus Areas

- Staffing Support
- Data Integration within a Single System
- Improve Data to Care (D2C) Capacity

FL DOH Focus Areas

- Enhance Capacity for Data Sharing between Data Systems
- Legal Agreements for Data Sharing
- Establish Data Sharing Mechanism between FL DOH and RW Part A Programs

LA DOH Focus Areas

- Coordinate and Enhance Data Sharing between SHHP Data Systems
- Transition Linkage Database away from Microsoft Access System
- Enhance Data to Care (D2C) Activities via Utilization of RW Data in Linkage Activities

DC DOH Focus Areas

- Enhance the Strategic Information Division (SID) Data Linkage Process
- Enhance Data Sharing between Surveillance (SID) and RW (CTD) data systems
- Enhance Data to Care (D2C) Activities for PLWH in the DMV Region

Preliminary Implementation Design: TA Themes per Jurisdiction

In order to the further identify areas of TA support to participating jurisdictions, Georgetown identified the following TA Themes across the project:

- **Integrated Data System/Data Warehouse Development -** Jurisdictions may elect to develop/enhance an integrated data system within the DOH. These systems will be a space in which a user can retrieve comprehensive and up-to-date data on an individuals within the various DOH HIV and STD disparate data systems.
- **Data System Enhancement –** Jurisdictions with existing systems to enhance those systems, rather than migrate to a new data system altogether. Data enhancements may include increased data compatibility with other sources, refined protocol surrounding data system usage, enhanced quality assurance measures, automation of processes, etc.
- **Data Transfer Enhancement -** Incorporating new variables, new matching criteria, or automating the data transfer mechanism between HIV, STI, and RW data systems can improve data quality, timeliness of data, and overall efficiency within the department.
- **Business Process Development -** The development of a standard, well-documented, comprehensive, optimized business process will improve efficiency and work flow within the jurisdiction.
- **Collaboration Building -** From the initial case diagnosis to care provision, data for People Living with HIV (PLWH) passes through many hands (staff, case workers, etc.), many data systems, and the responsibility for reporting, action, and outreach passes from team to team. Process inefficiencies in the management of data can affect care outcomes when there is a lack of collaboration between different teams, jurisdictions, facilities, etc. Collaboration building to bridge these gaps allows for the development of a more streamlined process, to better equip all actors to provide higher quality care to PLWH.
- **Data Utilization for Outreach Efforts-** The effective use of integrated HIV/STD surveillance and care data is critical in improving health outcomes of newly diagnosed HIV cases, Ryan White recipients, and for out-of-care populations living with HIV. Better quality data must be translated to better quality care provision.

Preliminary Implementation Design: TA Themes per Jurisdiction (cont.)

Relevant TA Themes for AL Working Group

- Integrated Data Warehouse Development
- Business Process Development
- Data Transfer Enhancement
- Collaboration Building
- Data Utilization for Outreach Efforts

Relevant TA Themes for FL Working Groups

- Integrated Data Warehouse Development
- Data System Enhancement
- Business Process Development
- Data Transfer Enhancement
- Collaboration Building
- Data Utilization for Outreach Efforts

Relevant TA Themes for LA Working Groups

- Data System Enhancement
- Business Process Development
- Data Transfer Enhancement
- Data Utilization for Outreach Efforts

Relevant TA Themes for DC Working Groups

- Business Process Development
- Data Transfer Enhancement
- Collaboration Building
- Data Utilization for Outreach Efforts

Results from Project Year One

Data System Enhancement → Defined the enhancements needed in order for FL's STD data system to benefit from enhanced eHARS data sharing, work plan developed

Business Process Development → Proposal to enhance AL's HIV data flow process has been developed after review of current business process – will enable HIV team to more effectively commit to integration with STD

Data Transfer Enhancement

New data sharing pathway between FL DOH HIV section and the six Ryan White Part A programs has been outlined after 6 months of collaboration between all parties. As of June 2020:

- Data Elements to share are under legal review
- Pilot data sharing with single Part A has occurred with promising outcomes

Template Data Dashboard for implementation in AL has been drafted, including surveillance and care data elements, a step towards real time, automated data sharing within the DOH

Collaboration Building

Monthly meetings established to enhance collaboration between key stakeholder groups, including:

- FL DOH HIV and STD sections;
- FL HIV section and six RW Part A Programs;
- AL DOH and Jefferson CHD

Data Utilization for Outreach Efforts → Data Use Plan was drafted to ensure FL DOH HIV section – RW Part A data sharing loop is effective in engaging clients to care, extensive discussion regarding best practices has occurred

Technical Assistance Provision: Challenges

Organizational Differences within Jurisdiction may Lead to Collaboration Challenges

The TAP must:

- Effectively encourage collaboration between groups who have not had successful collaboration in the past;
- Navigate legal barriers to data sharing between DOH and non-DOH entities;
- Account for differences in goals of departments, which often arise due to a difference in funding requirements.

Varying Technological Baseline

The TAP must:

- Recognize a wide array of jurisdiction expertise in SAS, database management, database design, etc.
- Design implementations that are appropriate for the technological capacity within each jurisdiction/stakeholder department

Limited Staffing Resources

The TAP must:

- Recognize the existence of staff vacancies and subsequent limitations of staff time resources;
- Ensure that jurisdiction staff time requested for project activities yields maximum TA benefit

Impact of COVID-19 on Project Activities

- COVID-19 response in many states has required reallocation of staff from HIV and/or STI departments
- Two of the four jurisdictions have had to pause activities related to HRSA 19-039
- GU has focused on advancing TA with the remaining two jurisdictions in the meantime,
  - Additionally, time has been dedicated towards preparing documentation for communities of practice meetings and best practice guidelines

Acknowledgements

Thank you!

The presenter would like to acknowledge our jurisdictional collaborators at, Alabama Department of Health, DC Department of Health, Florida Department of Health, Louisiana Department of Health, and the Georgetown University HRSA 19-039 Team:

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VIRTUAL 2020 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Evaluation of Enhancing Linkage of STI and HIV Surveillance Data in the RWHAP

Leigh Evans, PhD, Project Director for HRSA-19-039

Abt Associates

Purpose of evaluation contract

- Design, pilot, and conduct the evaluation of HRSA-19-039 to demonstrate the *achievement* and *effectiveness* of the project's objectives and activities.
- *Disseminate findings* on behalf of HRSA, as this helps HAB promote replicability of project interventions.

HRSA-19-039 – Enhancing Linkage of STI and HIV Surveillance Data in RWHAP

- 3-year cooperative agreement with HRSA HAB Special Projects of National Significance
- Evaluator and Technical Assistance Provider (TAP) funded separately, but work together:
  - TAP – Georgetown University
  - Evaluator – Abt Associates
- Provides tailored TA to 4 jurisdictions to improve STI, HIV, and RWHAP data sharing and linking
- Jurisdictions can use those data for enhanced Data to Care

Collaboration is key

Georgetown University (TAP)

- Identify and recruit jurisdictions
- Assess jurisdictions' needs and capacity
- Provide TA
- Coordinate communication with jurisdictions

Abt Associates (Evaluator)

- Understand TA
- Develop evaluation plan
- Collect evaluation data
- Analyze evaluation data
- Disseminate findings to HRSA, TAP, and jurisdictions

Evaluation aims

1. Describe the Technical Assistance (TA), and assess the extent to which TA was provided as planned and met jurisdictions' needs
2. Assess to what extent the demonstration project impacted the data linking *processes* within participating jurisdictions
   - **Organizational** processes (staffing, data sharing agreements, memoranda of understanding, standard operating procedures)
   - **Technical** processes (data flow and electronic matching of person-level data)

Evaluation aims

3. Assess to what extent the demonstration project had the intended *impact* on client and policy outcomes
   - Data use by health department staff, clinicians, and policy stakeholders
   - Enhancement of data-to-care activities
   - HIV outcomes (linkage to and re-engagement in care)
4. Conduct a cost analysis
5. Disseminate key findings to HRSA and Technical Assistance Providers (TAP) to inform decision making

Data sources

Qualitative

- Semi-structured interviews
  - TAP
  - Jurisdictions
  - Policy stakeholders
- Document review
  - TAP-generated documents
  - Jurisdiction-generated documents

Quantitative

- Data end-user survey
  - Use of data for data to care
- Aggregate statistics
  - Service delivery and health outcomes
- Personnel time reporting template
  - Monthly hours spent

Mixed methods evaluation

Aim	Approach	Data sources
1. Describe the TA, and assess the extent to which TA was provided as planned and met jurisdictions' needs	Qualitative	• Document review • Semi-structured interviews with TAP and jurisdictions
2. Assess to what extent the demonstration project impacted the data linking processes within participating jurisdictions	Qualitative	• Document review • Semi-structured interviews with jurisdictions
3. Assess to what extent the demonstration project had the intended impact on client and policy outcomes	Quantitative	• Aggregate statistics • Data end-user survey
4. Conduct a cost analysis	Qual/Quant	• Personnel time reporting template • All data sources
5. Disseminate key findings to HRSA and TAP to inform decision making.	Qual/Quant	• All data sources

Progress to date

Pilot evaluation activities

- Conduct first round of interviews
- Analyze contextual documents
- Test and refine data collection for:
  - Aggregate statistics
  - Personnel time reporting template
  - Data end-user survey

Lessons learned

- Evaluation needs to evolve and align with tailored TA plans
- TAP and jurisdiction input is essential
- Start with what's already collected or available
- Need to meet jurisdictions where they are with data collection capacity

Next steps


Analyze pilot data
Update data collection processes and tools
Host evaluation kickoff
Begin full data collection – Sept 2020

Thank you!

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Shannon Hitchcock
Giulia Norton

Anne Rhodes
Jennifer Carter
Katie Armstrong
Yvonne Cristy
John Thacker
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Janet Myers, UCSF

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