WEBINAR VIDEO TRANSCRIPT

DHHS / Health Resources and Services Administration (HRSA)

Innovative HIV Care Strategies for People with HIV with Co-occurring Conditions

14 December 2022

ANGEL JOHNSON: Welcome to the Integrating HIV Innovative Practices webinar on replicating innovative HIV care strategies and the Ryan White HIV/AIDS Program. Today's webinar features two interventions focused on innovative HIV care strategies for people with HIV and co-occurring conditions. I'm Angel Johnson with the MayaTech Corporation and I'll be moderating this webinar series.

Before we meet our presenters, we're going to do a little housekeeping and go over the webinar logistics and the agenda, and get a brief overview of the SPNS IHIP Project from our project director Shelly Kowalczyk. Before we hear from our speakers, Shelly will give a brief overview about the SPNS IHIP project.

Next our presenters will talk about their interventions. Following the presentations, we'll do a Q&A. Shelly, you're up.

SHELLY KOWALCZYK: Great. Thanks, Angel. Good afternoon, everyone. So the project supporting this webinar Integrating HIV Innovative Practices or IHIP is funded through the HIV/AIDS Bureau Special Projects of National Significance. So through this project, MayaTech along with our teaming partner Impact Marketing and Communications supports the coordination, dissemination, and replication of innovative HIV strategies in the Ryan White HIV/AIDS Program.

So our project falls within this third section of the SPNS framework. And that we are developing implementation tools and resources coordinating the delivery of technical assistance on the resources that we create and supporting uptake and integration of these interventions by Ryan White and other HIV service providers. Additionally, this project is meant to align with HRSA's best practices compilation by supporting the development of tools and resources for interventions that are included in the compilation to encourage and support application.

So key support that IHIP offers includes the development dissemination of tools and resources for feature interventions. This project has expanded to feature not only SPNS interventions, but other interventions that are implemented by Ryan White grant recipients and subrecipients. And these include evidence based as well as evidence informed and emerging strategies.

So tools that we create include implementation guides, fact sheets, FAQs, and for some of the interventions video spotlights. So once they are cleared by HRSA, we post them to our IHIP page on target HIV. We offer capacity building technical assistance through webinars such as this. And we're happy to be able to offer continuing education credits in eight different disciplines. Angel will talk about that in just a moment.

We also are offering peer to peer TA. So if you're interested in implementing any of the interventions that we are featuring, you can send a request to us and request one on one TA with the interventionist

themselves. We are also providing support to those who are interested in developing their own tools and resources. So if you've begun implementing your own intervention or are partway through it and want some assistance and developing implementation resources, we can assist.

We facilitate webinars. We've actually got one tomorrow at 1:00 on using data for storytelling. So please join us. And we also offer one on one support. So again, if you want some more one on one TA with subject matter experts in developing your own tools and resources and/or disseminating them, you can reach out to us. Any information on IHIP or for any request for technical assistance can be sent ihiphelpdesk@mayatech.com.

ANGEL JOHNSON: Please note that the opinions expressed during these presentations are those of the presenters and do not necessarily represent the views of the webinar sponsors and planners. And information presented is not meant to serve as a guideline for patient management. Additionally, our presenters have nothing to disclose and no conflicts of interest.

So now it's time to meet our presenters. Our first presenter is Pamela Gorman. Ms. Gorman is the administrative director for Cooper University Health Care Department of Early Intervention Program and the Division of infectious Disease in the Department of Medicine. She worked as the clinical research supervisor trainer for Cooper Early Intervention Programs for five years enrolling people with HIV and various pharmaceutical and clinical trials. Pam currently provides clinical, administrative, and fiscal oversight for Cooper EIP's medical, dental, and support services and 340B pharmacy services.

Following Pam, will be Alicia Knapp and Erin Parrish who will present on behalf of early intervention services and outreach. Alicia Knapp has worked in the field of public health for 15 years. She started as a research evaluation analyst working on various public health grants. In 2010, Alicia happily began working in HIV care and prevention and has been with the Oregon Health Authority for the last four years. When she's not working, she enjoys being outdoors, hiking and backpacking with her two children.

Erin Parrish started in the field of Public Health working for a Reproductive Health Organization and volunteering with HIV Prevention and Treatment Clinic. She currently works for Washington County Public Health in Hillsboro, Oregon as the HIV, STI, and harm reduction program coordinator. Let's welcome Pam.

PAMELA GORMAN: Oh, thank you so much for the introduction, Angel. And good morning or good afternoon to everyone that's joined us for this presentation. I'm going to be presenting a comprehensive HIV medical care and addiction services model that supports EHE initiatives and is focusing on people with HIV and substance use disorder and how this model also addresses the continuum of care.

We've already gone over disclaimer. This is my children with myself. And again, Angel has already introduced. So let me tell you a little bit about our health system and our program. We are an urban hospital based outpatient ambulatory care center and we are located on the campus of Cooper University Hospital.

We're located in the city of Camden, Camden County, New Jersey. We are supported by multiple funding sources federal part A and C, The state of New Jersey, and we also rely on third party reimbursements and program income from our 340B pharmacy program. In 2021, our program served 1,119 people with HIV.

So let me start off with a poll and get an idea of what location all of you your agencies are described as urban or rural. If you wouldn't mind voting in the poll. OK. Great. So 78% of those of you who are urban and 22% are rural. So thank you so much for providing that information.

So the first process with trying to identify this intervention or the program was completing a needs assessment at Cooper. And what we identified was that people with HIV and co-occurring substance use disorder were referred to external agencies for substance use disorder care and treatment. And this was a barrier to them accessing services and we felt that it was best to have them on site.

Our Ryan White Data report, so this is going back a few years because now it's the RSR, we didn't have anything indicated within our reporting mechanisms that demonstrated that our outpatient substance use care was being provided. And so that was of concern. We also work in partnership with our emergency department. And they were reporting increased numbers of opioid overdoses in persons with HIV infection.

As a result of our opt out HIV screening, we also identified that there was an outbreak of HIV infection among persons who inject drugs. And as I mentioned, this was due to our health system HIV screening process and then actually getting all of those positive test results directly sent to our navigators within the program. So persons with substance use disorder and newly diagnosed HIV infection required immediate connection to HIV and STD services to prevent future acquisition of others at risk.

And so we really felt that this was a very important intervention and also something that needed to be integrated within our program. So the overview, as I mentioned, this is an integrated comprehensive HIV medical care and addiction services with medication protocols. And so our goal was to improve access to HIV primary care and addiction medicine for persons with HIV and substance use disorder. And the objectives were to improve viral load suppression and also improve retention and care for this group of individuals.

So let's get another poll question in here. And will you please describe for me what your agency's setting is. It academic, hospital based, community based? Are you an FQHC? Are you a government agency, tribal health center, or other? OK. So it's a pretty good mix. It's a pretty good mix. It does look like community based agency and hospital based clinic are the predominant agencies that are joining us here today. Thank you so much for addressing this question.

So the intervention. So as I mentioned, I'm going to describe for you today what we did to integrate addiction medicine medical care and treatment in a hospital based one stop shop clinic. And this is for persons with HIV that are also reporting co-occurring substance use disorder. And we focus our efforts on comprehensive medical care and supportive services and do our best to provide a stigma free caring environment.

Let's talk about how we model our integrated care design. And we actually use the chronic care model. This is a very effective model in integrating multiple services. So it's one stop shop for patient centered medical care. We provide multidisciplinary medical care team for comprehensive patient care. So we have multiple specialists that provide services at one location.

We also use this model as a way to maximize resources. So it's not just the physician and the medical care services, but it's wraparound services, including case management, social services, navigators, clinical psychology, and in addition to all of our specialty, 340B pharmacy as we had mentioned early on.

We have internal and external referral processes. And our model is performance driven, quality medical care. So we do monitor health care outcomes for all of our services.

So let's go to another poll. So I would like for all of you to give some thought to this statement. What best reflects your process for addressing medical care and treatment for people with HIV and substance use disorder? Do you provide services on site for both HIV and SUD care and treatment? Do you provide HIV care and treatment and refer persons out for substance use disorder to an external agency? Or do you provide medical care and treatment for substance use disorder and then refer people with HIV out to an external agency? OK.

So this is great. So most persons are providing services on site for both. And then the remainder are mostly providing HIV care and treatment and referring out. So thank you so much for providing answers to that question.

Part of the process is identifying stakeholders and partners. And this really is necessary when you're thinking about integrating care services. So first thing that I needed to do was make sure that we had leadership and system wide policies and procedures in place are being developed. And that the health system leadership was also buying into what it was that we needed to do in order to address this concern.

We needed to have specialists on site that not only provided medical care and treatment, but that were reflective of other departments within the health system, such as the emergency department, addiction medicine, infectious diseases, as well as hospitalists because we wanted a nice referral base from the hospital to the outpatient setting. We also needed psychiatrists and primary care providers on site because we know that our patients many of them with substance use disorder also have co-occurring mental health disorders. And primary care providers to address all other comorbid conditions that may be of concern.

We also have behavioral health and counseling services case management, social services for housing, transportation, and then insurance. Collaborative efforts with Medicaid insurance carriers. And these systems could either be on site or also through memorandums of agreement or co-management agreements. We also have established relationships with community based organizations such as syringe access programs, HIV testing outreach services for community based agencies that are providing that in the community, and then also a strong relationship with the county jail and correctional facilities to support persons that are incarcerated with HIV and substance use disorder or identifying people that are incarcerated with substance use disorder that may be newly identified as HIV positive.

And then, of course, our government health departments which are always very key in helping support our efforts. Identification of people with HIV and SUD and facilitating access to care services. What is most important is having systems in place for identifying these patient populations of need. At Cooper, we have a hospital a health system wide opt out HIV screening process.

And this process also includes immediate notification of persons that are testing positive to our navigators so that we can reach out to the providers or the patients to identify that they've been informed of their test results and that they are connected to care. We offer Rapid HIV point of care tests at the emergency department and through our other areas, our other officers that provide addiction services.

In the emergency department even though we have opt out HIV screening, because you need a rapid turnaround especially for persons that are coming in and maybe possibly detoxing off of substances or for those that have actually experienced an overdose, the ability to keep them in that emergency department while you await a test result is very challenging. So we do partner. One of our other clinics partners with the emergency department to provide point of care testing at that location. Collaboration With your emergency department physicians, hospitalists. And we use this partnership to bridge access to care from the emergency department and inpatient to the outpatient clinic. And fortunately the hospital supports all of our efforts. And we are well known throughout the health system as the place to go if somebody tests positive for HIV infection.

Also connecting with county or state correctional facilities, we have an MOA with our local county health correctional facility. We also go there to provide. Our infectious disease specialist goes to the jail in order to provide infectious disease services. And we have a navigator that also goes during these on site medical care services that are offered at the facility to help facilitate these individuals getting connected to care as they are released.

We also have a point person for internal and external agency referrals and linkage to care at program and established MOAs with external agencies. So we have MOA that is called Safe Path. That's the name of the committee. And all of the agencies that participate on this committee contribute information in the form of an MOA. And it's a one document with multiple agencies. And it identifies what the services are, the hours of operation, who the point person is that you want to contact if you're interested in receiving those services, or referring patients to those services.

And so that's been very helpful. And that committee meets on a monthly basis. And it's been going strong since 2012.

Processes and protocols. Develop and establish processes and written protocols for immediate access to HIV and substance use care and treatment. And as I mentioned, we have a navigation protocol for screening identification and linkage to care. This is called SILC. That's our acronym for this process.

And it helps identify persons testing positive for HIV infection. And then it also helps support those that are at high risk of acquiring HIV to get connected to our PEP and PrEP counselor, as well as syringe access program services if that's what's required. We have health system wide rapid HIV point of care testing policies and procedures for linkage to care. And then we have as I mentioned before establish written memorandums of agreements and understanding. We also have co-management agreements with different divisions and departments that provide services within our clinic. And we have contracts such as our 340B pharmacy services.

Internal communication process. Well, we've identified throughout the years challenges related to getting patients connected not only externally, but internally because of gaps or opportunities within communication. So we really felt that this was important. And we've done a lot of work on trying to improve this process.

Navigation. Our outreach navigators they complete intakes and our non medical case management staff triage to identify unmet needs and the acuity of clients and connect them to our services such as case management, behavioral health, or other support services. Maybe access to Medicaid is a requirement and they need to connect with financial counseling. We have electronic health record flow sheets that help supports these efforts.

We've also established electronic health record messaging pools per service line to improve internal communication. And this allows people to directly send messages to all of the staff that are providing a particular service line so that we can get patients connected to the appropriate care internally. We also have established a smartphone and data plan protocol which includes client agreements for phone services. And then we use our program income to cover these particular expenses.

But we do know that with COVID and post-COVID that telehealth has become a very important resource tool. And it also helps improve access to care and retention in care. So this was something we felt was incredibly important to maintain.

Addiction medicine team to daily, monthly communication meetings. When we first started this process, we quickly learned that it was important to have all individuals that were responsible for providing services to get on team meetings. And so we have one dedicated specifically for this particular service line. And it has really helped facilitate improving service as well as addressing day to day access and care needs.

And then establish monthly multidisciplinary addiction med meeting and webinars. And so this is a way of sustaining this effort. So integrated staffing plan for substance use disorder services.

We looked at our staffing plan and we thought, well, what do we need to add to our staffing plan in order to make sure that we have positions that will support this particular patient population and primary care? So we have board certified physicians and advanced practice providers for infectious diseases, addiction medicine, primary care, and psychiatry. We have registered nurses and certified medical assistance, counselors, clinical psychologists.

We use the staffing plan to identify challenges and this is an ongoing process. Awareness of behavioral reactions using a trauma informed lens. So this was something that we identified. Many patients come to us with trauma in their past, but we also noticed that this was a situation that was also affecting our staff. Sensitivity to events that occur during a client encounter. And then also attending to compassionate fatigue burnout.

Education and staffing support. So we need to make sure that we address issues during morning huddles, behavioral response meetings, and at monthly meetings. We addressed our behavioral concerns proactively by developing a behavioral response team. And we proactively look at clients prior to meetings to make sure that we're looking at possible challenges prior to situations becoming a challenge.

So this helped us develop a de-escalation plan to respond to potential adverse behavior. And also provide in a sensitive, non-threatening manner. We provide trauma informed care staff training and ongoing staff coaching for managing clients psychosocial challenges such as homelessness and food insecurities.

Integrated quality management plan updated annually. So as I mentioned, we do want to look at our performance measures. We need to make sure that we have appropriate software platforms such as our electronic health record and care ware. That we do data entry evaluation analysis of our quality management plan. We want to make sure that we're looking at reports to identify issues or missed opportunities to improve our services for retention and care and viral load suppression.

And then also identify a specific methodology in order to facilitate these efforts. And we utilize the Lean Six Sigma DMAIC methodology as well as plan, do, study, act, PDSAs for short term interventions. So let's do a fourth poll for agencies that make referrals to outside agencies for HIV. Do you have contracts or MOAs with these outside agencies? Perfect. OK.

So it looks like most agencies have a formal mechanism in place either through a contract or an MOA or MOU. Accomplishments. So what have we done as a result of integrating these services? We have a staffing plan and education training requirements for trauma informed care. We've established treatment protocols for addictions.

We utilize integrative behavioral health team to conduct mental health and substance use assessments. Very key in identifying persons that need access to these services. We're fully integrated. We have a rapid response multidisciplinary team and the protocols to manage disruptive patient incidents.

And then we also have billable services for care and treatment through Medicaid and Medicare, charity care, and private insurance carriers. We do bill for our clinical psychology services and our addiction med services. Sustainability. The reason I ask these questions, sustainability occurs through MOA, MOUs, and co-management agreements. It also occurs when you have policies and procedures. And sharing them on a network share drive helps access to those policies and procedures for all staff.

Data management team is crucial in order to identify opportunities and drive improvements. Financial management systems to make sure that you're generating third party payers that you're billing and that you're generating program income. And then also that you have an adequate staffing plan that will address the needs of these patients.

This is some of our outcomes. As you can see over the years, our viral load suppression continues to improve. And also our retention and care. So we are at 78.8% from 78% in 2019. Our viral load suppression went from a low of 61.5% in 2018 to 81.8% in 2021. So we are continually seeing improvements in health care outcomes for these patients.

And then this is also another slide that demonstrates data outcomes over the years. So you can see that our ability to gain more persons into care is increasing over the years. We're seeing more persons with substance use and HIV connecting in care. We're very pleased that we're able to see improvement from year after year.

Lessons learned. Leadership by in is a must have and collaboration with different departments within your agencies. Patience. Extremely important. Development and implementation of integrated services takes time. And it evolves year after year. It's not something that's going to just be perfect from day one.

Staffing and client trauma is intertwined. So please be sure not only to address the concerns of your patients, but also be mindful of what you need to do to support your staff to prevent provider care fatigue and burnout. And for a strategy to remain sustainable, ongoing process improvement must occur.

So here are some references for you if you're interested in finding out more information about our program. If you need to contact me or if you would like additional information, here is my information. And I want to leave you all with my happy thoughts.

And these are my grandchildren. And this was, of course, Halloween. They like being super heroes. So I thank you all for your attention. And I'd like to pass this presentation over to Alicia.

ALICIA KNAPP: Thank you, Pam. Hi, everyone. My name is Alicia Knapp, she/her. I am the project coordinator of HIV Early Intervention Services and Outreach in Oregon. I work at the Oregon Health Authority and I will also be presenting with Erin Parrish from Washington County.

So End HIV STI Oregon is an initiative that was developed by our statewide planning group in 2017. Goals of the initiative are to eliminate HIV and STI inequities through increased access to testing, education, and linkage to care. Our planning group is made up of public and private agencies as well as community groups and members with lived experience.

HIV Early Intervention Services and Outreach or EISO, which is how I will refer to it ongoing in the presentation, was a key project as part of the End HIV STI Initiative in Oregon. It was designed by the Oregon Health Authority in partnership with the statewide planning group and was implemented by six Local Public Health Authorities or LPHAs based on specific eligibility criteria. Some of our LPHAs work funded as a regional model so the project represents a total of 12 Oregon counties and the Confederated tribes of Siletz Indians.

Oregon is a decentralized state. So our public health authority sits within each county. And EISO provides services and outreach to help identify, treat, and prevent HIV and sexually transmitted infections. And also helps clients receive viral suppression or reach viral suppression. And it is funded by Ryan White Part B.

So EISO aims to eliminate new HIV infections through testing, prevention treatment, and responding to end inequities. Short term goals for accomplishing this are to increase HIV and STI testing hours and increase access to testing. It also includes the expansion of HIV STI partner services.

Longer term goals of EISO are identifying new HIV positive cases of those who may not know or are unaware of their status. And the development of community partnerships that are foundational to health equity. So the EISO intervention seeks to ensure persons with HIV have access to high quality care free from stigma and discrimination. The intervention enhances services and expands geographic coverage by building partnerships across sectors and within multiple communities.

Outreach strategies are focused on priority populations known through local epidemiology to be at increased vulnerability for HIV. And as mentioned in the previous slide, EISO jurisdictions increased HIV and STI testing hours and locations. As well as provided testing and partnership with other harm reduction services.

EISO jurisdictions linked those who tested positive for HIV to care quickly and offered health education about HIV. Those with an early syphilis or rectal gonorrhea diagnosis and/or who tested negative for HIV were offered health education about HIV prevention and PrEP. So our first point question, I know from the last presentation that not all of you are government agencies. And that is OK.

But is your jurisdiction decentralized like Oregon? So do each of your counties hold the health authority or does your state hold it? That's just yes, no, or don't know. And it's OK if you don't. I think we could probably push this and just a couple more seconds. OK. So actually most of you don't know. That's really great and I appreciate that. So thank you.

And then it's a split. So 29% for both yes and no. But a whopping 43% don't know. And that's OK. Appreciate that.

So this is just a map of the grantee counties in the state of Oregon. And as you can see, they're pretty centralized around the Western part of the state. And essentially these are just the grantees from 2018 until the end of this year. And Erin, I'm going to have you go ahead.

ERIN PARRISH: So Washington County Public Health has been a grant recipient of the Oregon Early Intervention Services and Outreach funding since 2018. We are the second largest county in Oregon. We are located just west of Portland and consist of the western suburbs with rural areas that stretch toward the coast. Washington County is continuing to grow, particularly among our communities of color as you can see. While the majority does identify as white, we have a growing population of Hispanic and Latino individuals as well as people who are identify as Asian. Just kind of a larger group of that.

So I wanted to show a brief overview of some of our STI rates during the grant period. So you can see here that we've had a consistent drop in new HIV infections which is really promising. However, there's been a consistent rise in syphilis rates. So we do acknowledge that we have work to do to continue to avoid these syphilis infections from leading to New HIV infections.

So I'm going to talk about some of that work coming up. In addition to monitoring our overall HIV and STI rates, we are looking really closely at disparities in particular populations. And so with this grant funding, then we focus on those priority populations where we're seeing the largest rise and the largest disparities in new HIV infections. And so one prime example of this disparity in Washington County is within the Latinx community.

As you can see on the slide here, the Latinx community in Washington County we did look over the past about four years from 2016 to 2020. And we can see that approximately 37% of all new HIV infections comprised people who identify within the Latinx community. But this population makes up 17% of our total population.

And then of those new infections, about 30% have been diagnosed with AIDS at the time of their HIV diagnosis. So this really shows us that this is a community that we have a lot of work to do around testing, around stigma reduction, getting education and outreach, and helping people understand their risk for HIV.

So one example of this work that we're doing in the Latinx community is a partnership that we have with a local community based organization Familias en Accion. In 2020 we began this partnership with Familias to develop an education and outreach program. So a curriculum was designed in Spanish, Me Cuido, Te Cuido. Which translates to I take care of myself, I take care of you.

This curriculum was designed to be culturally responsive and specifically for the Latinx community. It focuses on stigma reduction, basic sexual health education, education on transmission of STIs and HIV, prevention methods, and then local resources for testing and treatment. So the idea behind this curriculum was to train community health workers and health educators on how they can have these conversations with their clients. Start having non-judgemental conversations wrap those into work that they're already doing. If they're going to work with someone around their diabetes care or high blood pressure, they also talk to them about if they've ever had an HIV test. And really destigmatize and normalize those conversations.

And then in addition to that, they were trained to hold these whole community classes where they teach the curriculum to community members. And as you can see on the slide here, Familias is seeing a really good response. They have a lot of interest from community health workers and health educators and community members themselves.

People feel like they have more knowledge around STIs. They feel more willing to go and receive testing and seek that out. And so this program is now going to roll out across the state.

So in addition to the outreach and education work that we're doing with different community partners, in our county we're also looking at how we can improve linkage to care. So we work closely with our local Federally Qualified Health Centers that offer HIV testing, PrEP prescribing, and HIV treatment, as well as with HIV case management agencies that serve people that live within the TGA that we're located in Portland.

So prior to the EISO grant funding in Washington County, we had no local in person HIV case management agencies. And none that were integrated within HIV treatment providers. So if someone needed to work with an HIV Case Management Agency because they were having barriers to getting into and staying in treatment, they typically had to actually go into Portland to meet with case management providers to receive those services.

And for those of you that responded you work in rural areas even suburban areas, you can understand that that's a barrier for a lot of clients. And particularly those that have really limited transportation. This funding did allow us to facilitate a relationship between one of our local case management agencies partnership project and one of our local FQHCs agencies neighborhood health center.

So we were able to work with both of these agencies to integrate HIV case management services into the clinic. And that allows clients to be able to receive both their HIV treatment services and their case management services in the same place. In addition to this integration, we've worked with the clinic to prioritize appointments for people who are newly diagnosed with HIV, individuals who are out of care that we're trying to back into treatment.

Because it's a Federally Qualified Health Center, a lot of the providers do double duty. So all of the providers who are doing HIV treatment are also PCPs so their schedules are very full. So we've been able to work out an arrangement where we can prioritize some of those appointments. And it's really led to greatly improving our linkage to care rates in our county. And we're also able to facilitate better connections and opportunities for education with our state AIDS Education and Training Center.

So we have another poll. So does your jurisdiction partner with Syringe Service Programs? And the options are yes, no, or don't know. So there's a pretty good mix of yes, no, and people who aren't sure. So in Washington County we work very closely with our Syringe Service Program. I think probably everyone on here knows that there are many different funding sources that allow us to put together the services we provide. And some of them allow you to do some services. Some of them allow you to only do certain other services.

So you kind of have to jigsaw puzzle funding together to make it all work. And sometimes it's just easier to partner with an existing agency or service. And so in Washington County we've been working really closely with a community partner HIV alliance to operate a syringe service program.

So in Washington County this program began in late 2019. So it's really a partnership between HIV alliance and our public health department. Through the EISO funding, our public health department was able to purchase an HIV testing van that allows us to do a lot of outreach testing throughout the community, but it also allows us to do testing at our syringe exchange locations which are all currently mobile. And then we're able to offer syringe exchange through the van as well.

So during our syringe service sites, HIV alliance will offer the typical syringe services like safe injection supplies, syringe disposal, and naloxone distribution through their program. And then our community health workers and nurses offer HIV testing, risk reduction counseling, PrEP referrals, and referrals to our HIV and STI clinic. So we know in our County that we have pretty low rates of individuals who identify that they use or inject drugs testing for HIV and other STIs.

So we truly believe that there is an unmet need in our county for getting this testing out there. We believe that the rates of HIV and other STIs are likely much higher than we realize. And so this as a partnership is a great way for us to find new infections, to do outreach and education, and prevention with individuals that we otherwise might not be able to do that with our other outreach methods that we were using prior to this program.

So this is just a quick overview of other testing efforts that we offer. So we have our high risk clinic. So we really focus on individuals at highest risk for HIV infection. And we do that in partnership with another community based organization called Cascade AIDS Project.

And then in addition to our Syringe Exchange, like I said, we do other outreach testing. We really prioritize events and community organizations where we're seeing disparities and increased new HIV infections and other STIs.

And then finally, I'm going to end my portion of the presentation today with some success stories. I won't read all of this, but I am going to talk about one particular story that really shows how our partnership with our Syringe Exchange has been really successful.

So we had an individual that was coming to the Syringe Exchange with their friends. This person didn't identify to us as someone who was using drugs. But they would always come along with other people. In the fall of 2021 with some other funding that we were able to get we were able to offer testing incentives. So this was a great way to get syringe exchange clients to be more interested in doing HIV testing.

So this individual agreed to do HIV testing for the incentive. But they had no belief that they would test positive. They had no idea that they were at higher risk. Even though during the testing and kind of the interview and talking to them about their risks, we really did identify some risk factors for them.

Through a rapid test at our exchange, this individual did test positive. And they agreed to go back to our HIV and STI clinic for a confirmatory test and a full panel of STI testing. And then through that testing at the clinic, we were able to confirm their HIV diagnosis.

We also found out they had syphilis, which we were able to treat them for. And we were able to talk to them about other contacts and find individuals, other sexual partners, that they had that we were able to test and treat as well. For this particular person because of the relationship that we built with our local case Management Agency and our clinics, we were able to get them very quickly into HIV treatment. And this person is currently virally suppressed.

And then really quickly, I also wanted to talk about our partnership with our Washington County Jail. If any of you work with the jail, you understand that when someone is released it can be really hard to locate them again. So we've created a good partnership with our jail to identify to get people tested for HIV, to identify new infections, to find and locate people that are known to have HIV but we haven't been able to locate.

Our nurses are able to meet with people while they're still in the jail, meet with our HIV case Management Agency, and create a care plan and treatment plan for this person before they're released so we don't lose them to follow up after they're released from jail.

ALICIA KNAPP: Thank you, Erin. So I'm going to talk about some statewide outcomes. We've collected data in every year of EISO, but I'm just going to focus on 2021. And I'm going to probably move through this rather quickly because of time. But in 2021, 76% that was odd. 76% of newly diagnosed HIV cases were linked to care within 30 days or less.

This was an increase from before EISO was funded. From about 2013 to 2017 only about 66% were linked to care within 30 days or less from diagnosis. Median days to viral load suppression in EISO counties was 58 days.

Integrated testing is important in our EISO intervention. So 56% of those newly diagnosed with HIV were also tested for other STIs. Among those who were tested, 34% tested positive for syphilis and 32% tested positive for gonorrhea. 89% of the 174 newly diagnosed with HIV received partner services.

HIV and syphilis coinfection is common in Oregon. So 18% of people diagnosed with early syphilis had a previous HIV diagnosis. And then of all the new early syphilis cases in 2021, 48% were tested for HIV resulting in 12 new HIV cases.

32% of HIV negative or early syphilis cases were offered a PrEP referral in 2021. HIV and gonorrhea co-infection is also common in Oregon. 28% of people diagnosed with rectal gonorrhea had a previous HIV diagnosis. And of all new rectal gonorrhea cases in 2021, 58% were tested for HIV resulting in 10 new HIV cases.

25% of HIV negative rectal gonorrhea cases were offered a PrEP referral in 2021. And I just want to note that these PrEP referrals seem rather low and this could be due to a data collection error or some confusion on whether someone took the referral or not. And so that's something that we're looking into just streamlining a little bit better in the future. So that might not be accurate.

So lessons learned. Our EISO program was successful in many ways. But we also learned quite a bit over the past five years. One thing, building partnerships with and within communities takes time and often the ways in which we can fund community based organizations ends up resulting in more barriers for them. So the Oregon Health Authority hopes to work more closely with our local public health authorities on how to best navigate this moving forward as they are the ones who do most of that on the ground work with those community partners.

EISO partners who did not have a foundation for HIV prevention found it more challenging to implement this enhanced intervention because they really had to build capacity for HIV prevention and treatment in their jurisdictions first. So while most EISO grantees took about a year to implement their program, those that didn't have that foundation for HIV prevention really took them a couple of years.

Our regional approach was successful, but did prove to be challenging for regional cohesion and reporting particularly when staff at that contracting county or the main county left positions. It just made it a little more challenging to keep that streamline of the project going forward. Our LPHAs did give us feedback that moving forward they can work together regionally, but they would prefer not to have that regional funding model.

Creating standards, meeting frequently, and the availability for technical assistance like truly were very important for our partners to feel successful. Many of our programs needed to adapt rapidly during the COVID-19 response. And I think that this consistency and communication and reporting requirements was valuable.

And then local programs that made strong community connections had better linkage to care outcomes like Washington County just presented on. And this will be a focus in our work in the next four and a half years hopefully. EISO services are enhanced services that were built upon existing local and state prevention services. And we leverage program income generated through 340B for this intervention.

Cost to build capacity and trained staff are frontloaded in the first year of the project, which we refer to as the implementation year. Oregon Health Authority where I work in partnership with health management associates conducted a billing assessment to optimize how EISO services are billed to insurance. This work continues to help with sustainability of our program.

And we did ask EISO grantees to submit a sustainability plan in year four of that first phase to help with planning the future of this work. And at that time, it was clear that in Oregon we could not sustain this intervention statewide without those leverage funds through program income.

Here are some resources. So it's the Washington County Public Health STI website and then our End HIV STI Oregon Initiative website. And then I think it's just our contact information. Yeah. So thank you.

ANGEL JOHNSON: So thank you Alicia, Erin, and Pam for sharing that wonderful information. We would love to get your feedback on this presentation and on the presenters. So you can use this link on the screen to provide that feedback. We're also going to drop the link into the chat box and you can use it there to give us some feedback.

So now we're going to open the floor for questions.

SHELLY KOWALCZYK: Angel, this is Shelly. I have a quick question for Alicia and Erin. Thinking about that comment Alicia you made about the regional approach being somewhat of a challenge and maybe not necessarily counties wanting something different, Erin curious if you kind of felt that way and what the biggest challenge was in applying that approach.

ERIN PARRISH: Yeah. So my county was in a regional partnership with two other counties in our metro area. I think some of the bigger challenges can be when your counties aren't demographically quite the same. Maybe don't have all of the same needs. And so you have to try to work together to prioritize the various needs that your residents have.

So for example, in Washington County we're a suburban to rural population. And our neighboring county Multnomah County, which was the lead in our region is a more urban county for Oregon urban county. And then the other county in our region was Clackamas County, which is probably more similar to Washington County with even more rural areas I would say.

So I think the types of strategies that you want to implement are really different depending on if you're in a rural area, if you're in an urban area. We didn't necessarily have some of the resources that tend to center in the city of Portland. So it can be harder to get those resources out to the other parts of the county.

So I think moving forward it can be more helpful if we still collaborate with the other counties and learn from one another, but are able to have our own focus utilize our funding sources to really focus in on our county and our client. But I don't want that to say that we don't find partnering with the other counties unimportant. It's great to learn from one another.

I think one of the great advantages to the EISO grant that the state has also done is that they convene all of the partners all of the grantees within the ISO grant together so that we can learn from one another throughout the grant period. And I find that really helpful as well.

SHELLY KOWALCZYK: Thank you.

ANGEL JOHNSON: Are there are any other questions? Any comments? Well hearing none, I want to thank all of our presenters for providing that information and for being here today and sharing with us. We really appreciate it. And unless there are other questions or comments, I want to thank all of our attendees for attending the webinar and hope that we'll see you again in February. And remember that these webinars will be posted to the target HIV site. But thank you everyone for your time and attention today. And have a great day and a great holiday.