Ending the HIV Epidemic/Integrated HIV Prevention and Care Planning Body
Ryan White Office of Support
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TREAT COMMITTEE

AGENDA

Noon, March 8, 2024 — This is a virtual meeting.

Join Zoom Meeting: https://us02web.zoom.us/j/8899837982
Meeting ID: 889 983 7982
Or, join by telephone at: 346 248-7799

I. Welcome — Co-Chairs Pete Rodriguez and Paul "Conlee" Stone
   A. State who will facilitate today's meeting
   B. Introductions

II. Process — Co-Chairs Pete Rodriguez and Paul "Conlee" Stone
   A. Review goals (see below)—All
   B. Add members?—All
      Identify individuals who should be invited to serve?
   C. Create inventory of resources related to the goals—All
   D. Justify editing or giving goals away—All
   E. Educate, educate, educate (data, speakers and more)—All
      Pete Rodriguez recommended inviting Lindsay Lanagan, Vice President of Government Relations and Public Affairs for Legacy Community Health Services
   F. Meet the evaluators from the Research, Data, and Implementation Committee and the Monitoring, Quality Assurance, and Evaluation Committee—All
   G. After much education, take action/make recommendations—All
   H. Document progress for Leadership Team at each meeting (see below)—All

III. Review Goals — Co-Chairs Pete Rodriguez and Paul "Conlee" Stone
   Review each goal assigned to the committee and workgroups under the committee

IV. Assign Tasks and Set Date for Next Meeting — Co-Chairs Pete Rodriguez and Paul "Conlee" Stone

V. Adjourn

NEXT MEETING DATE: _____

SUMMARY OF MEETING (write on back if necessary):

DECISIONS MADE & TASK ASSIGNMENTS:

Submitted by: _____ Date: _____
Tori Williams, Staff

Treat Committee

Goal 1C: Establish a Houston Area HIV Education Council by reaching out to colleges, consumers, in-person educators, youth, and professional healthcare workers in partnership with AETCs, the RW program, CPG, and city and county health departments to increase consumer input and participation into science-based health education and Houston Area HIV linkage to prevention and care services.

Goal 2A: Ensure 90% of clients are retained in care and virally suppressed.

Goal 2A.1: Ensure rapid linkage to HIV medical care and rapid ART initiation for all persons with newly diagnosed or re-engaging in care.

Key Activities:

- Increase retention in medical care through rapid treatment initiation.
  - *In FY 2020, the Ryan White Program, in partnership with South Central AETC, Baylor College of Medicine, and Harris County Public Health, launched Rapid Start Treatment Programs at Ryan White funded primary care sites. The next step is to increase outreach to priority populations and launch Rapid Start Treatment Programs at sites other than RWHAP-funded primary care sites.*
- Offer a 24-hour emotional support and resources line available with trauma informed staff considerate to the fact individuals are likely still processing a new diagnosis.
- Health literacy campaign to educate those diagnosed on benefits of rapid start and TasP.
- Support rapid antiretroviral therapy by providing ART "starter packs" for newly diagnosed clients and returning patients who have self-identified as being out of care for greater than 12 months.
- Expand community partnerships (e.g., churches and universities) to increase rapid linkage and ART availability at community-preferred gathering venues.
- Promote after-hour medical care to increase accessibility by partnering with providers currently offering expanded hours, like urgent care facilities.

- Develop a provider outreach program focused on best HIV treatment - related practices and emphasizing resources options for clients (Ryan White care system) as well as peer-to-peer support resources for providers (e.g., Project ECHO, AETC, UCSF).

Goal 2A.2: Support re-engagement and retention in HIV medical care, treatment, and viral suppression through improved treatment related practices, increased collaboration, greater service accessibility, and a whole-health emphasis.

Key Activities:

- Develop informative treatment navigation, viral suppression, and whole-health care program including regularly held community forums designed to maximize accessibility.
  - Partner with providers to expand hours and service location options based on community preferences (after-hours, mobile units, non-traditional settings).
  - Assess feasibility of expanded telehealth check-in options to enhance accessibility and promote bundling mobile care services (including ancillary services).
  - Increase the number of referrals and linkage to RW.
  - Increase integration, promotion, and the number of referrals to ancillary services (e.g., mental health, substance use, RW, and payment assistance) through expanded partnerships during service linkage.
  - Increase case management support capacity.
  - Develop system to monitor referrals to integrated health services.
  - Hire representative navigators, promote job openings in places where community members with relevant lived experience gather, and invest in programs such as the Community Health Worker Certification.
  - Survey users of services to evaluate additional service-based training needs.
- Conduct provider outreach (100 initial/100 follow-up visits) to improve multidisciplinary holistic health practices including importance of trauma-informed approach, motivational interview-based techniques, preferred language, culturally sensitive staff/setting, behavior-based risk vs demographic/race, and routine risk assessment screenings (mental health, gender-based or domestic violence, need for other ancillary services related to SDOH).
- Build and implement a mental health model for HIV treatment and care that includes routinizing screenings/opt-out integration into electronic health records.
- Source resources for referral/free initial mental health counseling sessions.
- Maintain at least one crisis intervention specialist on service link linkage staff.

- Partner community health workers with local community gathering places (e.g., churches) to recognize and reach individuals who may benefit from support and linkage to resources.
- Widely share analyses of collected data with emphasis on complete context and value to community, including annual science symposium; Allow opportunities for community to share their stories to illustrate the personal connection.
- Utilize a reporting system to endorse programs or environments that show training application and effort to end the epidemic. Conduct quarterly quality assurance checks after the secret shopper project established by END.
- Use the HIV system to fill gaps in healthcare by creating a grassroots initiative focused on social determinants of health.
- Increase access to quality health care through promoting FQHCs to reduce the number of uninsured to under 10% in the next 10 years.
- Revamp data-to-care to achieve full functionality

Goal 2A.3: Establish organized methods to raise widespread awareness on the importance of treatment.

Key Activities:

- Collaborate with CPG to gain real-time public input during meetings on preferred language and promotion of critical messages of Undetectable=Untransmittable (U=U) and Treatment as Prevention (TasP).
- Collaborate with CPG to regularly promote diversifying clinical trials.
- Increase education and awareness around the concept of U=U and TasP to reduce stigma, fear, and discrimination among PLWH.
- Implement community preferred social marketing strategies over multiple platforms to establish messaging on the benefits of rapid and sustained HIV treatment (include basic terminology, updates on treatment/progress advances, and consideration for generational understanding of information).

Goal 2A.4: Advance internal and external policies related to treatment.

Key Activities:

- Implement and monitor immediate ART with a standard of 72 hours of HIV diagnosis for Test and Treat protocols.
- Revise policies to simplify linkage through use of an encrypted universal technology such as patient portal and/or apps to easily share information across health systems, remove administrative (e.g., paperwork and registration) barriers, incorporate geo-fencing alerts and anonymous partner elicitation.
- Refresh policies to establish a retention/rewards program that empowers community to optimize health maintenance and encourages collaboration with health department services and resources.
- Focus on necessary requirements and reduce turnaround time from diagnosis to care (e.g., Change the 90-day window for Linkage Workers).

- Update prevention standards of care to reflect a person-centered approach.
- Develop standard of treatment and advocate for implementation for those incarcerated upon intake.
- Institute policies that require recurring trainings for staff/providers based on community feedback and focused on current preferred practices (emphasis on status-neutral approach, trauma-informed care, people first-language, cultural sensitivity, privacy/confidentiality, follow-up/follow-through).
- Revise funding processes and incentivize extended hours of operation to improve CBO workflow.

Goal 2B: ***Increase access to services that replace or provide identification documents so that lack of identification as a barrier will decrease regardless of immigration or legal status by working with identification providers including CBOs, NGOs, and government agencies.***

Goal 2C: ***Create a case manager job description and fund the position so that fewer people with a history of sexual offense will be lost to care by working with street outreach workers, harm reduction teams and others experienced working with people with a history of sexual offense by prioritizing this historically underserved population.***

Goal 2D: ***Gather information from RW-funded pharmacists, case managers, executive directors, and Coalition for the Homeless to create ease of access via phone provision for historically underserved communities and to mitigate challenges towards maintaining care. Have meetings to develop pros and cons and to synthesize information to develop a consensus decision by September 2024.***

UPDATED:
02/29/24

INTEGRATED PLANNING BODY (IP)

Unless otherwise noted, all meetings will be held via Zoom or hybrid

PACHA = President's Advisory Council on HIV/AIDS

Z = Zoom (virtual only)

March 2024

Sun	Mon	Tue	Wed	Thu	Fri	Sat
					1	**2**
3 Walk to End HIV 2024	**4** ***6:00 p.m. Z*** ***IP Youth Wg*** ***(Normally meets on 1st Tues.)***	**5** Election Day	**6**	**7** 12 noon RW Steering Committee	**8** ***12 noon*** ***IP Treat Committee***	**9**
10 National Women & Girls HIV Awareness Day	**11**	**12** ***12 noon*** ***IP Prevention & Policy Comm***	**13** ***10:00 a.m.*** ***IP Needing in Person Engagement Wg*** ***3:00 p.m.*** ***Status Neutral & Diagnose Comm***	**14** 12 noon RW Planning Council 2:00 pm RW Comp HIV Planning with the ***IP Research, Data & Implement. and Monitoring, QA & Evaluation committees***	**15** **12noon** ***Road to Success*** Bering Church	**16**
17	**18** 11:00 a.m. RW Operations	**19** 2:00 p.m. RW Quality Improvement ***6:00 p.m.*** ***IP Racial & Social Justice Wg***	**20** ***12 noon*** ***IP HIV & Aging Wg*** Nat'l Native American HIV Awareness Day	**21**	**22**	**23**
24 **31**	**25** 11:00 a.m. RW Affected Community with the ***IP Consumer & Community Engagement Wg***	**26**	**27** PACHA mtg in Houston **12noon** ***Camino Hacia tu Salud*** Bering Church	**28** PACHA mtg in Houston 12 noon RW Priority & Allocations ***2:00 pm*** ***Housing Wg*** 4:00 p.m. CPG	**29** **HOLIDAY**	**30**