2023 RESOURCE GUIDE

HealthHIV

REINFORCE Initiative

RE-engaging People Living with HIV
IN Care Through Work**FORCE**
Response and Resiliency

Retention and Re-Engagement in HIV Care

www.healthhiv.org

INTRODUCTION

It has been estimated that 43% of the new HIV transmissions in the US occur from people with HIV (PWH) aware of their status, but not in care. Engagement of PWH who are out of care – recognizing the unique needs of individuals – is critical for reaching and maintaining viral suppression and preventing HIV transmission. Reasons for disengagement are varied in both high- and low-income settings, and include health system, structural, and psychosocial barriers to care. Adherence to an HIV care and treatment plan is essential to reducing morbidity and mortality for PWH, and also can improve their quality of life. Sustained linkage can open-up social determinants of health (SDOH) resources to help maintain care. Successful retention and re-engagement in HIV care depends largely on the ability of the provider to involve and motivate patients to attend ongoing care and supportive service appointments, as well as addressing SDOH that may cause patients to disengage.

To ensure that healthcare professionals who treat, care for, and/or support PWH are aware of retention and re-engagement interventions, HealthHIV launched **REINFORCE: An Initiative to Implement Individualized Strategies to RE-engage People with HIV IN Care Through WorkFORCE Response and Resiliency**. The following HealthHIV's REINFORCE 2023 Resource Guide was developed throughout this year-long education, robust capacity building initiative supporting five healthcare organizations to increase their retention and re-engagement in HIV care rates. These sites, situated around the country, ranged from large multi-site hospitals and health centers to small community-based organizations. Because of this diversity, the resources in this document provide insight into HIV retention and re-engagement in a variety of settings and with a variety of populations.

All links and information included in this resource were accessible as of February 2024.

HealthHIV
REINFORCE
Initiative

1630 Connecticut Ave, NW, Suite 500
Washington D.C. 20009
202.232.6749

www.healthhiv.org

TABLE OF CONTENTS

INTRODUCTION **2**

Section 1: RETENTION/RE-ENGAGEMENT IN HIV CARE **4**

Best practices for effective patient follow-up for PEH 4
Best practices for optimizing patient engagement strategies 4
Resources for enhancing patient engagement 5
Resources to support patient reactivation strategies 6
Trainings/resources on providing HIV services to rural communities 6
Resources to collect, implement, analyze, and integrate patient feedback into organizational quality improvement 7
Strategies to gather and incorporate patient feedback into care and retention strategies 8

SECTION 2: PATIENT EDUCATION **9**

Resources for development, implementation, and sustaining a peer support program 9
Best practice strategies on advertising organization services 10

SECTION 3: CULTURAL COMPETENCY AND IMPLICIT BIAS **11**

On-demand (CME/CE-preferred) stigma and discrimination/ cultural competency/implicit bias training for providers 11
Trainings/resources on providing HIV services to transgender community 12
On-demand, self-paced learning opportunities on working with clients dealing with substance use issues 13
On-demand, self-paced learning opportunities on motivational interviewing 14

SECTION 4: MOBILE HEALTH/COMMUNITY OUTREACH **15**

Best practices on providing HIV services through mobile health/community outreach 15
Funding/resources to expand transportation (e.g. bus passes) to clients 18

SECTION 5: DATA COLLECTION & EMR **19**

Model practices and/or data collection templates 19
Training resources on documentation strategies and reporting in CAREWa 19

SECTION 6: WORKFORCE DEVELOPMENT **21**

Resources for development, implementation, and onboarding of case management navigation services 21
Best practices on integrated care coordination between medical and non-medical care providers 23
Best practices on supporting clients to maintain documentation, enrollment status, etc. 24
Workflow and retention model best practices for FQHCs 26

RETENTION/RE-ENGAGEMENT IN HIV CARE

RESOURCE	KEY TOPICS COVERED
1.1 Best practices for effective patient follow-up for PEH	
Optimizing HIV & HCV Treatment Among People Experiencing Homelessness	Dr. Stacey Trooskin and Dr. Arsalan Shah discuss screening for HIV and HCV and optimal strategies to link PEH to care, including how to incorporate community and outreach services and external partners. Clinic models for colocation services to simplify screening and linkage to care are discussed. *ARCHIVED TRAINING MODULE*
Systems Models Providing Care and Treatment to People with HIV Experiencing Homelessness and Under/Unemployment	This workshop will describe three site models, including protocols, resources, and tools for engaging and retaining people in care, achieving viral suppression, attaining stable housing, and gaining employment. Presenters will also share systems developed and implemented for internal and external partnerships with housing, employment, and other service providers. *ARCHIVED TRAINING MODULE*
Using peer care navigators to connect individuals who are experiencing homelessness and living with HIV with a medical home in the San Gabriel Valley	• Provide peer support and advocacy for multiply diagnosed PLWHA who are experiencing homelessness and diagnosed with mental health and/or sub stance use disorders • Increase clients' adherence to treatment to improve medical status • Implement "mobile" care-coordinated services, i.e., meeting the clients where they are, be it on the streets or in a shelter, to ensure linkage to care • Improve the stability or status of clients' housing *ARCHIVED TRAINING POWERPOINT PRESENTATION*
North Carolina Rurally Engaging and Assisting Clients Who Are HIV Positive and Homeless (NC REACH) Project	Build and maintain sustainable linkages to mental health, substance abuse treatment, and HIV/AIDS primary care services that meet the complex service needs and ensure adherence to treatment of HIV positive homeless or unstably housed individuals. *ARCHIVED TRAINING POWERPOINT PRESENTATION*
Home Health Care for Patients Without Shelter	This article describes Chicago Street Medicine, an organization that implements HHC to improve health outcomes and care continuity for patients experiencing homelessness. *PEER-REVIEWED ARTICLE*
1.2 Best practices for optimizing patient engagement strategies	
Project CAATCH	Project CAATCH (Consumer Access and Adherence to Care for HIV) uses evidence-informed practices, including motivational interviewing, to address identified gaps in the continuum of care for client retention and viral load suppression measures. *ONLINE RESOURCE*

RETENTION/RE-ENGAGEMENT IN HIV CARE

RESOURCE	KEY TOPICS COVERED
1.2 Best practices for optimizing patient engagement strategies	
Engaging Out-of-Care Patients **Additional Resource**	Identification of the five stages of the HIV care continuum; definition of how Data to Care supports the HIV Care Continuum and the 6 steps to get patients back to a healthcare practice. *ARCHIVED CONFERENCE SESSION AND POWERPOINT PRESENTATION*
Promoting Patient Engagement by Reducing Barriers to Care Related to Comorbidity **Additional Resource**	People with HIV can experience disabling comorbidities that limit their ability to access HIV services, resulting in potential discrimination and negative health outcomes. This session will include a summary of federal protections for people with disabilities and how providers can address barriers to care caused by comorbidities. *ARCHIVED CONFERENCE SESSION AND POWERPOINT PRESENTATION*
Quality Improvement Strategies to Engage and Retain Postpartum Women with HIV **Additional Resource**	University of Mississippi Medical Center utilized known barriers to care for postpartum women with HIV and leveraged that information toschedule individualized interactions with pregnant and postpartum women with HIV. This low-cost, low-effort initiative resulted in statistically significant improvements in both retention in care and viral suppression rates in postpartum women with HIV. *ARCHIVED POWERPOINT PRESENTATION*
Utilizing Texting and Social Media Communication to Engage Patients in Routine Medical Care and Financial Assistance Programs	Utilizing texting and social media, the organization was able to see marked improvements in viral load suppression due to better access to healthcare communication. *ONLINE RESOURCE*
1.3 Resources for enhancing patient engagement	
Enhanced Patient Navigation for Women of Color with HIV **Peer Navigator Curriculum**	This intervention is part of the Dissemination of Evidence-Informed Interventions project—the first SPNS project of its kind to apply a rigorous implementation science approach and evaluate intervention replication and fidelity of evidence-informed intervention models across the country. *ONLINE RESOURCE*

RETENTION/RE-ENGAGEMENT IN HIV CARE

RESOURCE	KEY TOPICS COVERED
1.4 Resources to support patient reactivation strategies	
Culturally Appropriate Interventions of Outreach, Access and Retention among Latino/a Populations Initiative: Intervention Monographs	These monographs describe interventions for the engagement and retention of Latinos in HIV care, including Latinos who are at high risk or living with HIV and out of care or unaware of their HIV-positive status. *ONLINE RESOURCE*
Leveraging Health Information Exchanges to Re-Engage Hardest-to-Reach People with HIV **Additional Resource**	Bottom Up leverages the Healthix-Health Information Exchange (HIE), including real-time alerts and updated contact information via housing services, to mobilize community-based outreach teams to find and re-engage patients in care. *ARCHIVED CONFERENCE SESSION AND POWERPOINT PRESENTATION*
Data-Driven Strategies for HIV Care Re-Engagement: A Southern Perspective From Tennessee **Additional Resource**	This session highlights the Data to Care program coordinated by the Tennessee Department of Health. Participants will learn how data is used to identify people with HIV who are considered 'out of care' and how to successfully re-engage patients into HIV medical care and supportive services. *ARCHIVED CONFERENCE SESSION AND POWERPOINT PRESENTATION*
Improving Re-Engagement in Care using a Community Health Worker Model: Evidence from New Orleans **Additional Resource**	Lessons learned from an EMA-wide effort to embed CHWs in RWHAP Part A agencies to improve retention and re-engagement in care in New Orleans and address COVID-19 related barriers to HIV care. *ARCHIVED CONFERENCE SESSION AND POWERPOINT PRESENTATION*
1.5 Trainings/resources on providing HIV services to rural communities	
Youth in Rural Communities: Unique Needs and Approaches to Engagement, Adherence, and Service Delivery	Overview of data on youth with HIV, their needs and programs in rural communities, and implementing initiatives to reach youth and retain them in care. *ARCHIVED CONFERENCE SESSION*

RETENTION/RE-ENGAGEMENT IN HIV CARE

RESOURCE	KEY TOPICS COVERED
1.5 Trainings/resources on providing HIV services to rural communities	
Implementing a Community Engagement Program to Enhance Viral Suppression in Rural Populations	In this workshop, participants will gain resources and strategies for implementing community engagement programs, including training community health workers to be part of a health care team to enhance viral suppression and management of HIV in rural populations. *ARCHIVED CONFERENCE MODULE*
Addressing the HIV Workforce Challenges in Rural Communities	This resource focuses on rural workforce challenges and corresponding data, highlights recipient innovative approaches to ameliorate the challenges, and reviews a vast array of free resources and training offered by HRSA Federal Office of Rural Health Policy and HRSA Bureau of Health Workforce. *ONLINE RESOURCE*
1.6 Resources to collect, implement, analyze, and integrate patient feedback into organizational quality improvement	
Obtaining Feedback From Sub-Recipients and PLWH to Improve Linkage to Care in the Atlanta EMA	As part of an ongoing initiative, surveys were developed to inform the Atlanta EMA Quality Management Program on the successes and challenges related to the linkage to care process. The Quality Management (QM) Committee of Metropolitan Atlanta HIV Health Services Planning Council elected to conduct a quality improvement (QI) project noting variability across the Ryan White Part A Network in measuring and achieving linkage to care within 30 days. *ONLINE RESOURCE*
DISQ Office Hours: Gender-Affirming Data Collection	Collecting data on sexual orientation and gender identity (SOGI) using gender-affirming approaches is critical to providing high-quality, patient-centered care and reducing health disparities. Join this discussion to learn about new approaches to gender-affirming demographic data collection among RWHAP agencies. *ARCHIVED TRAINING MODULE*
Going to PROM: Incorporating the Patient Voices in Quality Improvement	Patient-reported outcome measures (PROMS) and patient-reported experience measures (PREMS) can help guide quality improvement activities by utilizing the patient voices and input. Learn about these measures and how HIV providers have utilized these metrics to continuously improve patient health outcomes and experiences with the HIV care system. *ARCHIVED CONFERENCE SESSION*
Roadmaps: The Journey of PLWH Improving Health Outcomes for PLWH	This presentation will share innovative strategies in the creation of a reflective Consumer Advisory Board, HIT HIV. The presentation will showcase quality improvement projects the HIT HIV CAB completed while leveraging technology, social media, consumer feedback, and CQM principles ensuring a community-driven and equitable process toward ending the HIV epidemic. *ARCHIVED CONFERENCE SESSION*

RETENTION/RE-ENGAGEMENT IN HIV CARE

RESOURCE	KEY TOPICS COVERED
1.6 Resources to collect, implement, analyze, and integrate patient feedback into organizational quality improvement	
Using patient feedback to drive quality improvement in hospitals: a qualitative study	The objective of this study is to explore how patient feedback is currently used in hospitals to improve quality. *PEER-REVIEWED ARTICLE*
1.7 Strategies to gather and incorporate patient feedback into care and retention strategies	
Meaningful Consumer Engagement in QI: Best Practices for Involvement and Improvement	This module discusses the importance of engaging consumers to improve quality through program involvement and feedback. Includes strategies to involve consumers at every step of the program. *ONLINE TRAINING MODULE*
Using Patient Feedback	The Picker Institute's quality improvement activities help you to involve patients, staff and the public in translating patient feedback into real improvements. *ONLINE RESOURCE*
Involving Consumers in Quality Improvement	• Participants will understand why consumer involvement is a key element for high quality services • Learn strategies to meaningfully engage consumers in QI activities. • Understand the principles of voice of the consumer techniques • Gain strategies for how to utilize qualitative consumer input to implement QI projects. disabilities, substance use and co-occurring disorders. *ONLINE RESOURCE*

PATIENT EDUCATION

RESOURCE	KEY TOPICS COVERED
2.1 Resources for development, implementation, and sustaining a peer support program	
Building Blocks to Peer Program Success: Toolkit for Developing HIV Peer Programs	Training compendium for agencies seeking to develop programs that utilize peers to help engage and retain other people with HIV in care. Covers: • Organizational Readiness • Designing a Peer Program • Peer Roles and Responsibilities • Recruiting, Hiring, and Orienting Peers • Supervising Peers • Evaluating Peer Programs • Funding Sources *ONLINE RESOURCE*
Organizational Readiness Assessment for Integration of Peer Staff	Assessments and other tools and resources to integrate peer staff. *ONLINE RESOURCE*
Positive Peers Mobile App	Positive Peers is a mobile app for youth and young adults with HIV aged 13–34. The app offers information, social networking, and self-management tools to support holistic HIV care. The Positive Peers application was designed to improve retention in HIV healthcare, facilitate greater viral suppression, lessen perceived isolation and stigma, and support HIV self-management for users. *ONLINE TOOLKIT RESOURCE*
Innovative HIV Care Strategies for Priority Populations: Housing First and Positive Peers Interventions	This session is part of the Ryan White HIV/AIDS Program (RWHAP) Part F Special Projects of National Significance (SPNS) Webinar Series. *ARCHIVED TRAINING MODULE*
Project CAATCH Medical Care Coordinator/Peer Intervention Manual	A care coordinator and peer team co-deliver a curriculum that includes six core CAATCH educational sessions on the following topics: 1) the HIV viral life cycle and medications at work, 2) communicating with health care providers, 3) understanding basic lab tests (CD4, viral load and others), 4) managing stigma and disclosure, 5) HIV and substance use disorders, and 6) HIV and wellbeing. *ONLINE RESOURCE*
Implementing a Community Engagement Program to Enhance Viral Suppression in Rural Populations	In this workshop, participants will gain resources and strategies for implementing community engagement programs, including training community health workers to be part of a health care team to enhance viral suppression and management of HIV in rural populations. *ARCHIVED TRAINING MODULE*

PATIENT EDUCATION

RESOURCE	KEY TOPICS COVERED
2.2 Best practice strategies on advertising organization services	
Introduction to Promoting PrEP Through Community-led Campaigns	This E-learning module provides health department staff, community-based organization staff, and other public health professionals with knowledge and skills related to designing, creating, and implementing a PrEP promotion campaign. **How to Access this Course** • Create a CDC TRAIN account at **train.org/cdctrain/user/register**. • Join the HIVCBA Learning Group. **Here are step-by-step instructions**. • Register for this course at **train.org/cdctrain/course/1109222**. *ONLINE TRAINING MODULE*
Marketing Strategies for Sustainable Client Recruitment and HIV Services	Experts in HIV service delivery, health promotion, and infrastructure development shared lessons learned, outreach strategies, and ways to improve recruitment and retention of clients. *ONLINE RESOURCE*
Best Practices for Marketing HIV Services	Marketing HIV services resource. *ONLINE RESOURCE*
Recruitment Best Practices	Marketing HIV services resource. *ONLINE RESOURCE*
Nonprofit Marketing and Branding 101	This is a toolkit detailing how nonprofit organizations can utilize marketing tactics to promote the message of their organization, as well as raise awareness for its cause. *ONLINE RESOURCE*
Digital Technology, HIV Prevention and Care Post COVID-19; Part II: What is Digital Outreach Marketing?	• Identify strategic use of social media tools • Improve data collection by using social media and digital marketing • Strengthen connection with target population using virtual/digital tools *ARCHIVED TRAINING POWERPOINT PRESENTATION*
Marketing & Branding to Increase Linkage to Care	This webinar will provide a high-level overview of the concepts of marketing and branding. Branding is who you are and marketing is how you build awareness. A strategic combination of branding and the marketing tools will engage your target audience, build their trust, and open them to follow your advice. It will also drive them to your services that will allow you and your organization to link them, and keep them. *ARCHIVED TRAINING MODULE*
PrEP Demand Generation Toolkit	The aim of this toolkit is to support community organizations to increase awareness of and generate demand for PrEP for HIV prevention. *ARCHIVED TRAINING MODULE*

CULTURAL COMPETENCY/IMPLICIT BIAS

RESOURCE	KEY TOPICS COVERED
3.1 On-demand (CME/CE-preferred) stigma and discrimination/ cultural competency/ implicit bias training for providers	
Achieving Health Equity: Countering Racism & Implicit Bias in Healthcare	It is important for health care leaders to understand the impact of racism, implicit bias and health inequities on access to and quality of HIV care and treatment for Black Women. Dr. Dazon Diallo and Ethlyn McQueen-Gibson explore how providers and clients can maximize health promotion and wellness, resilience, and self care education, leading to necessary positive and sustainable change. *ARCHIVED TRAINING MODULE*
Do No Harm: Incorporating Harm Reduction Strategies into Patient-Centered Care (Powerpoint)	This workshop was for front-line staff looking to enhance their use of harm reduction strategies in practice. Participants discussed harm reduction and its role in patient-centered care, explored organizational workflow and competency in working with active drug users, and practiced implementing harm reduction tools through hands-on demonstrations. *ARCHIVED POWERPOINT PRESENTATION*
Roots of Racism in Healthcare: Creating a Climate for Culturally-Responsive Care	This webinar explores the concept of race and health inequities: outlines the history of scientific racism: and reveals its influence on the modern medical establishment's values, beliefs, and practices towards BIPOC communities. *ARCHIVED TRAINING MODULE*
Enhancing Cultural Humility and Understanding Barriers to Care	Module 5 of HIVPCP certification course: This module focuses on the role that stigma, discrimination, trauma and social determinants of health play in HIV prevention and care and ways to mitigate their impact through cultural humility and trauma-informed care. 1.0 CEUs (CME, CNE, CPE, MOC) Expires 3/26/2024. *ONLINE TRAINING MODULE*
Understanding Implicit Bias in Healthcare	• Explain the difference between implicit/unconscious and explicit bias. • Identify at least five types of bias present in healthcare. • Describe the effects of unconscious bias on everyday interactions with patients, students, colleagues, and team members. • Describe how personal unconscious biases impact perceptions of gender, race/ethnicity, and/or cultural attributes in healthcare. • Provide strategies to correct or eliminate personal unconscious biases in daily interactions *ARCHIVED TRAINING MODULE*

CULTURAL COMPETENCY/IMPLICIT BIAS

RESOURCE	KEY TOPICS COVERED
3.2 Trainings/resources on providing HIV services to transgender community	
Transgender Care for HIV Clinicians	• List key barriers to care among the transgender people seeking health services, including HIV/STI prevention and treatment • Describe gender-affirming medical and surgical interventions for transgender individuals • Review HHS Adult ART guidelines for transgender people with HIV • Describe key components of culturally competent care for transgender patients *ARCHIVED TRAINING MODULE*
Strategies to Support Positive Experiences for Transgender and Gender Non-Conforming Individuals	• Define and identify key terms to understand Trangender and Gender Non-Conforming (TGNC) clients • Identify and examine the impact that social determinants of health (SDOH) has on TGNC individuals' health outcomes • Identify prevention, care, and support needs of TGNC individuals who are survival workers, engage in drug use, and are returning home from incarceration as a tool to EHE • Identify needs of TGNC members incarcerated and returning home • Identify tools to ending barriers to care for TGNC individuals *ONLINE TRAINING MODULE*
Effective Strategies for Affirming and Engaging Transgender Clients	The purpose of this toolkit is to use an approach to health care delivery in which organizations, programs, and providers recognize, validate, and support the identity stated or expressed by the individuals served.
Toolkit for Providing HIV Prevention Services to Transgender Women of Color	The intended audience for this toolkit is staff at CBOs, health departments, clinics, and other organizations that currently provide, or are planning to provide, HIV prevention services for transgender WOC. The toolkit may be of use for staff at all levels of an organization, including those at the executive level, program managers, and frontline staff such as those working in HIV testing, linkage, outreach, and programs. It is also intended for clinical providers and staff that provide the range of social support services needed by transgender WOC. *ONLINE RESOURCE*
Providing Inclusive Care for LGBTQ Patients	This resource toolkit is designed to assist healthcare agencies in meeting the needs of their lesbian, gay, bisexual, transgender and queer (LGBTQ) patients.
The Trans Experience: Pride in Our Health	This webinar, presented at the HAHSTA Ryan White Case Management Operating Committee Quarterly Training, addresses the need for accurate comprehensive data on transgender health, as well as how to provide specialized, culturally competent care to transgender individuals in a non-stigmatizing environment. 2.0 CEUs (CME, CNE, CPE, AAPA, APA, ASWB, IPCE) Expires 10/19/2024. *ONLINE TRAINING MODULE*

CULTURAL COMPETENCY/IMPLICIT BIAS

RESOURCE	KEY TOPICS COVERED
3.3 On-demand, self-paced learning opportunities on working with clients dealing with substance use issues	
Drug User Health in a Syndemic Environment	This session addresses challenges related to living and accessing services in a syndemic environment. It covers those strategies that ensure individuals are able to address co-morbidities. Additionally, the session addresses strategies to prioritize health needs and expected outcomes from a drug user health perspective. The complex intersectionality of the law and harm reduction efforts are discussed. 1.0 CEUs (AAPA, ACPE, AMA, ANCC, ASWB, APA CEP, ADA CERP) Expires 10/24/2024. *ARCHIVED TRAINING MODULE*
Social Justice/Language Justice Implications for Services and Retention in Care	**Scenario Discussion 1:** Analyze methods used to decrease stigma by using terms that avoid negative associations to increase access to services while promoting a positive and affirming space. **Scenario Discussion 2:** How can we educate and strengthen community responses to address drug user health, and promote retention in care? What has history taught us as it pertains to policies and access for the harm reduction community within hospital settings, and how do we continue to move forward? *ARCHIVED TRAINING MODULE*
Bridging Care Outreach and Secondary Exchange	This webinar seamlessly combines theory and practice to empower participants with the essentials of outreach and secondary exchange. Discover highly effective strategies for outreach, recruitment, and engagement. Recognize the indispensable role of People Who Use Lived Experience (PWLE) in all aspects of Syringe Services Programs (SSPs). *ARCHIVED TRAINING MODULE*
Crossing The Threshold: Navigating The Gateway To SUD Treatment Spaces	This insightful webinar guides you through the crucial steps in accessing substance use disorder (SUD) treatment spaces. Gain a nuanced understanding of the diverse range of SUD treatment options available within the continuum of care. Learn to discern the right candidates for referral to these programs and develop effective communication strategies for facilitating these crucial conversations. We'll explore the pivotal role of sustained, open-ended discussions in the context of SUD treatment, and recognize the invaluable perspectives brought by People Who Use Lived Experience (PWLE) to this process. *ARCHIVED TRAINING MODULE*
Culture and Society: Influencers of Mental Health and Substance Misuse	This webinar discusses how to promote equity, improve access, and increase retention in care among BIPOC communities in healthcare. Barriers and myths relating to PrEP use in BIPOC communities are identified and dispelled to encourage patients' use of PrEP while emphasizing the importance of a strong patient-provider relationship. Additionally, innovative healthcare delivery methods and initiatives will be explained to improve patients' knowledge of PrEP and to increase PrEP uptake. 1.0 CEUs (AAPA, ACPE, AMA, ANCC, ACE, APA CEP, IPCE) Expires 8/8/2024. *ARCHIVED TRAINING MODULE*

CULTURAL COMPETENCY/IMPLICIT BIAS

RESOURCE	KEY TOPICS COVERED
3.3 On-demand, self-paced learning opportunities on working with clients dealing with substance use issues	
Beyond Boundaries: Transforming Intimacy Dynamics in Drug Inclusive Relationships	This webinar provides participants with an overview of how to apply harm reduction principles for people who use drugs (PWUD) to the context of sexual health and relationships. The faculty will review how practicing harm reduction within sexual relationships between PWUD can reduce the risk of HIV, HCV, and other sexually transmissible infections. *ARCHIVED TRAINING MODULE*
Integration of Comprehensive HIV Medical Care with Addiction Services	The Cooper Health System's Early Intervention Program Expanded Care Center (CEEC) has integrated comprehensive HIV medical care with addiction services and medication protocols for substance use disorder (SUD), as a treatment model for people with HIV. CEEC provides a "one-stop shop" for HIV primary care, wraparound services, and addiction medicine services. For clients with HIV and SUD, both retention in care and viral suppression increased. *ARCHIVED TRAINING MODULE AND ONLINE RESOURCE*
3.4 On-demand, self-paced learning opportunities on motivational interviewing	
Motivational Interviewing to Improve Health Outcomes	• Explain the importance of engaging in HIV care • Describe tangible forms of support they could provide to a friend or family member living with HIV • Describe intangible forms of support they could provide to a friend or family member living with HIV *ONLINE TRAINING MODULE*
Patient-centered care: Implementing harm reduction & motivational interviewing	• Define harm/risk Reduction as it applies to HIV prevention • Explain client/patient-centered harm/risk reduction practices • Discuss what Motivational Interviewing is • Practice Motivational Interviewing for the purposes of harm reduction *ARCHIVED TRAINING MODULE*
Motivational Interviewing: New Tools for HIV Prevention and Care	• Name at least three (3) factors that impact behavior change; • List at least four (4) qualities of effective helping relationships; and • Identify at least three (3) core communication skills to enhance readiness to change. *ARCHIVED TRAINING MODULE*

MOBILE HEALTH/COMMUNITY OUTREACH

RESOURCE	KEY TOPICS COVERED
4.1 Best practices on providing HIV services through mobile health/community outreach	
HHOME: Homeless Health Outreach Mobile Engagement	Homeless Health Outreach Mobile Engagement (HHOME) is a robust, mobile care and systems intervention that helps link, engage, and deliver rapid HIV treatment to some of San Francisco's most vulnerable and homeless communities. During the RWAP SPNS initiative, the intervention was able to stably house and retain in care (at 12-month chart review) 83.6 percent of intervention clients. *ONLINE RESOURCE*
Co-Located HIV and SUD Care on a Mobile Unit for Homeless People with HIV and SUD	A community health center uses a mobile health unit to provide integrated substance use disorder (SUD) and HIV care and treatment for those suffering from housing instability. This low-barrier, mobile, integrated care model, supported by intensive case management and outreach, has made a significant impact on engagement, antiretroviral treatment (ART) initiation, and viral suppression. *ARCHIVED CONFERENCE SESSION*
Tips for Implementing a Mobile Health App for People Living with HIV	A mobile health application, or app, is intended to improve patient care and advance health equity by addressing barriers to care. This web page offers six tips to successfully implement a mobile health app at an organization. *ONLINE RESOURCE*
MORE: Mobile Outreach Retention and Engagement	The Whitman-Walker Health (WWH) Mobile Outreach Retention and Engagement (MORE) intervention increased retention and viral suppression among people with HIV through a tailored service delivery model, which includes increasing access to supportive services and providing HIV care services in community settings. *ONLINE RESOURCE*
Implementing a Community Engagement Program to Enhance Viral Suppression in Rural Populations	In this workshop, participants gain resources and strategies for implementing community engagement programs, including training community health workers to be part of a health care team to enhance viral suppression and management of HIV in rural populations. *ARCHIVED CONFERENCE CENTER*
HIV Testing in Non-Clinical Settings	This webpage provides key references and information for persons conducting HIV testing in nonclinical settings. *ONLINE RESOURCE*
HIV Treatment Outcomes in POP-UP: Drop-in HIV Primary Care Model for People Experiencing	Homelessness-Informed by the capability-opportunity-motivation-behavior (COM-B) model and patient preference research, we developed POP-UP, an integrated drop-in (nonappointment-based) HIV clinic with wrap-around services for persons with housing instability and viral nonsuppression in San Francisco. *PEER REVIEWED ARTICLE*

MOBILE HEALTH/COMMUNITY OUTREACH

RESOURCE	KEY TOPICS COVERED
4.1 Best practices on providing HIV services through mobile health/community outreach	
HIV Speaks Español: Best Practices for Developing Latinx Outreach Programs	HIV infections continue to rise among members of the Latinx community, especially youth. To reverse this increasing trend, it is important to recognize the social, economic, linguistic, and cultural barriers that hinder the prevention and treatment efforts for HIV when developing an outreach strategy. *PEER-REVIEWED ARTICLE*
Clients' perceptions of barriers and facilitators to implementing hepatitis C virus care in homeless shelters	Studied the experiences of homeless individuals related to accessing HCV care to inform the design of a shelter-based HCV prevention and treatment program.
A pilot outreach HIV testing project among homeless adults	Community-engaged research approaches were employed via a partnership between the local health department, a federally qualified faith-based health center, and an academic university. An interviewer-administered survey to measure potential factors associated with HIV testing history and voluntary HIV testing services were offered to adults living in transitional housing establishments. The goal was to determine the association between predisposing, enabling, and need variables with HIV testing history in the past 12 months. *PEER-REVIEWED ARTICLE*
Early Intervention Services and Outreach (EISO)	This guide details components of the EISO intervention and outlines the capacity required by organizations/clinics to replicate this work and support others in their implementation efforts. *ONLINE RESOURCE*
Utilizing the Community to Reach the Community: Ending the Epidemic with Community Health Workers **Additional Resource**	DC Health piloted three innovative care models to strategically ensure the community's voice is permanently embedded in HIV services. *ARCHIVED TRAINING MODULE*
Barriers and facilitators to use of a mobile HIV care model to re-engage and retain out-of-care people living with HIV in Atlanta, Georgia	To guide the development of a mobile HIV clinic (MHC) model as a strategy to re-engage and retain PLWH who are out of care, researchers aimed to explore stakeholder perceptions of barriers and facilitators to MHC implementation and use. *PEER-REVIEWED ARTICLE*

MOBILE HEALTH/COMMUNITY OUTREACH

RESOURCE	KEY TOPICS COVERED
4.1 Best practices on providing HIV services through mobile health/community outreach	
Using Outreach to Increase Access	Learn how to implement an outreach service to expand access to health services, practices, or products. *ONLINE RESOURCE*
Promoting Safety in Street Outreach **Additional Resource**	Training the street outreach workforce in core competencies for promoting safety. *ARCHIVED TRAINING MODULE*
Innovative Outreach Strategies for HIV Prevention	• Identify the target population to tailor outreach events to fit the needs of the community. • Recognize the benefits of marketing to provide resources and assist with linkage to care services. • Discuss strategies to promote HIV prevention and reduce stigma during outreach events. • Describe methods to upscale campaigns to increase engagement. • Identify strategies to provide safe spaces for community members. *ARCHIVED TRAINING MODULE*
Homeless Outreach: A Pre-Treatment Guide	Through integration of storytelling/case illustration and applying five clinical principles of care, this presentation will provide participants with a pretreatment model to assist health care delivery with highly vulnerable unsheltered homeless individuals who often present with mental health, substance abuse, and medical issues. Each case illustration will provide a context for active exploration, questions for further consideration, and open dialogue with your team members. *ARCHIVED TRAINING MODULE*
Adapting Outreach Services: Discreet HIV Testing for Rural Kentucky MSM Populations and More	The Target4 project with the Kentucky Income Reinvestment Program (KIRP) has developed unique outreach strategies to better serve rural MSM populations impacted by cultural, geographic, and resource-related barriers to HIV testing. *ARCHIVED CONFERENCE SESSION*
Lehigh Valley Health Network Street Medicine Policy & Procedure Outline	Sample street medicine policies and procedures. *ONLINE RESOURCE*
Doctors Without Walls – Santa Barbara Street Medicine	Sample street medicine policies and procedures. *ONLINE RESOURCE*

MOBILE HEALTH/COMMUNITY OUTREACH

RESOURCE	KEY TOPICS COVERED
4.2 Funding/resources to expand transportation (e.g. bus passes) to clients	
Lyft Up	Transportation access programs. *ONLINE RESOURCE*
Medicaid Services	Condensed Version of a Primer on How to Use Medicaid to Assist Persons Who Are Homeless to Access Medical, Behavioral Health, and Support Services. *ONLINE RESOURCE*
Virginia Department of Rail and Public Transportation	Grant programs. *ONLINE RESOURCE*

DATA COLLECTION AND EMR

RESOURCE	KEY TOPICS COVERED
5.1 Model practices and/or data collection templates	
EMR Data Collection and Infrastructure Improvement	Positive Health Clinic successfully completed a quality improvement project related to our EMR, EPIC. The focus of this project was streamlining data collection, data utilization, and reporting processes in the EMR. *ARCHIVED POWERPOINT PRESENTATION*
5.2 Training resources on documentation strategies and reporting in CAREWare	
CAREWare Recipient Spotlight: Maricopa County and Baltimore City	Presentation on innovative uses of CAREWare by two Ryan White HIV/AIDS Program (RWHAP) Part A recipients: Maricopa County (Phoenix) Arizona and Baltimore City, Maryland. *ARCHIVED TRAINING MODULE*
CAREWare Features in Focus - RSR Client Issue Viewer	This webinar reviewed some new features in CAREWare, especially the brand new RSR client issue viewer, which shows what outstanding RSR-related issues still remain for each client and adds a summary screen indicating where the issues are occurring. *ARCHIVED TRAINING MODULE*
CAREWare Features in Focus - Basics of Building Client Reports	This webinar is for those new to CAREWare and covered the basics of building CAREWare client reports, including: • Built-in templates • Custom reports • Use of filters and • Saving reports. *ARCHIVED TRAINING MODULE*
CAREWare Features in Focus - Advanced Custom Reports and Performance Measures	This session reviewed some of the more advanced CAREWare custom reports and Performance Measures. *ARCHIVED TRAINING MODULE*
CAREWare Features in Focus - PDI and PDE New Build Features	CAREWare programmer Roy Carubba provided an overview of the next major CAREWare build, under in mid-2022, which includes an overhaul and redesign of the data import and export features (PDI and PDE). *ARCHIVED TRAINING MODULE*
CAREWare Features in Focus – A Look at the FHIR API	This follow-up to an earlier presentation on the re-design of the Provider Data Import (PDI) module in CAREWare provided a sneak preview of the FHIR Application programming interface (API). API is a standardized way to move data from electronic medical records (EMRs) into another platform like CAREWare. *ARCHIVED TRAINING MODULE*

DATA COLLECTION AND EMR

RESOURCE	KEY TOPICS COVERED
5.2 Training resources on documentation strategies and reporting in CAREWare	
CAREWare and the RSR	Review of CAREWare and RSR reporting, including: • Criteria for including a client in the RSR (e.g., contract/funding sources) • RSR data and what features of CAREWare allow users to review the quality of their data; and • The sharing feature for those in a networking version of CAREWare. *ARCHIVED TRAINING MODULE*
Epic and CAREWare Integration	Discussion of how to integrate CAREWare with Epic and other electronic health record (EHR) systems. Three grant recipients discussed their strategies for importing data into CAREWare through the Provider Data Import (PDI) and HL7. Insights on Epic integration are relevant to other applications. *ARCHIVED TRAINING MODULE*
HIVQM File Export: An excerpt from Miscellaneous Features Guide	Step-by-step instructions on how to create a .CSV file in CAREWare to upload to the HIVQM Module. *ARCHIVED TRAINING SESSION*
Centralized Eligibility and Unified CAREWare	The presentation will describe how CAREWare and eligibility integration eased access to services by clients in our jurisdictions. Presenters will be to provide Ryan White jurisdictions with actionable ideas and processes to integrate their CAREWare and eligibility processes to improve access to services, reporting, monitoring, and quality management. *ARCHIVED CONFERENCE SESSION*
Managing Multiple Data Sources and Overcoming Interoperability Barriers for HIV Care	This session will help recipient and subrecipient sites to successfully connect their CAREWare and other electronic health information systems with external sources of data to report and monitor HIV care and treatment outcomes. This session will provide practical examples of successful data integration and highlight ongoing issues and costs in long-term management and maintenance. *ARCHIVED CONFERENCE SESSION*
HCV Linkage, Screening, and Treatment among Co-infected Clients: Enhancing CAREWare and Electronic Health Records	As HIV elimination activities increase, jurisdictions can address HIV/Hepatitis C (HCV) co-infection by enhancing HCV screening and treatment data collection. This session will discuss NASTAD's work with North Carolina to incorporate HCV data in CAREWare and electronic health records (EHRs), as well as recommendations for integrating HCV services into the HIV care infrastructure. *ARCHIVED CONFERENCE SESSION*

WORKFORCE DEVELOPMENT

RESOURCE	KEY TOPICS COVERED
6.1 Resources for development, implementation, and onboarding of case management navigation services.	
Electronic Case Management Tracking System: A Tool for Case Managers and Managers	This session will describe the development and implementation of a web-based electronic and administrative tracking system developed for use by clinic case managers. This electronic tracking tool allows case managers to easily view patient data with the overall goal of improving retention in care and adherence to medication. *ARCHIVED CONFERENCE SESSION*
Behavioral Health Screener and E-health Intervention Implementation within a Multi-county HIV Medical Case Management System	AIDS Foundation Chicago is launching an innovative, system-wide behavioral health screener for RWHAP case management clients in Chicago and surrounding counties. This presentation outlines the rationale (including pilot data) of the Wellness Questionnaire, implementation strategies, and initial client impacts, as well as use of an online e-health intervention for depression. *ARCHIVED CONFERENCE SESSION*
Collaborative Medical Case Management Team to Address Barriers to Adherence	Collaborative medical case management team called Tri-Pod (registered nurse, a social worker, non-medical case manager) utilizes a psychosocial assessment to identify barriers to adherence (e.g., lack of support/other priorities), facilitating collaboration among the medical case management team and allowing the MCM to provide patient-centered care, promote health and wellness, and assist in removing barriers to accessing health care. *ONLINE RESOURCE*
HIV/AIDS Medical Case Management Acuity Assessment **Evaluation Report**	Medical case management acuity tool to assess severity of needs of clients living with HIV in various areas of functioning and categories of severity. Comes with an evaluation report on its development. *ONLINE RESOURCE*
Using an Electronic Health Record to Support Non-Medical Case Management Processes, Assessments, and Program Graduation **Additional Resource**	Prism Health North Texas will share the challenges and successes of integrating non-medical case management workflow processes into an integrated electronic health record system. The presenter will discuss workflow processes, assessments that allow non-medical case managers to gather required information and determine outcomes and identify patients appropriate for program graduation. *ARCHIVED CONFERENCE SESSION POWERPOINT PRESENTATION*
PWH Involvement in Case Conferencing	How quality management teams can enhance their efforts by incorporating PWH into QI projects to enhance outcomes. *ARCHIVED CONFERENCE SESSION*

WORKFORCE DEVELOPMENT

RESOURCE	KEY TOPICS COVERED
6.1 Resources for development, implementation, and onboarding of case management navigation services.	
Recognizing Quality with Value-Based Payment for Ryan White Part A Medical Case Management Services	The New York City Department of Health and Mental Hygiene (Health Department) used a conceptual model of evidence-based practice implementation to outline a system for value-based payment for medical case management (MCM) services. The Health Department collaborated with key stakeholders, including MCM service providers, in the system's design. *ARCHIVED CONFERENCE SESSION*
DC Health Ryan White Services Standards: Medical Case Management (MCM) Services	This course describes the Services Standards elements and expectations all Ryan White service providers are to follow when implementing Medical Case Management Services. Service Standards define the minimal acceptable levels of quality in service delivery and to ensure that a uniformity of service exists. *ONLINE TRAINING MODULE*
DC Health Ryan White Services Standards: Non-Medical Case Management (NMCM) Services	This course describes the Services Standards elements and expectations all Ryan White service providers are to follow when implementing Non-Medical Case Management. Service Standards define the minimal acceptable levels of quality in service delivery and to ensure that a uniformity of service exists. *ONLINE TRAINING MODULE*
Systematic Collaboration – Adapting an In-house Case Management Data System **Additional Resource**	There is a lack of case management products for HIV surveillance programs, many states develop home-grown systems in response. In 2019, Louisiana prioritized upgrading their home-grown case management database – and identified Florida's system as a potential replacement. This presentation will review process of implementing the FL system in LA. *ARCHIVED CONFERENCE SESSION AND POWERPOINT PRESENTATION*
Enhanced Patient Navigation for Women of Color Intervention Manual	This manual is designed to share best practices for implementing an enhanced patient navigation intervention for women of color with HIV. It can be used by HIV primary care clinical providers, coordinators, and clinics. *ONLINE RESOURCE*
AETC Southeast Curriculum	Online curriculum modules that offer free, self-paced learning and educational training. The courses provided are aligned with the AETC program mission to increase the number of health care providers who are effectively educated and motivated to counsel, prevent, diagnose, treat and medically manage people with HIV, and to help end the HIV epidemic. Free CEU credits are available for some of the courses. *ONLINE TRAINING MODULE*
Texas HIV Case Management	Case Management is a multi-step process to ensure timely access to and coordination of medical and psychosocial services for a person living with HIV. Medical and non-medical case management are distinct service categories on their own, and the role of these services is to link clients with many needs to a continuum of health and social service systems. *ONLINE RESOURCE*

WORKFORCE DEVELOPMENT

RESOURCE	KEY TOPICS COVERED
6.1 Resources for development, implementation, and onboarding of case management navigation services.	
Adapting and Implementing the Youth-Focused Case Management Model for the SPNS BMSM Initiative **Additional Resource**	• Understand the key components of the Youth-focused Case Management model. • Compare adaptations between organizations with different needs and populations. • Apply lessons learned to adapt and replicate the Youth-focused Case Management model of care. *ARCHIVED TRAINING MODEUL AND POWERPOINT PRESENTATION*
6.2 Best practices on integrated care coordination between medical and non-medical care providers	
Patient Engagement and Care Coordination in HIV Health (PEACCH) Tool	This tool describes the role of care coordination in serving people with HIV. It outlines steps and resources a clinic may need to set up a care coordination program.
Integrating Navigators into Care Systems	Best practices (and extensive resource links) for integrating into medical care teams the non-medical staff called Navigators, whose focus is on identifying and addressing client barriers to care and other immediate needs. *ONLINE RESEARCH*
Project CAATCH	Project CAATCH (Consumer Access and Adherence to Care for HIV) uses evidence-informed practices, including motivational interviewing, to address identified gaps in the continuum of care for client retention and viral load suppression measures. *ONLINE RESOURC*
Using an Electronic Health Record to Support Non-Medical Case Management Processes, Assessments, and Program Graduation **Additional Resource**	Prism Health North Texas will share the challenges and successes of integrating non-medical case management workflow processes into an integrated electronic health record system. The presenter will discuss workflow processes, assessments that allow non-medical case managers to gather required information and determine outcomes and identify patients appropriate for program graduation. *ARCHIVED TRAINING MODEUL AND POWERPOINT PRESENTATION*
Optimizing the Care Team: Lessons Learned Best Practices, Critical Issues, and Site Examples	Insights on operating Care Teams: multidisciplinary collection of providers who work together to meet multiple patient needs to improve care delivery and outcomes. *ONLINE RESOURCE*

WORKFORCE DEVELOPMENT

RESOURCE	KEY TOPICS COVERED
6.3 Best practices on supporting clients to maintain documentation, enrollment status, etc.	
Develop a comprehensive plan to engage and enroll clients in health coverage and help them stay enrolled.	Organizations should establish and maintain comprehensive policies and procedures that clearly describe their plan for engaging and enrolling clients in health coverage and helping them use their coverage and stay enrolled. **Account Tune-Ups: Getting Ready for Marketplace Open Enrollment** *ONLINE RESOURCE*
Train staff with direct client contact to determine eligibility, enroll clients, and help clients maintain coverage.	All staff with direct client contact should be prepared to provide basic information about health coverage options and connect clients to staff or external partners who can provide direct enrollment assistance. HIV programs should provide tailored training to staff on how to determine client eligibility, enroll clients, and help clients use and maintain their coverage. Staff should be prepared to explain Marketplace financial assistance options (e.g., premium tax credits and cost sharing reductions) to clients, as well as information about the potential state-specific tax penalties for not enrolling. Staff should also communicate to clients how the RWHAP may be able to help with insurance and medication costs. **Health Coverage Eligibility Decision Tree** **The Basics of Medicare for Ryan White HIV/AIDS Program Clients** **Making the Most of Your Coverage** *ONLINE RESOURCE*
Assess your work flow to routinely screen clients for eligibility and plan renewals.	Clients are most likely to successfully enroll in new coverage when the transition between engagement activities and enrollment support is seamless. Structure clinic workflow to screen clients for changes in eligibility both during routine clinic visits throughout the year and during Marketplace Open Enrollment. This will help ensure clients who are newly eligible for Marketplace coverage or eligible to re-enroll get enrolled promptly, and receive appropriate enrollment assistance. **E-learning Course:Preparing for Marketplace Open Enrollment (November 1 - January 15)** *ONLINE TRAINING MODULE*

WORKFORCE DEVELOPMENT

RESOURCE	KEY TOPICS COVERED
6.3 Best practices on supporting clients to maintain documentation, enrollment status, etc.	
Develop procedures for eligible clients that do not enroll.	RWHAP recipients must demonstrate vigorous pursuit of enrolling clients in health coverage. Organizations should document their efforts. Clients that are eligible but choose not to enroll should be asked to sign an affidavit saying that they have declined to enroll in coverage. **Tracking your Efforts to Engage Clients who Experience Barriers to Enrollment** *ONLINE RESOURCE*
Tailor messaging and communication appropriately for your client population.	RWHAP clients may have concerns about enrolling in health coverage for many reasons, including fear of sharing their personal information, concerns about stigma and discrimination, and previous negative experiences with the health care system. Given these challenges, trusted RWHAP staff should provide clients with comprehensive information about coverage options using clear, plain language and allow time to listen to and discuss people's specific concerns. **Health Coverage Resources for Consumers** **The ABCDs of Medicare Coverage** **Talking with Clients about Health Coverage Common Questions and Suggested Responses** *ONLINE RESOURCE*
Train staff on health insurance literacy to communicate with clients about how to enroll in health coverage, use their health coverage, and stay covered.	Clients may not understand everything about how health insurance works. Staff with strong health insurance literacy skills who are knowledgeable about key health insurance terms, forms, processes, and instructions will be able to work with clients more effectively and help them to enroll in health coverage, use their health coverage, and stay covered. Staff will also be more prepared to help clients address health insurance-related challenges as they arise, minimize gaps in coverage, and manage potential health and financial challenges. **Health Insurance Literacy Training Module** *ONLINE TRAINING MODULE*

WORKFORCE DEVELOPMENT

RESOURCE	KEY TOPICS COVERED
6.4 Workflow and retention model best practices for FQHCs	
Optimizing the Care Team: Lessons Learned Best Practices, Critical Issues, and Site Examples	Insights on operating Care Teams: multidisciplinary collection of providers who work together to meet multiple patient needs to improve care delivery and outcomes. Best practices cover: preparation, staffing, buy-in, formalization, and adaptability. *ONLINE RESOURCE*
Data Tools & Best Practices for Continuity of Ryan White Part B Services	Description of methods to implement data tools and best practices for continued client enrollment in RWHAP Part B, including steps being taken to make data driven decisions to improve patients' access, engagement and health outcomes across our care continuum. *ONLINE RESOURCE*
Assess your work flow to routinely screen clients for eligibility and plan renewals.	Clients are most likely to successfully enroll in new coverage when the transition between engagement activities and enrollment support is seamless. Structure clinic workflow to screen clients for changes in eligibility both during routine clinic visits throughout the year and during Marketplace Open Enrollment. This will help ensure clients who are newly eligible for Marketplace coverage or eligible to re-enroll get enrolled promptly, and receive appropriate enrollment assistance. Staff should also routinely screen for RWHAP Part B/ ADAP eligibility. **E-learning Course:Preparing for Marketplace Open Enrollment (November 1 - January 15)** *ONLINE TRANING MODULE*
Patient Engagement and Care Coordination in HIV Health (PEACCH) Tool	This tool describes the role of care coordination in serving people with HIV. It outlines steps and resources a clinic may need to set up a care coordination program. *ONLINE RESOURCE*
Estimating Unmet Need: Key Steps for RWHAP Parts A and B Recipients High Level Workflow Infographic	This infographic provides a high-level workflow for RWHAP recipients completing the required or enhanced Unmet Need Estimates and Analyses. Six key activities are outlined to help recipients plan for and successfully complete the estimates and analyses. *ONLINE RESOURCE*
TA Manual - Improving Health Outcomes: Moving Patients Along the HIV Care Continuum and Beyond	Evidence-informed interventions along the HIV care continuum. Includes: • Intervention steps at-a-glance to provide an overview of featured activities • Resource checklists outlining necessary capacity for replication • Staffing tables with personnel overviews • Narrative sections to walk readers through processes for replication *ONLINE RESOURCE*

WORKFORCE DEVELOPMENT

RESOURCE	KEY TOPICS COVERED
6.4 Workflow and retention model best practices for FQHCs	
Active Referral Intervention: Case Study, Overview, and Replication Tips	Evidence-informed intervention that uses Disease Intervention Specialists (DIS) to more actively link clients to HIV care services. These services are described in the following terms: • Intervention steps at-a-glance to provide an overview of featured activities • Resource checklists outlining necessary capacity for replication • Staffing table with personnel overviews • Narrative sections to walk readers through processes for replication *ONLINE RESOURCE*
Collaborative Medical Case Management Team to Address Barriers to Adherence	Collaborative medical case management team called Tri-Pod (registered nurse, a social worker, non-medical case manager) utilizes a psychosocial assessment to identify barriers to adherence (e.g., lack of support/other priorities), facilitating collaboration among the medical case management team and allowing the MCM to provide patient-centered care, promote health and wellness, and assist in removing barriers to accessing health care. *ONLINE RESOURCE*
No-Show Phone Script to Improve Appointment Keeping	Script developed and used by front office staff to follow-up with no-shows by phone to assess reasons for missed appointments and respond accordingly (e.g., mail bus pass to those not showing due to transportation challenges), with subsequent improvements seen in viral suppression rates among MSM of color. *ONLINE RESOURCE*
Red Carpet: Expedited Intake for Newly Diagnosed	An expedited intake process for newly diagnosed patients (MSM of color), characterized by flexibility in scheduling, multi-service delivery in single visits, and first visit clinician encounters. *ONLINE RESOURCE*
Patient Option to Text Message with Patient Navigators	In response to data that navigating the healthcare system was a key barrier to achieving viral suppression, patient text messaging to patient navigators enabled within the existing system of mobile device appointment reminders and check-ins. *ONLINE RESOURCE*