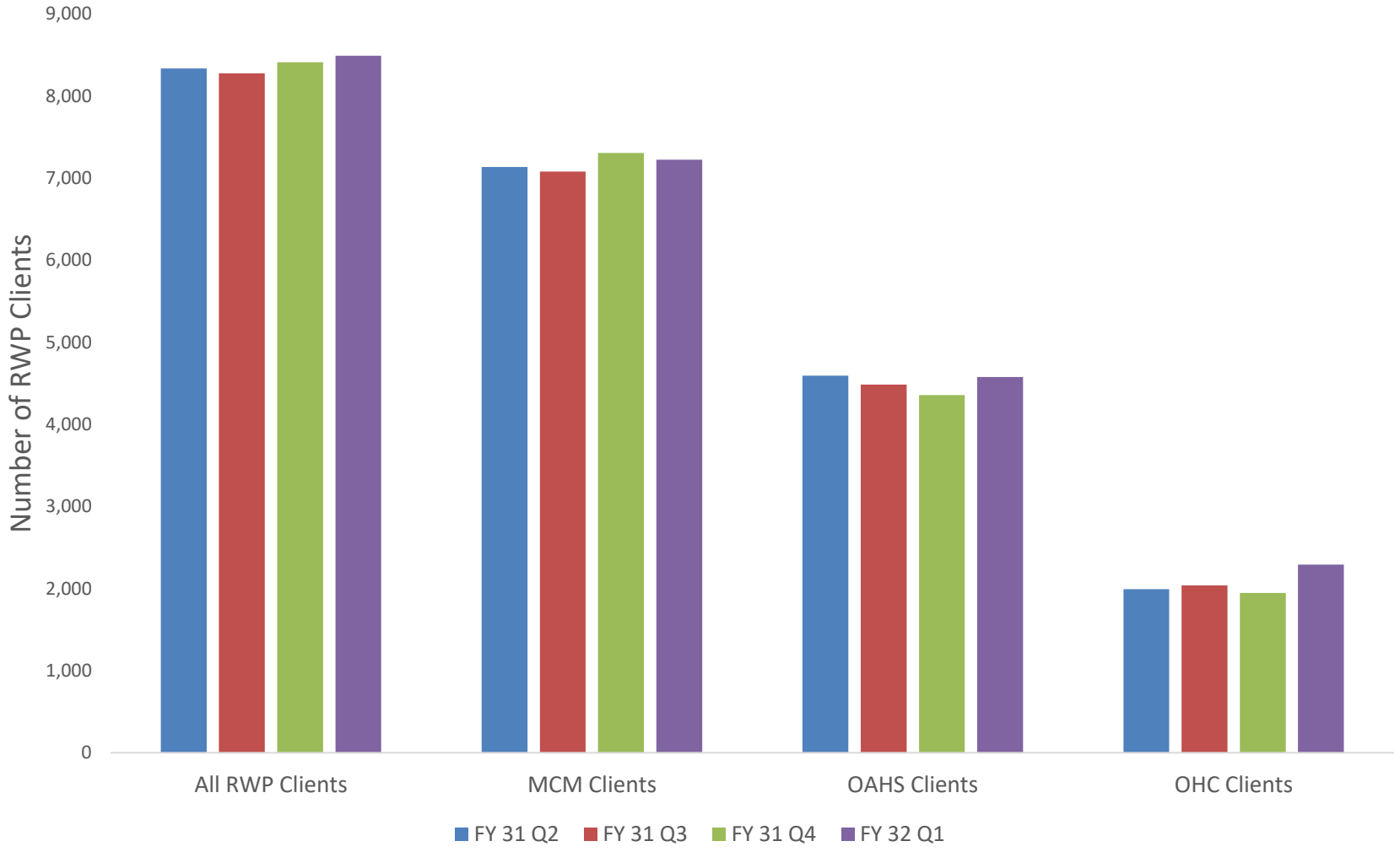
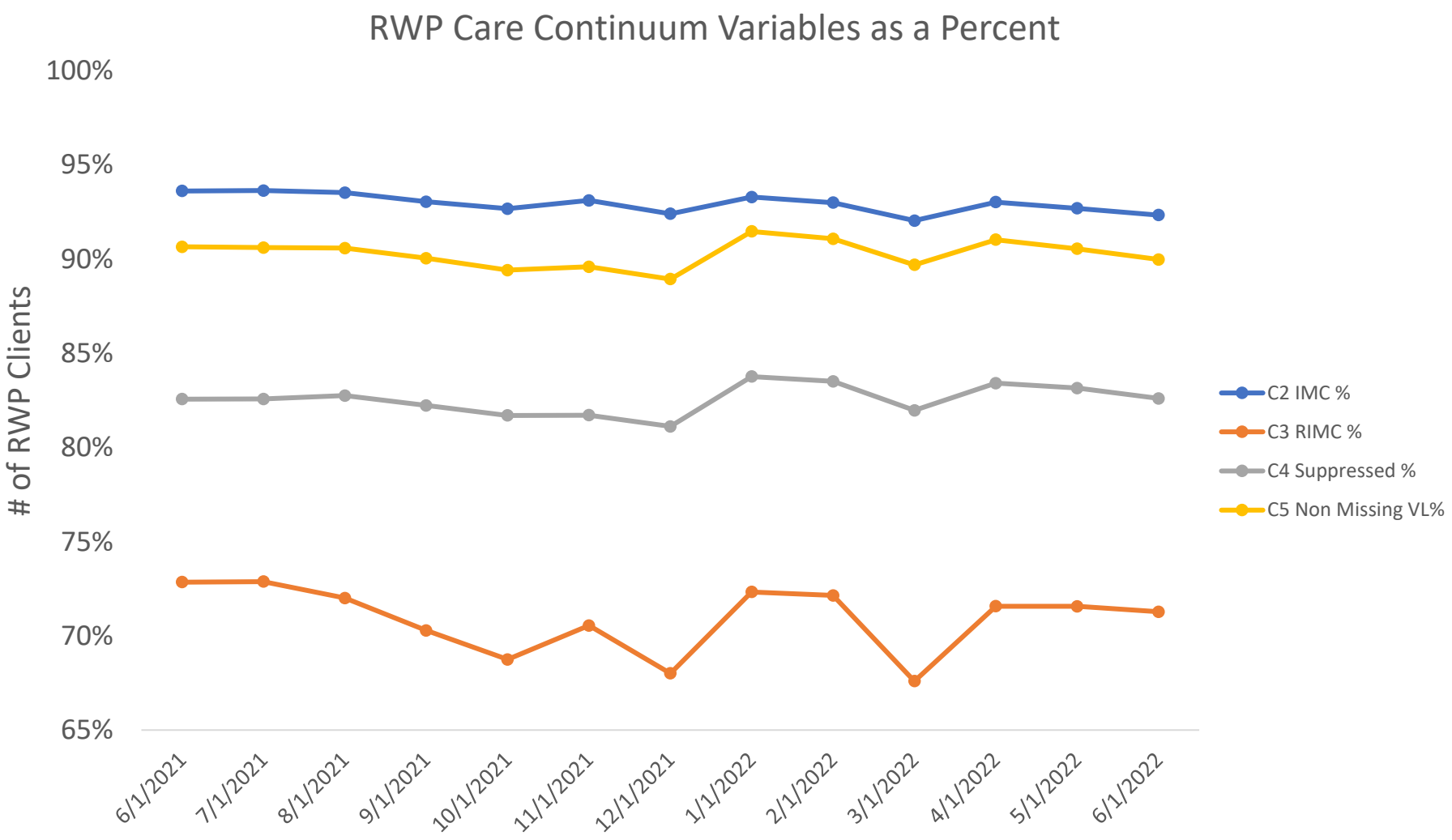
Number of Clients in Ryan White Program By Service Category Per Quarter




RWP Care Continuum Variables as a Percent
# of RWP Clients
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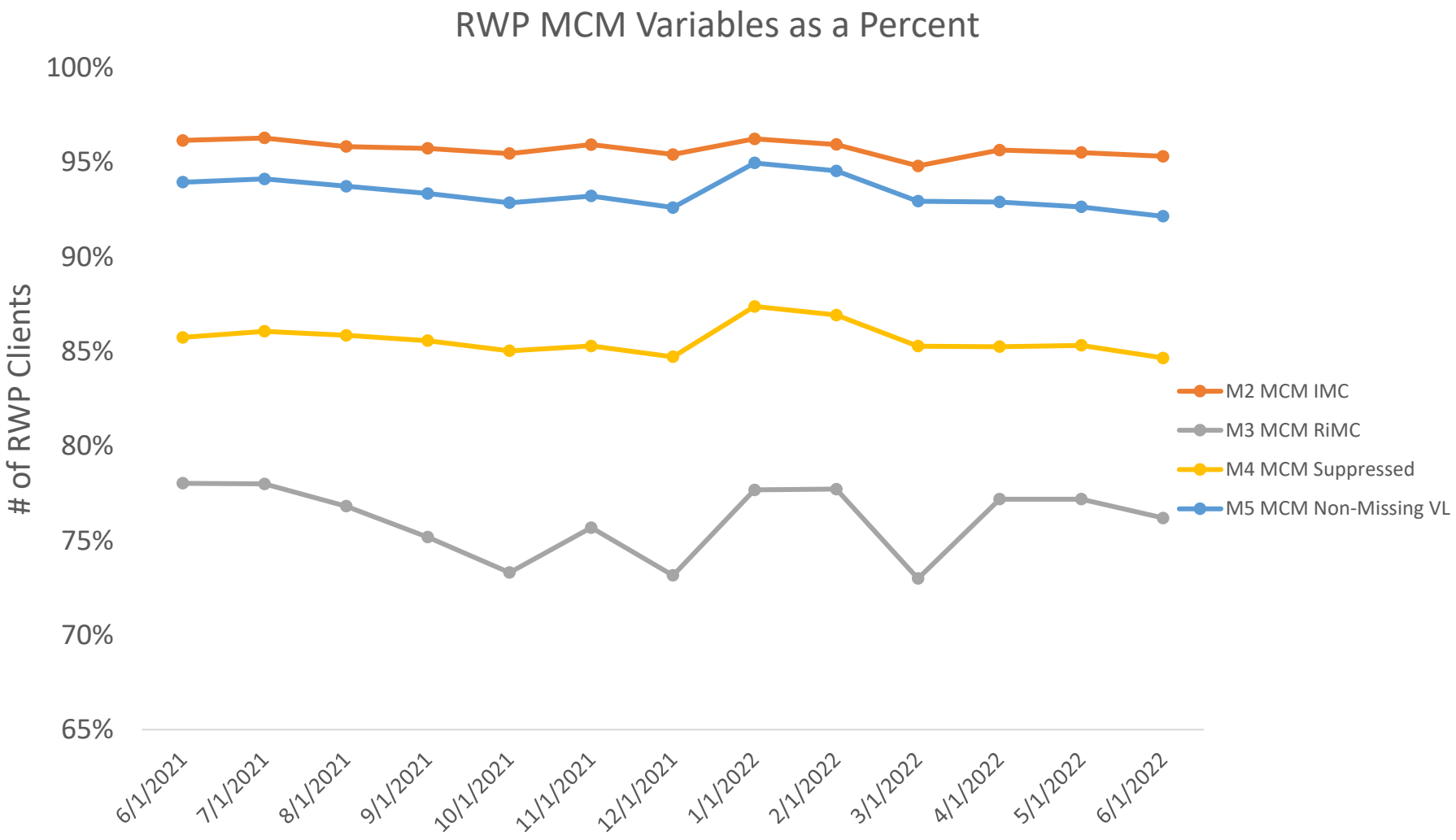
95%
90%
85%
80%
75%
70%
65%
6/1/2021
7/1/2021
8/1/2021
9/1/2021
10/1/2021
11/1/2021
12/1/2021
1/1/2022
2/1/2022
3/1/2022
4/1/2022
5/1/2022
6/1/2022
C2 IMC %
C3 RIMC %
C4 Suppressed %
C5 Non Missing VL%


RWP MCM Variables as a Percent
# of RWP Clients
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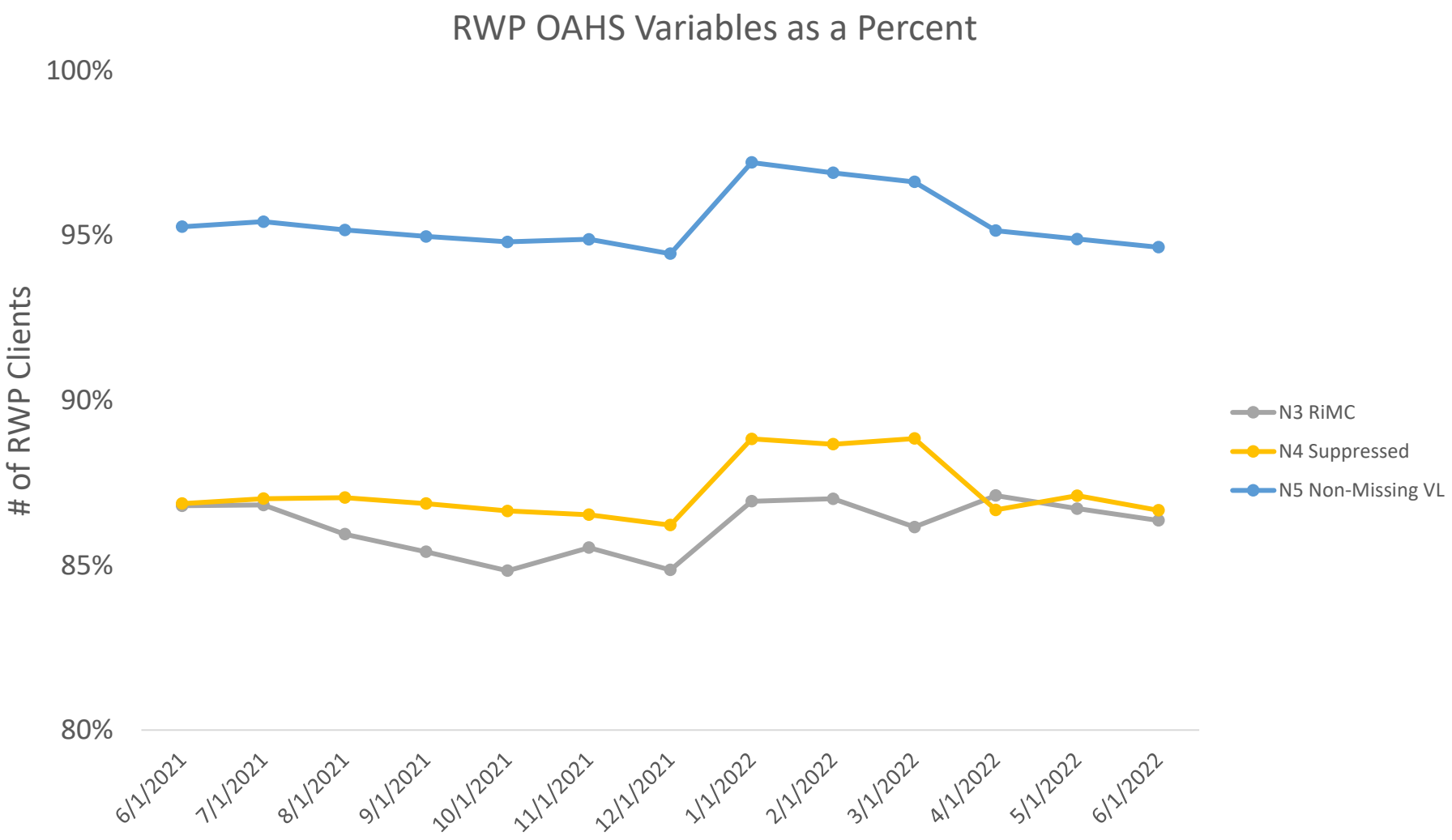
95%
90%
85%
80%
75%
70%
65%
6/1/2021
7/1/2021
8/1/2021
9/1/2021
10/1/2021
11/1/2021
12/1/2021
1/1/2022
2/1/2022
3/1/2022
4/1/2022
5/1/2022
6/1/2022
M2 MCM IMC
M3 MCM RiMC
M4 MCM Suppressed
M5 MCM Non-Missing VL


RWP OAHS Variables as a Percent
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95%
90%
85%
80%
# of RWP Clients
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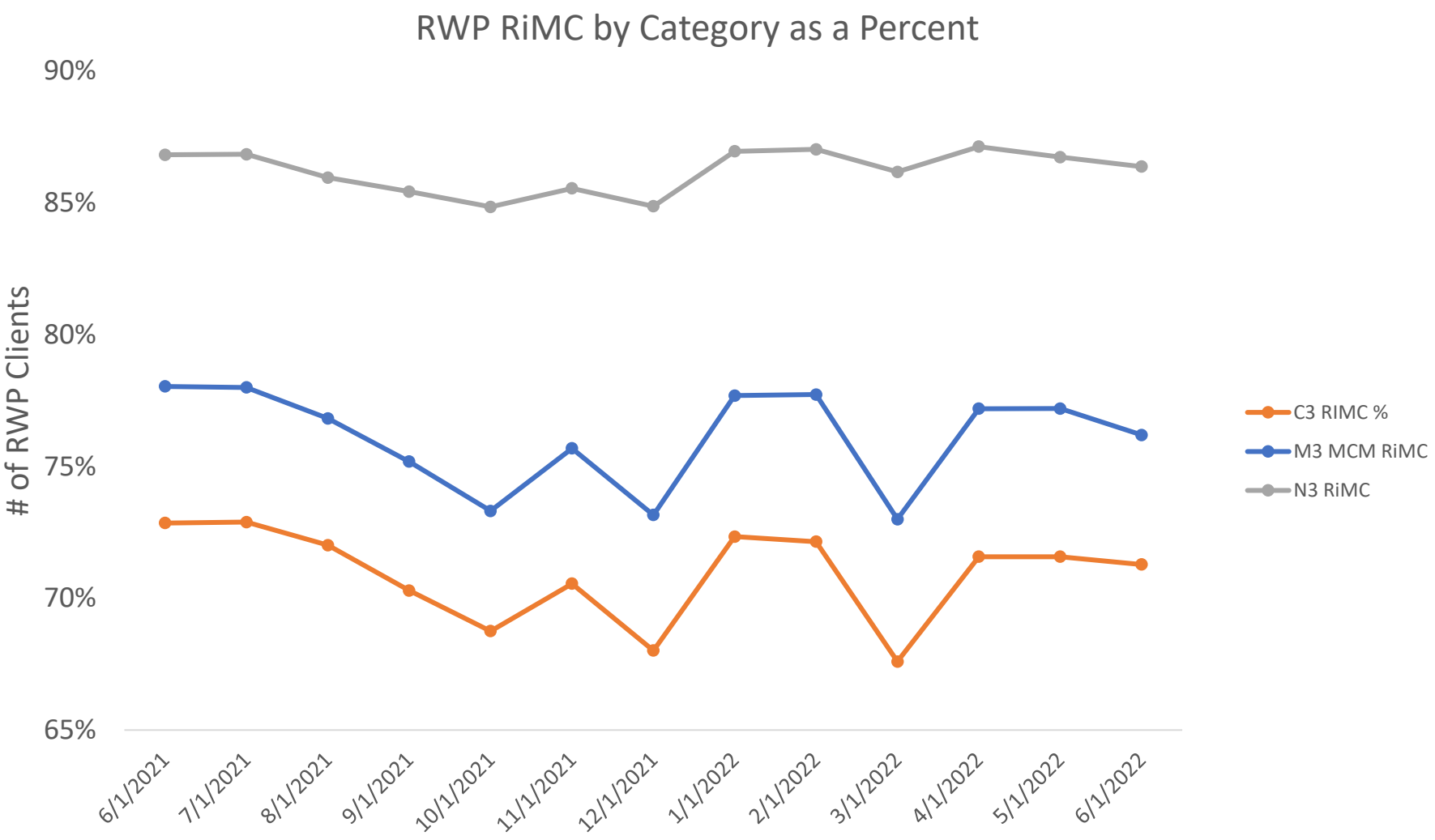
7/1/2021
8/1/2021
9/1/2021
10/1/2021
11/1/2021
12/1/2021
1/1/2022
2/1/2022
3/1/2022
4/1/2022
5/1/2022
6/1/2022
N3 RiMC
N4 Suppressed
N5 Non-Missing VL


RWP RiMC by Category as a Percent
90%
85%
80%
75%
70%
65%
# of RWP Clients
6/1/2021
7/1/2021
8/1/2021
9/1/2021
10/1/2021
11/1/2021
12/1/2021
1/1/2022
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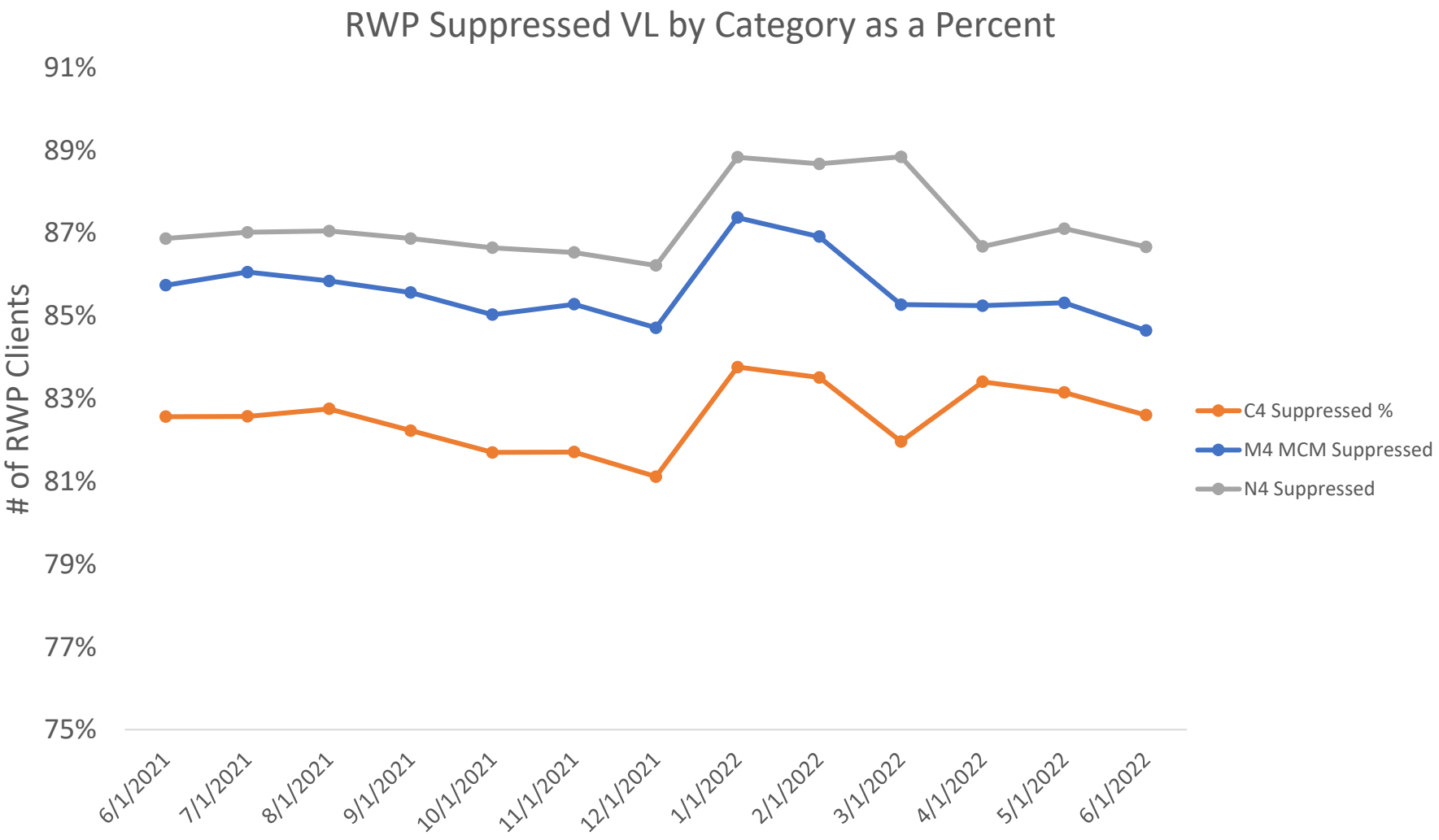
6/1/2022
C3 RIMC %
M3 MCM RiMC
N3 RiMC


RWP Suppressed VL by Category as a Percent
# of RWP Clients
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89%
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83%
81%
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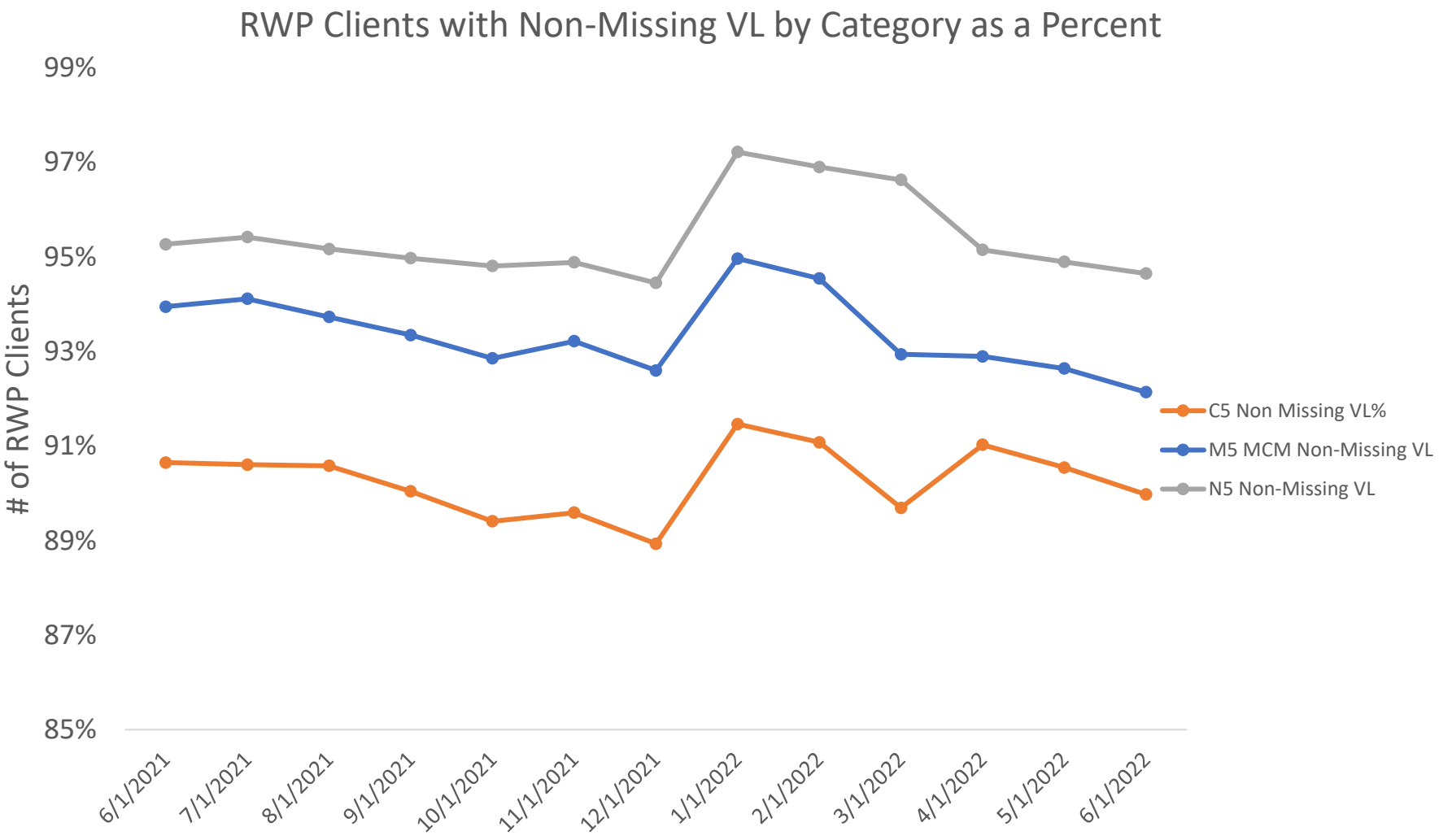
77%
75%
6/1/2021
7/1/2021
8/1/2021
9/1/2021
10/1/2021
11/1/2021
12/1/2021
1/1/2022
2/1/2022
3/1/2022
4/1/2022
5/1/2022
6/1/2022
C4 Suppressed %
M4 MCM Suppressed
N4 Suppressed


RWP Clients with Non-Missing VL by Category as a Percent
# of RWP Clients
99%
97%
95%
93%
91%
89%
87%
85%
6/1/2021
7/1/2021
8/1/2021
9/1/2021
10/1/2021
11/1/2021
12/1/2021
1/1/2022
2/1/2022
3/1/2022
4/1/2022
5/1/2022
6/1/2022
C5 Non Missing VL%
M5 MCM Non-Missing VL
N5 Non-Missing VL

BEST PRACTICES AND PROGRAMS.

ADDRESSING URGENT CHALLENGES TO ENGAGEMENT IN CARE

Addressing barriers and challenges can empower individuals across the HIV care continuum to engage in HIV care frequently and sustainably. These examples of best practices and programs from around the United States are categorized by their approach to helping address barriers to engagement in care. The following pages provide a summary of each program's goals and outcomes.

Actor Portrayals

GILEAD | HIV | STOP THE VIRUS.

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CLICK ON TOPICS OF INTEREST TO READ THE SUMMARIES

HOMELESSNESS

Enhanced Housing Placement Assistance Program
New York City, NY

Provide rapid-rehousing assistance to improve circumstances that assist with adhering to ART

SUBSTANCE USE

Community Health Recovery Program
New Haven, CT

Reduce risk behaviors among people who use substances in treatment, while improving adherence to PrEP medicines

HEALTH LITERACY

Viral Combat
Oxford, MS

Improve PrEP medicines adherence and HIV health literacy through an interactive gaming app targeted for young people

TRANSPORTATION

FL-mAPP
Florida

Address ART adherence by providing remote telehealth services through a mobile health app

IMMIGRATION STATUS

Maintaining Access to HIV Care for Immigrants
San Francisco, CA

Documenting best practices for maintaining access to HIV prevention, care, and treatment in an era of shifting immigration policy and discourse

ART=antiretroviral therapy.
PrEP=pre-exposure prophylaxis.

ENHANCED HOUSING PLACEMENT ASSISTANCE PROGRAM[1]

New York City, NY

GOAL: Place low-income, homeless people living with HIV into rapid housing, plus 12 months of case management.

The Enhanced Housing Placement Assistance Program (EHPA) was a collaboration between the New York City HIV/AIDS Service Administration (HASA) and the NYC Department of Health to enhance the level of housing assistance provided to people living with HIV. EHPA impacted how well participants found housing and their ability to engage in care to maintain viral suppression.

Eligibility criteria included people ages 18 years or older, living with HIV, residing in an HIV emergency shelter (ie, not a visiting acquaintance), and being able to live alone without the assistance of a live-in aide (based on self-report).

CI=confidence interval.
SOC=standard of care.
*Viral suppression=HIV viral load <200 copies/mL.

KEY PROCESSES AND DELIVERABLES

- Case managers played dominant role, performing the following duties for homeless people with HIV in shelters for one year:
  - Identify available and affordable housing as quickly as possible
  - Provide rent and move-in assistance
  - Assist with entitlements advocacy to secure housing subsidies
  - Conduct housing quality standard reviews

OUTCOMES: METRICS

n=119 intervention participants and n=117 SOC

- Program participants received housing faster than nonparticipants (25% by 150 days vs 243 days, respectively; $P = 0.02$)
- Program participants were twice as likely to be placed in homes (adjusted hazards ratio=1.8; 95% CI, 1.1-2.8)
- Program participants were twice as likely to achieve or maintain viral suppression* (adjusted odds ratios, 2.1; 95% CI, 1.1-4.0) ($P < 0.01$)

Reference: 1. Towe VL, Wiewel EW, Zhong Y, Linnemayr S, Johnson R, Rojas J. A randomized controlled trial of a rapid re-housing intervention for homeless persons living with HIV/AIDS: impact on housing and HIV medical outcomes. *AIDS Behav*. 2019;23(9):2315-2325. doi:10.1007/s10461-019-02461-4

COMMUNITY HEALTH RECOVERY PROGRAM[1,2]

New Haven, CT

GOAL: Promote PrEP medication adherence and reduce HIV risk among people who use substances.

The Community Health Recovery (CHR) program was an HIV prevention intervention specifically for people who used opioid substances and were enrolled in a methadone maintenance program. Education, motivation, and skill coaching were provided to participants. Materials were specifically tailored to users who may have cognitive impairment.

The CHR program saw increases in PrEP knowledge as well as engagement in HIV prevention behaviors, including condom use and safe substance-use practices. Importantly, participants significantly reduced their use of substances throughout the duration of the program.

KEY PROCESSES AND DELIVERABLES

- Multimodal presentation of materials
- Mobile health component
- Cognitive remediation strategies
- Curriculum delivered by trained professionals using a motivational enhancement style

OUTCOMES: METRICS

n=40 participants

Significant increases in:

- PrEP knowledge
- HIV prevention behaviors
  - Condom use
  - Safe substance-use practices

Significant reduction in:

- Overall substance use

References: 1. Shrestha R, Altice FL, Sibilio B, Ssenyonjo J, Copenhaver MM. Rationale and design of an integrated bio-behavioral approach to improve adherence to pre-exposure prophylaxis and HIV risk reduction among opioid-dependent people who use drugs: the CHRP-BB study. *Contemp Clin Trials*. 2019;82:77-84. doi: 10.1016/j.cct.2019.06.012 **2.** Shrestha R, Altice FL, Karki P, Copenhaver MM. Integrated bio-behavioral approach to improve adherence to pre-exposure prophylaxis and reduce HIV risk in people who use drugs: a pilot feasibility study. *AIDS Behav*. 2018;22(8):2640-2649. doi:10.1007/s10461-018-2099-0

VIRAL COMBAT[1,2]

Oxford, MS

GOAL: Develop a cutting-edge, engaging, and entertaining app/gaming intervention for improving health literacy among young adults and adherence to PrEP medicines.

Viral Combat is an immersive, action-oriented gaming app to educate young people and improve motivation for adherence to PrEP. The entire game avoided terms like “HIV,” “AIDS,” and other medical verbiage to protect the anonymity of players while playing this game in public. Viral Combat significantly improved adherence to PrEP medicines at 12 weeks and 24 weeks.

KEY PROCESSES AND DELIVERABLES

- Hand-held game focused on improving HIV health literacy skills, including prevention measures like PrEP medicines and condom use
- Avoidance of the terms “HIV,” “AIDS,” “antiretroviral,” and other identifying verbiage to protect the players’ medical status and to avoid possible stigmatization
- Unlimited opportunities to rehearse skills and receive personalized feedback throughout gameplay

OUTCOMES: METRICS

n=69 participants randomized to either intervention or control

- **At 12 weeks:**
  Significantly more likely to be taking PrEP medicines more days per week than those in the control group
- **At 24 weeks:**
  ~4 times more likely to engage in optimal PrEP medicine dosing (ie, 4 or more days/week), compared to those in the control group

References: 1. Whiteley L, Craker L, Haubrick KK, et al. The impact of a mobile gaming intervention to increase adherence to pre-exposure prophylaxis. *AIDS Behav*. 2021;10.1007/s10461-020-03118-3. doi:10.1007/s10461-020-03118-3 **2.** Whiteley L, Olsen E, Mena L, et al. A mobile gaming intervention for persons on pre-exposure prophylaxis: protocol for intervention development and randomized controlled trial. *JMIR Res Protoc*. 2020;9(9):e18640. doi:10.2196/18640

FL-mAPP[1-3]

(FLORIDA mHEALTH ADHERENCE PROJECT FOR PLWH)

Florida

GOAL: Address ART adherence through utilization of an app

The Florida Mobile Health Adherence Project for People Living with HIV (FL-mAPP) was designed to increase ART adherence through utilization of an app. The app provided the following features to improve engagement in care:

- Medication adherence tools and reminders
- Text messaging services for adherence reminders
- Pictures of pills and medicines to assist in understanding complicated regimens
- Prescription refill notifications

The FL-mAPP program significantly increased the percentage of users who achieved greater than 95% ART adherence, compared to those who did not use the app.

PLWH=people living with HIV.

KEY PROCESSES AND DELIVERABLES

- App with self-reported medication-adherence tools and reminders
- Short messaging services for adherence reminders only
- App with pictures of pills and medicines to simplify complicated regimens
- App and SMS providing refill notifications

OUTCOMES: METRICS

n=47 app users and 85 non-app users

- **53% (25 of 47 participants)** continued using the app after the 90-day follow-up period
- At 30-day follow-up, **81% of those who used the mHealth app reported >95% ART adherence,** compared with 59% who did not use the app
- **82% of users** liked or somewhat liked using the platform when evaluated via Likert scale
- **Top-rated features included:** medication reminders, ability to create custom reminders, and adherence reports

References: 1. Morano JP, Clauson K, Zhou Z, et al. Attitudes, beliefs, and willingness toward the use of mHealth tools for medication adherence in the Florida mHealth adherence project for people living with HIV (FL-mAPP): pilot questionnaire study. *JMIR Mhealth Uheal*th. 2019;7(7):e12900. doi:10.2196/12900 **2.** Escobar-Viera C, Zhou Z, Morano JP, et al. The Florida mobile health adherence project for people living with HIV (FL-mAPP): longitudinal assessment of feasibility, acceptability, and clinical outcomes. *JMIR Mhealth Uhealth*. 2020;8(1):e14557. doi:10.2196/14557 **3.** Care4Today. *Care4Today Connect Features*. June 30, 2017. Accessed June 18, 2021. https://care4today.com/index.html

MAINTAINING ACCESS TO HIV CARE FOR IMMIGRANTS[1]

San Francisco, CA

GOAL: Documenting best practices for maintaining access to HIV prevention, care, and treatment in an era of shifting immigration policy and discourse.

To better understand the circumstances that immigrants face, and how those circumstances impact engagement in care, 20 in-depth interviews were conducted with care providers frequently working with this population.

Inclusion criteria were being 18 years or older, being currently on staff at an agency or clinic serving immigrant communities impacted by HIV, and willingness to participate in the interview.

ICE=Immigration and Customs Enforcement.

KEY PROCESSES AND DELIVERABLES

- Framed best practices based on following themes:
  - Changes in the immigration climate following the 2016 presidential election
  - How to meet the needs of clients
  - Maintaining access to prevention and care

SUMMARY FOR BEST PRACTICES

- Hiring bilingual and bicultural staff
- Linking to legal services to assist with immigration status
- Holding trainings around immigrant rights and responses to ICE raids
- Building trust with immigrant patients by assuring them that their status will not be collected or reported
- Strengthening partnerships between legal and medical providers

Reference: 1. Arnold EA, Fuller SM, Martinez O, Lechuga J, Steward WT. Documenting best practices for maintaining access to HIV prevention, care and treatment in an era of shifting immigration policy and discourse. *PLoS One*. 2020;15(2):e0229291. doi:10.1371/journal.pone.0229291

BEST PRACTICES AND PROGRAMS.

ADDRESSING URGENT CHALLENGES TO ENGAGEMENT IN CARE

As we have shown, addressing barriers and challenges can empower individuals across the HIV care continuum to engage in HIV care frequently and sustainably, helping bring us closer to ending the HIV epidemic. We hope you've found these examples of programs and best practices to be informative and inspiring.

For more information, contact your Community Liaison.

GILEAD | HIV | STOP THE VIRUS.

www.helpstoptheviruspro.com

TOOLS AND RESOURCES.

TO KEEP INDIVIDUALS ENGAGED IN HIV CARE

When it comes to engagement in care, understanding best practices can help you mold organizational attitudes and processes towards achieving your goals. While best practices encompass the “what” and the “why,” this Booklet provides you with the “how”—the practical steps you can take to lift barriers to engagement in care. These tools can be applied at both an individual and organizational level to focus on achieving both your high-level and immediate goals.

Actor Portrayals

GILEAD | HIV | STOP THE VIRUS.
www.helpstoptheviruspro.com

CLICK ON TOPICS OF INTEREST TO READ THE SUMMARIES

HOMELESSNESS

Finding Home

Best practices and guide for helping people living with HIV find stable housing

SUBSTANCE USE

AIDS Education and Training Center: Screening, Brief Intervention, and Referral to Treatment (SBIRT)

Approach for motivating patients to commit to altering patterns of substance use to reduce personal harm

HEALTH LITERACY

In It Together Health Literacy Project

Improving health insurance literacy for Black MSM with HIV

TRANSPORTATION

Rideshare Transportation Services

Nonemergency medical transportation for individuals experiencing transportation barriers

IMMIGRATION STATUS

Medical Legal Partnership Guidelines

Guidelines for a successful collaboration between mental health providers and attorneys for improving HIV health for the immigrant population

OTHER

Antiretroviral Treatment and Access to Services (ARTAS)

Model that encourages a client to establish an effective working relationship with a linkage-to-care coordinator

The above tools are to help you practice engagement in care and are not an exhaustive list of all instruments and tools available for providers.

MSM=men who have sex with men.

NAVIGATING THE HOUSING SEARCH FOR HOMELESS INDIVIDUALS WITH HIV—BEFORE AND DURING[1]

MED-HEART, BOSTON UNIVERSITY

STEP 1

Determine your clients' housing readiness and goals

- What does an ideal housing situation look like?
- Is documentation (ID, social security card, or documentation for HIV or homelessness status) in order?
- Have living skills and abilities been assessed? What are the challenges?

STEP 2

Establish roles in the housing search for your clients

- What searching pace would your clients like to proceed with?

STEP 3

Set realistic expectations with your clients

- Have you gone over housing terminology or the entire process of finding a home?

STEP 4

Anticipate challenges and offer solutions

- Have you identified barriers to finding housing, such as history of past evictions, criminal record, or substance use?
- Have you discussed potential solutions, such as finding a lease cosigner or discussing with a landlord how their client is now supported?

Reference: 1. Center for Advancing Health Policy and Practice at Boston University. (2017). Finding Home: Tips and tools for guiding people living with HIV toward stable housing. Retrieved from http://www.cahpp.org/project/medheart/ housing-toolkit

NAVIGATING THE HOUSING SEARCH FOR HOMELESS INDIVIDUALS WITH HIV—BEFORE AND DURING[1]

MED-HEART, BOSTON UNIVERSITY

STEP 5

Stay organized during the housing search

- Are you helping clients keep track of options and the pros and cons of each housing unit explored?

STEP 6

Create a plan for helping your clients manage housing once it is attained

- What skills will your client need to maintain housing and make their living situation more comfortable?
  - Budgets
  - Scheduling rent and utility payments
  - Household chores
  - Nearby furniture stores

STEP 7

Encourage clients to stay healthy while housed

- Have you discussed with clients how they will maintain treatment regimens once they are housed?
- Do clients know where they can get their medications in a new neighborhood?
- Do clients know how to get to their appointments and support group meetings?

Reference: 1. Center for Advancing Health Policy and Practice at Boston University. (2017). Finding Home:
Tips and tools for guiding people living with HIV toward stable housing. Retrieved from http://www.cahpp.org/project/medheart/housing-toolkit

SBIRT: AN EVIDENCE-BASED APPROACH TO MOTIVATE SUBSTANCE USERS TO REDUCE PERSONAL HARM[1]

AIDS EDUCATION AND TRAINING CENTER (AETC), UNIVERSITY OF PITTSBURGH

SCREENING:

Identify unhealthy substance-use patterns and assign level of risk (see checklist)

BRIEF INTERVENTION:

Provide nonjudgmental feedback and education about unhealthy substance use

REFERRAL TO TREATMENT:

Increase patient willingness to accept substance-use treatment and facilitate access

CHECKLIST FOR SCREENING FOR SUBSTANCE USE

- ○ I asked permission to discuss alcohol or drug use and waited for a response
- ○ I elicited aspects of importance and confidence from the person regarding making changes in their life
- ○ I used an evidence-based screening tool that helped me identify the level of risk
- ○ I asked the person to evaluate their own readiness to make changes
- ○ I elicited a connection between alcohol/drug use and medical concerns
- ○ I allowed the person to negotiate a goal and provided advice only after asking permission from the person
- ○ I asked permission and made a specific connection between alcohol/drug use and the medical visit or other health concerns
- ○ I facilitated a referral to assessment and connection to treatment, if the person was willing
- ○ I employed the motivational interviewing spirit with a nonjudgmental approach and open-ended, affirming, reflective, and summarizing skills
- ○ The negotiated goal was specific and realistic, facilitated a plan for follow-up for the person, and stressed accountability

SBIRT=Screening, Brief Intervention, Referral to Treatment.

Reference: 1. MidAtlantic AETC. Screening, Brief Intervention, and Referral to Treatment. 2018. Accessed June 12, 2021. https://aidsetc.org/sites/default/files/resources_files_MMAAETC-SBIRT2018.pdf

IN IT TOGETHER: NATIONAL HEALTH LITERACY PROJECT [1]

RYAN WHITE HIV/AIDS PROGRAM, TARGETHIV

PROGRAM OVERVIEW

- **8-module** train-the-trainer series
- **100 trainers selected** from 34 communities
- **500+ health professionals trained**
- Materials developed for health professionals and clients:
  - Posters
  - Pamphlets
  - FAQ for providers and individuals
  - Videos

SUMMARY OF BEST PRACTICES

- Provide **one-on-one enrollment assistance for clients,** especially those who haven't had health insurance before
- Train a staff person as **enrollment assister**
- **Coordinate with other agencies** and venues that serve hard-to-reach individuals to engage them in enrollment discussions
- **Assess your workflow to routinely screen clients** for eligibility and plan renewals at the best times
- **Train staff to provide others with information** to help them use their coverage and manage costs

Reference: 1. TargetHIV. Health Literacy and Health Insurance Literacy: Helping Consumers Access Care and Use Coverage. July 21, 2016. Accessed June 2, 2021. https://targethiv.org/sites/default/files/supporting-files/ACE_HealthLiteracyWebinarSlides_508_0.pdf

8 ACTIONS TO HELP SUPPORT PEOPLE WITH HIV TO ENROLL IN HEALTH COVERAGE[1]

DEFINED BY THE ACCESS, CARE, AND ENGAGEMENT TECHNICAL ASSISTANCE (ACE TA) CENTER OF THE RYAN WHITE PROGRAM

Ryan White HIV/AIDS Program, TargetHIV

1. **Know that the Ryan White Program supports access to care for all consumers**
   - Uninsured, underinsured, or insured
   - Low-income individuals
   - Living with HIV or at risk for HIV

2. **Contact your state's Ryan White Program to learn how to obtain financial help for coverage**
   - Use locator.hiv.gov website to find a Ryan White provider

3. **Understand why continuous HIV coverage is essential**
   - Taking HIV treatment every day and getting to and staying undetectable for 6 months or more prevents transmitting HIV through sex. This is known as "Undetectable= Untransmittable," or "U=U"

4. **Explain insurance terms and benefits**
   - Use plain language and real-world examples
   - Ask consumers to state what they know and what they do not know in their own terms

5. **Help consumers find plans that cover their HIV drugs**

6. **Support continuity of care**
   - Ensure that consumers see same provider regularly and maintain consistent medication supply
   - Find a plan that includes a provider with whom consumers have developed a trusting relationship
   - Address barriers to care if having to switch providers

7. **Listen to consumer's needs and concerns**
   - Ensure that staff understands consumer's needs and life experiences, as well as additional health conditions and concerns

8. **Show compassion and cultural sensitivity**
   - Ensure a judgment-free zone that protects people's confidentialities and respects their cultural boundaries

Reference: 1. TargetHIV. Health Literacy and Health Insurance Literacy: Helping Consumers Access Care and Use Coverage. July 21, 2016. Accessed June 2, 2021. https://targethiv.org/sites/default/files/supporting-files/ACE_HealthLiteracyWebinarSlides_508_0.pdf

RIDESHARE TRANSPORTATION SERVICES FOR THOSE IN NEED[1]

MEDICAID

SUMMARY OF TIMELINES

RIDESHARE PRACTICE

Two business days before appointment

- **Appointment reminder from health system**
  - Robo-call
- **Study procedure**
  - Phone call from study staff[a]
  - Consent
- **Rideshare service[b]**
  - Ride scheduled by study staff
  - Text message 1: *"Ride has been scheduled"*

- Provided by some state Medicaid programs
- Web-based application designed by Lyft to preschedule appointment rides
- Requests for transportation initiated by staff member and not individual who needs appointment

Day of appointment

- **Rideshare service[b]**
  - Text message 2: *"Driver is en route"*
  - Text message 3: *"Driver is outside home"*
- **Travel to clinic (rideshare and usual mode)**

- **Rideshare service[b]**
  - Patient called study staff to schedule ride home
  - Text messages 1-3 (see above)
- **Travel home (rideshare and usual mode)**

[a]Up to three attempts.
[b]Among those who consented and utilized the service.

Reference: 1. Chaiyachati KH, Hubbard RA, Yeager A, et al. Rideshare-based medical transportation for Medicaid patients and primary care show rates: a difference-in-difference analysis of a pilot program. *J Gen Intern Med*. 2018;33(6):863-868. doi:10.1007/s11606-018-4306-0

MEDICAL-LEGAL PARTNERSHIPS[1]

CENTER FOR AIDS RESEARCH, NATIONAL INSTITUTES OF HEALTH

GUIDELINES FOR HEALTHCARE SERVICES THAT INTEGRATE CIVIL LEGAL ASSISTANCE

Use LGBTQ+-friendly staff representing:
- Community-based organizations
- Mental health providers
- Attorneys

Offset legal costs for clients through:
- Hosting a legal fellow
- Partnering with a law immigration clinic
- Fundraising

Educate clients on legal rights:
- One-year filing deadline for asylum
- Know-your-rights presentations to alleviate deportation fears and reporting abuse

Evaluations of legal services should include measures of service quality as well as other characteristics (eg, duration of case, inclusion of mental health provider) as mediators of program effects

Immigration relief, leaving abusive relationships, and attaining better work, housing, and health care

Reference: 1. Yamanis TJ, Zea MC, Ramé Montiel AK, et al. Immigration legal services as a structural HIV intervention for Latinx sexual and gender minorities. *J Immigr Minor Health*. 2019;21(6):1365-1372. doi:10.1007/s10903-018-0838-y

ANTIRETROVIRAL TREATMENT AND ACCESS TO SERVICES (ARTAS)[1]

CENTERS FOR DISEASE CONTROL AND PREVENTION

A Case Management Model That Encourages a Relationship Between Linkage Coordinator and Client

CORE ELEMENTS FOR LINKAGE COORDINATORS TO KEEP IN MIND

Focus on a client's strengths:

- Conduct a strengths-based assessment
- Encourage each client to identify and use strengths, abilities, and skills to link to medical care and accomplish other goals

Facilitate a client's ability to:

- Identify and pursue their own goals
- Develop a step-by-step plan to accomplish those goals

Maintain a client-driven approach by:

- Conducting one to five structured sessions with each client
- Conducting active, community-based case management
- Coordinating and linking each client to available community resources
- Advocating on a client's behalf

Reference: 1. Centers for Disease Control and Prevention. ARTAS. April 6, 2021. Accessed June 14, 2021. https://www.cdc.gov/hiv/effective-interventions/treat/artas?Sort=Title%3A%3Aasc&Intervention%20Name=ARTAS

ANTIRETROVIRAL TREATMENT AND ACCESS TO SERVICES (ARTAS)[1]

CENTERS FOR DISEASE CONTROL AND PREVENTION

A Case Management Model That Encourages a Relationship Between Linkage Coordinator and Client

Agency Readiness Checklist: Assessing ARTAS Readiness

CASE MANAGEMENT READINESS

- Does your agency provide case management services? **(Y/N)**
- Do you have staff with experience providing case management? **(Y/N)**
- Do you have staff with experience in strengths-based service delivery? **(Y/N)**
- Do you have the resources to obtain additional case management and strengths-based delivery training and education for staff? **(Y/N)**

HIV/AIDS READINESS

- Does your agency provide services to people living with HIV? **(Y/N)**
- Does your staff have knowledge of and experience providing services to people with HIV? **(Y/N)**
- Have you identified additional training and educational resources to increase staff capacity and knowledge of providing services to people living with HIV? **(Y/N)**
- Do you have the resources to obtain additional HIV/AIDS training and education for staff? **(Y/N)**

COMMUNITY READINESS

- Do you have relationships with community partners, such as HIV medical testing sites, medical providers, case management, or other supportive services? **(Y/N)**
- Do you have clear, specific ARTAS-related roles for community partners within the community's system of care? **(Y/N)**
- Do you have formal contracts and/or established referral protocols with existing community partners? **(Y/N)**
- Have you identified resources in the community to secure transportation subsidies or incentives for clients? **(Y/N)**
- Do you have staff or a consultant who can create marketing materials to promote ARTAS to community partners? **(Y/N)**

Reference: 1. Centers for Disease Control and Prevention. ARTAS. April 6, 2021. Accessed June 14, 2021. https://www.cdc.gov/hiv/effective-interventions/treat/artas?Sort=Title%3A%3Aasc&Intervention%20Name=ARTAS

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AGENCY READINESS

- Do you have funding for ARTAS? **(Y/N)**
- Do you have support from your board of directors and key agency staff for this intervention? **(Y/N)**
- Do all agency staff have an understanding of the importance and content of the ARTAS mission?
- Do you have staff who can implement ARTAS? **(Y/N)**
  - Program Director/Manager
  - LC Supervisor
  - Evaluator
  - LC(s)
  - Contracts Manager (if necessary)
- Have your staff participated in ARTAS training? **(Y/N)**
- Have you identified additional training needs? **(Y/N)**
- Have you identified existing policies that need to be revised to support ARTAS? **(Y/N)**
- Do you have office space for ARTAS staff? **(Y/N)**
- Do you have supplies and equipment to implement ARTAS (cell phones, pagers for LCs)? **(Y/N)**
- Do you have the capacity to develop a monitoring and evaluation plan? **(Y/N)**
- Do you have the technological capacity to collect and analyze data? **(Y/N)**
- Are staff proficient in the software necessary for these activities? **(Y/N)**

LC=Linkage Coordinator.

Reference: 1. Centers for Disease Control and Prevention. ARTAS. April 6, 2021. Accessed June 14, 2021. https://www.cdc.gov/hiv/effective-interventions/treat/artas?Sort=Title%3A%3Aasc&Intervention%20Name=ARTAS

TOOLS AND RESOURCES.

TO KEEP INDIVIDUALS ENGAGED IN HIV CARE

We hope that this Tool Guide is helpful in initiating and maintaining efforts to engage individuals in care regardless of their HIV status. Utilizing these tools and sharing them with your colleagues can improve engagement in care and bring us one step closer to helping end the HIV epidemic.

For further information, please reach out to your Community Liaison.

GILEAD | HIV | STOP THE VIRUS.

www.helpstoptheviruspro.com

ALIGNING ON THE MEANING OF ENGAGEMENT IN CARE.[1,2]

Engagement in care is a holistic concept. It consists of ongoing, productive interaction with individuals at every stage of the HIV care continuum. The goal of engagement in care is to maximize outcomes and individual experiences at all stages: from linkage to adherence support to retention, as shown.

Engagement in care requires a commitment to pursue quality care and therapeutic alliances so that the needs and concerns of every individual are met. By following this framework, you can empower individuals to better engage in care and do our part in helping to end the HIV epidemic.

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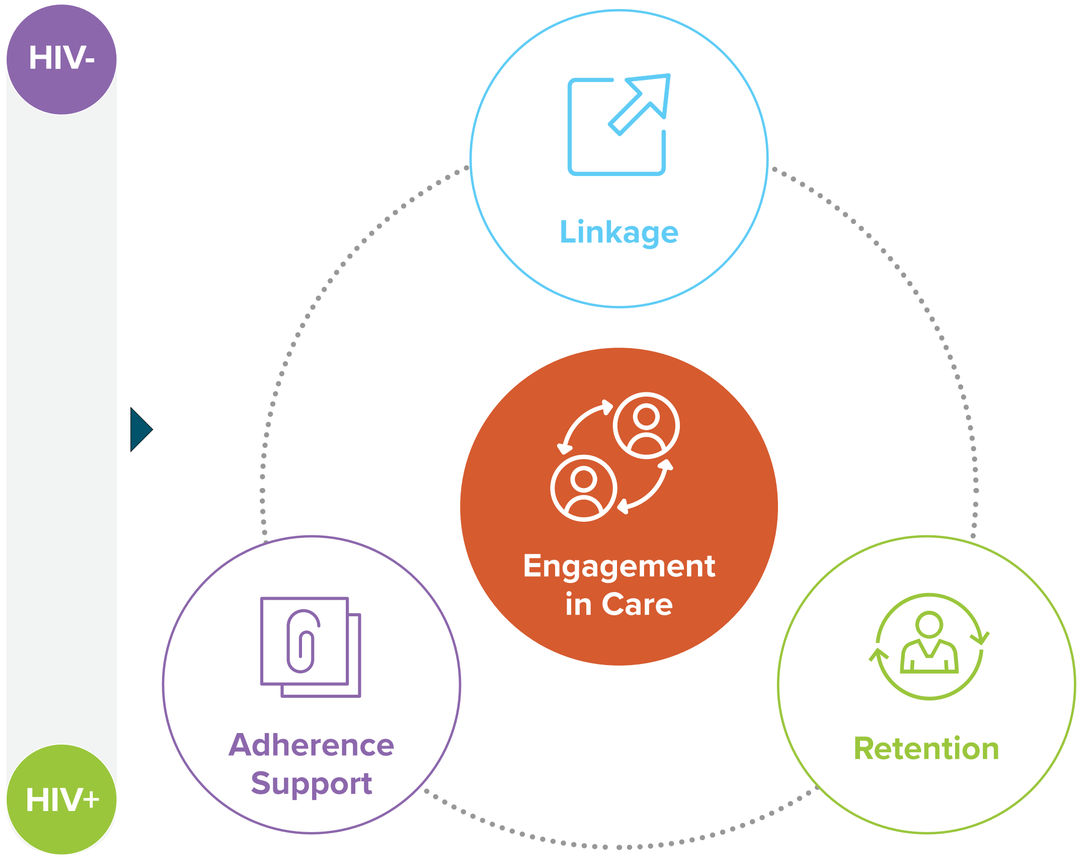
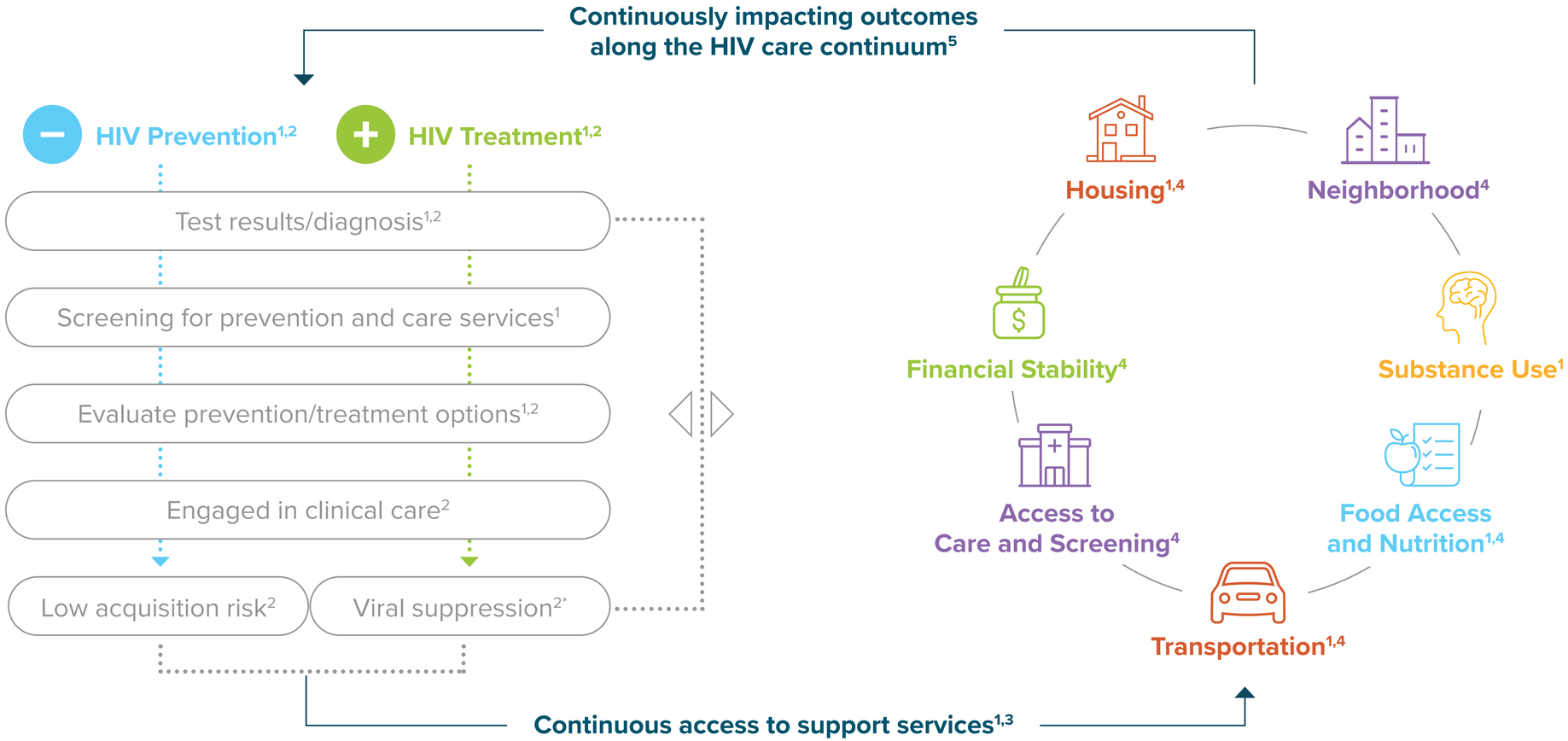


References: 1. Koester KA, Johnson MO, Wood T, et al. The influence of the 'good' patient ideal on engagement in HIV care. *PLoS One*. 2019;14(3):e0214636. doi:10.1371/journal.pone.0214636 **2.** AVAC Report 2016: Big Data, Real People. 2016. Accessed July 13, 2021. https://www.avac.org/sites/default/files/resource-files/bigData_RealPeople_AVACReport2016.pdf

SOCIAL DETERMINANTS OF HEALTH IMPACT ENGAGEMENT IN ALL STAGES OF HIV CARE



*Viral suppression=HIV viral load <200 copies/mL.

References: 1. Achieving Together: A Plan to End the HIV Epidemic in Texas. A Status-Neutral Approach: Achieving Together to End the HIV Epidemic. June 18, 2020. Accessed April 25, 2021. https://achievingtogethertx.org/wp-content/uploads/2020/11/Status-Neutral-White-Paper_06182020.pdf **2.** Myers JE, Braunstein SL, Xia Q, et al. Redefining prevention and care: a status-neutral approach to HIV. *Open Forum Infect Dis*. 2018;5(6):ofy097. doi:10.1093/ofid/ofy097 **3.** Committee on Review Data Systems for Monitoring HIV Care; Institute of Medicine; Ford MA, Spicer CM, eds. Monitoring HIV Care in the United States: Indicators and Data Systems. Washington (DC): National Academies Press (US); March 15, 2012. 2, Indicators Related to Continuous HIV Care and Access to Supportive Services. Available from: https://www.ncbi.nlm.nih.gov/books/NBK201376/ **4.** Healthy People 2030, US Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Accessed May 3, 2021. https://health.gov/healthypeople/objectives-and-data/social-determinants-health **5.** Abgrall S, Del Amo J. Effect of sociodemographic factors on survival of people living with HIV. *Curr Opin HIV AIDS*. 2016;11(5):501-506. doi:10.1097/COH.0000000000000301

FOR FURTHER INFORMATION ABOUT IMPLEMENTING ENGAGEMENT IN CARE, REACH OUT TO YOUR COMMUNITY LIAISON.