NACCHO-CAEAR COALITION
Ryan White Part A Community of Practice (COP)

Report on Status Neutral
February 2023

The joint CDC/HRSA-HAB Status-Neutral letter dated January 17, 2023, "encourage[d] public health partners to implement status neutral approaches to HIV care and prevention. Status neutral service provision is an example of a syndemic approach to public health, weaving together resources from across infectious disease areas and incorporating social determinants of health to deliver whole-person care, regardless of a person's HIV status."

The Communities Advocating Emergency AIDS Relief (CAEAR) Coalition and the National Association of County and City Health Officials (NACCHO) strongly support the implementation of status neutral approaches and appreciate the framework outlined in the letter.

Ryan White Part A Community of Practice (COP)

The CAEAR Coalition and NACCHO established a Ryan White Part A Community of Practice (COP) in 2021 to address concerns of siloed federal HIV/AIDS programs and funding streams, lack of flexibility within programs, and the need for Ryan White Part As and local health department HIV programs to come together for facilitated discussions.

Through the COP's bi-monthly calls, Part A jurisdictions and city and county health departments have a space to share best practices, discuss program and policy strategies, and determine current barriers to implementing effective HIV interventions.

Status neutral is a topic of great interest for the Ryan White Part A Community of Practice (COP) and was the focus of its first call in 2023. To prepare, all Ryan White Part A jurisdictions were sent a survey in early January followed by an in-depth discussion held on February 9. Survey results and discussion are highlighted below. Intel from this report will inform the work of the Ryan White Part A COP moving forward.

EXECUTIVE SUMMARY

Survey Highlights

- Forty percent of Ryan White Part A jurisdictions completed the survey.
- Sixty-seven percent of respondents did not currently have sufficient flexibility in other funding streams to implement status-neutral services independent of Ryan White funding.
- Top five funding streams paired with Ryan White Part A services to implement a status-neutral approach:

1. EHE HAB care funding
2. EHE CDC prevention funding
3. CDC prevention funding
4. Local HIV prevention
5. State HIV prevention

- Top five structural barriers to implementing status neutral:

1. Funding restrictions due to HRSA-HAB eligibility requirement of HIV+ diagnosis
2. Funding restrictions due to HRSA-HAB grant administrative cap
3. Siloed programs
4. Staff training
5. Need for federal guidance

Challenges to Implementation

- The HIV care and prevention systems were designed to be separate. They have different funding sources, clients, data systems and reporting requirements, fiscal years, program parameters, and policies. These different parameters – especially the fractured funding systems and the Ryan White legislative mandate of payer-of-last-resort for HIV-positive clients and the 10% administrative cap – make braiding funding and delivering status-neutral services difficult.
- Every Ryan White Part A jurisdiction is different; not all have EHE funding or direct CDC prevention funding. As a result, there are unique challenges for each jurisdiction in braiding funding and implementing status-neutral programming.
- Federal agencies may be encouraging the adoption of status-neutral approaches, but project officers have been less than supportive. Many project officers are not well informed on status neutral, resulting in confusion and mixed messaging at the jurisdictional level.

Solutions to Consider

- A new funding source is needed to provide and support the flexibility required to implement status-neutral approaches.
- Better integrate the Bureau of Primary Care and FQHCs. Primary care is the access point for many potential clients. FQHCs seem best-suited to implement status-neutral approaches because many receive Ryan White Part A, B, C, and D funding as well as CDC prevention funding.
- Provide concrete examples of how the CDC and HRSA-HAB are working collaboratively to advance status neutral, along with specific guidance and clarity on how to implement status-neutral approaches.
- Develop technical assistance and training to support the implementation of status neutral. Suggestions include:

» Highlight jurisdictions that have successfully implemented status-neutral programs. Emphasize program details and best practices.
» Gather lessons learned from jurisdictions responding to significant HIV outbreaks. It would be valuable to understand how the care and prevention sides worked collaboratively to address these public health emergencies. In addition, there are important general lessons from other outbreaks and the response of the chronic disease system. How did the community and providers work together to address client needs?
» Establish a similar program to the *Integrated HIV/AIDS Planning* (*IHAP*) *TA Center* (*TAC*) to help design and implement technical assistance for status neutral.

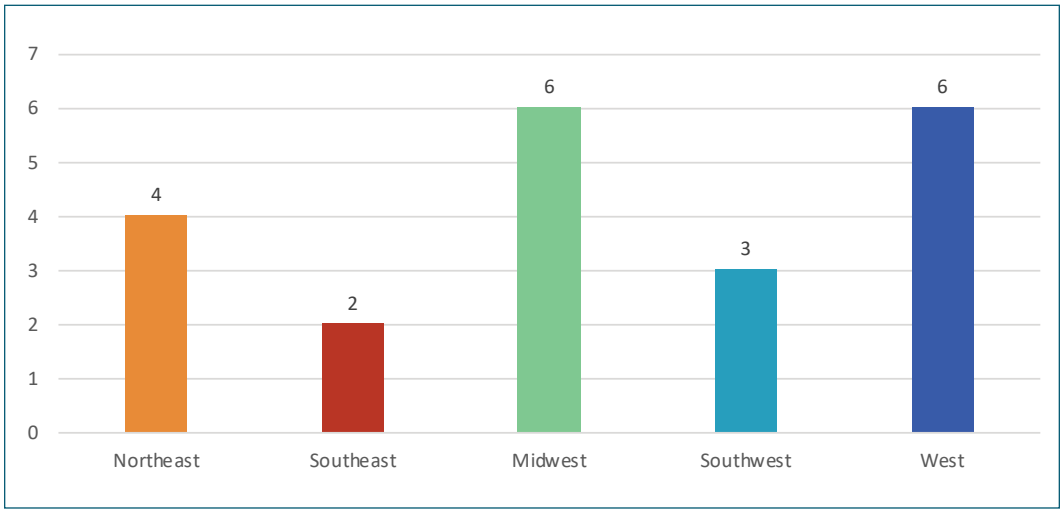
- Establish communication mechanisms between CDC and HRSA and ensure project officers are well-informed, working together, and supportive of jurisdictions as they work to implement status-neutral approaches.

SURVEY RESULTS

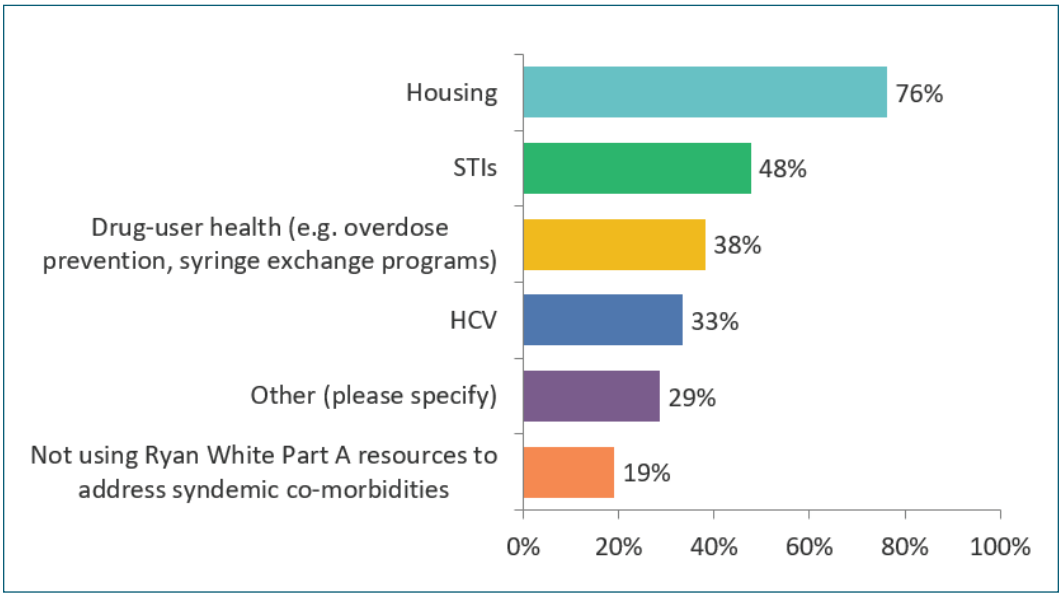
Respondents and Regional Representation

Twenty-one Ryan White Part A jurisdictions participated in the Status Neutral survey. This is 40% of all jurisdictions and included:

Alameda County
Austin
Chicago
Cleveland
Columbus
Hartford
Indianapolis
Jacksonville
Los Angeles
Maricopa County (Phoenix)
Miami-Dade County
Minneapolis-St. Paul
New Haven
New York
Philadelphia
Portland
San Bernardino/Riverside
San Francisco
San Jose
St. Louis City and Counties
Tarrant County (Ft. Worth)



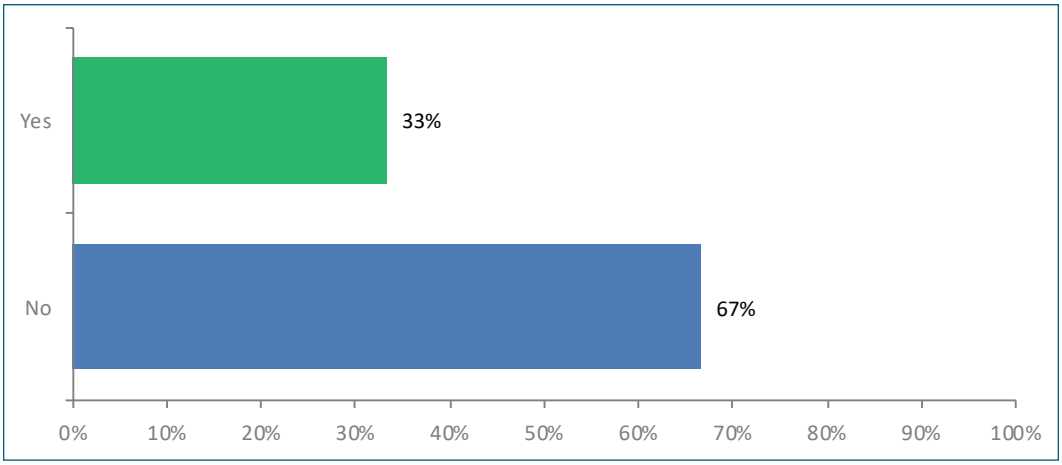
Q1: Are you using Ryan White Part A resources to address syndemic comorbidities, such as STIs, HCV, and drug-user health for people with HIV?



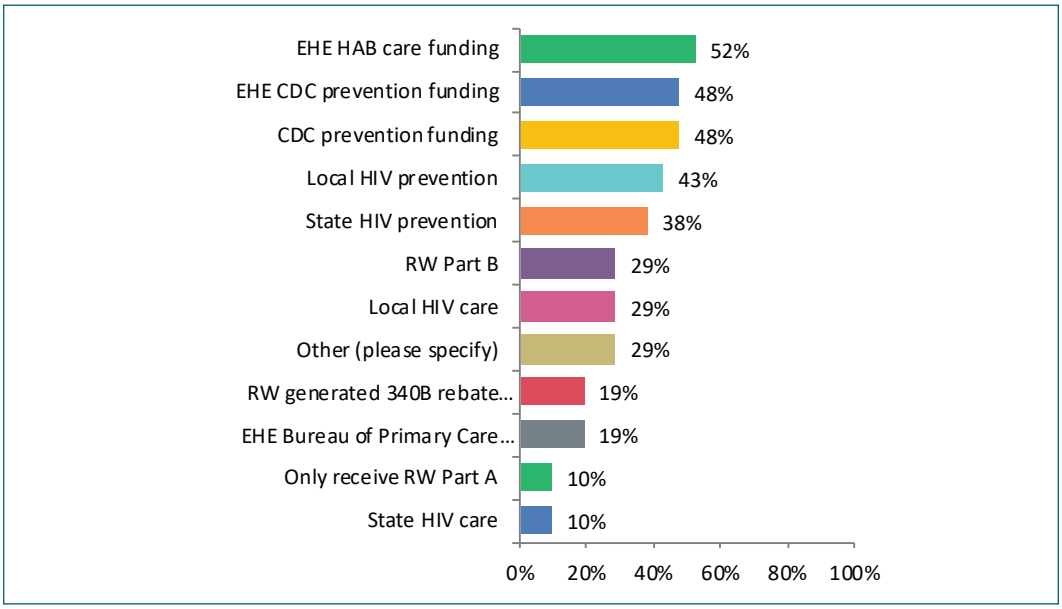
"Other" included:

- The state health department leads most of the syndemic approaches.
- While STI and HCV are noted above, I wanted to clarify that our Part A funds are used to provide outpatient medical care and support services to diagnose and treat these co-morbidities. As we are payer-of-last-resort, the medication therapies are supported by our partners under Part B, ADAP, and sometimes state general revenue funding.
- Mental health, SUD.
- Mental health, HIV testing for special populations.
- HCV testing, but not treatment.
- TB, HBV.

Q2: Do you currently have sufficient flexibility in other funding streams to implement status-neutral services independent of Ryan White funding?



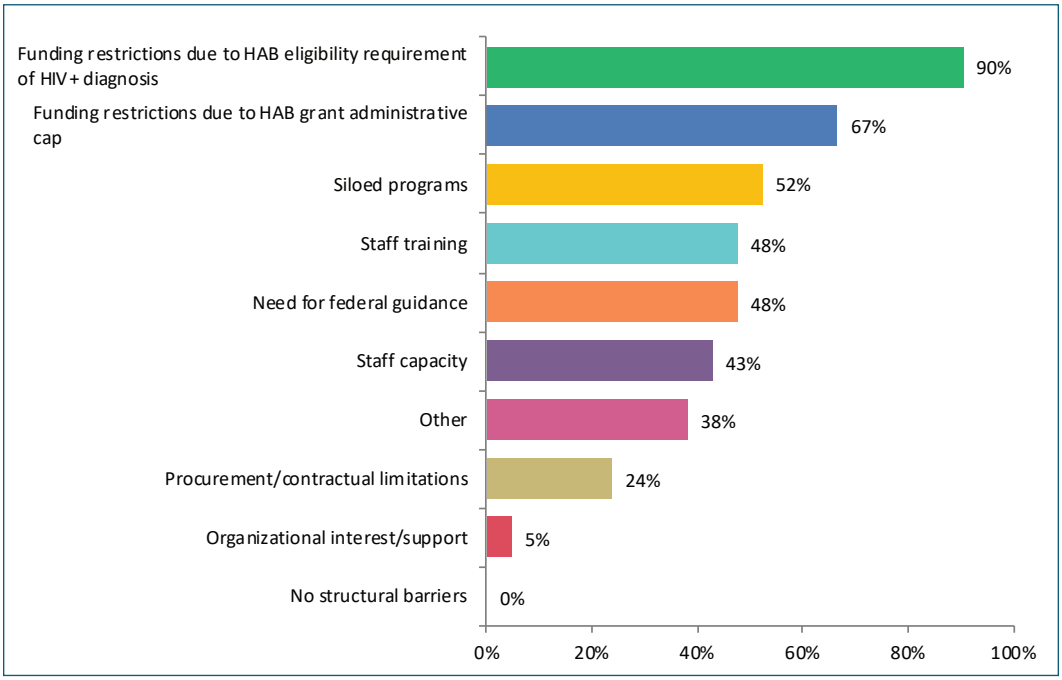
Q3: What other funding streams do you receive that can be paired or linked with Ryan White Part A services to implement a status-neutral approach?



"Other" included:

- We have a strong collaborative partnership with our local Part B partners for prevention, care, and EHE support. Some of our Part A subrecipients also receive CDC funding.
- HRSA EHE 078 funding
- HOPWA (3)
- AIDS United
- CDC STI prevention funding

Q4: What are the structural barriers to implementing a status-neutral approach in your jurisdiction?



"Other" included:

- It seems every time we implement a new process, HRSA and CDC move the goal post and ask us to implement yet another new idea or approach. However, the funding restrictions remain the same. Great ideas in theory, but if the federal-funding sources continue to tie our hands with outdated legislative restrictions, recipients and subrecipients are forced to become contortionists, i.e., constantly bending, changing, adapting, and developing new processes to weave/braid services together in a true one-stop, supportive fashion. This would hopefully be handled by staff behind the scenes, so all the client sees is a quality, one-stop, no-wrong-door process to better health outcomes. Again, wonderful in theory, but the burden and challenges staff face to implement these processes need to be considered.
- Most syringe exchange programs primarily rely on general funds or private grants as supplies are not allowed under federal grants.
- The way in which Ryan White Part A requires services to be siloed into categories perpetuates siloed programming. It complicates reporting and budgeting, forcing agencies to "enroll" clients or "assign" staff to one service versus being able to provide more holistic treatment. Prevention funds are local and focus on HIV; syphilis, and gonorrhea and have restricted outreach/testing to these diseases. If we want to incorporate MPOX or COVID testing and vaccines, we use other funding. This has been a barrier to working with homeless camps and wanting to provide "public health" outreach.

- Privacy, data collection systems, private grants.
- The problematic siloed programs are at the federal level. Our programs are fully integrated.
- EHE project officer required removing status-neutral activities from EHE workplan.
- State (Ohio) procurement and legislative requirements in receiving EHE jurisdictional funding from the CDC. Need direct access to federal funding to eliminate significant barriers.
- Limited funds for HCV and STI testing, along with HIV testing to provide *whole* person care.
- We have "flexibility" in non-Ryan White funding sources, we just do not have enough non-Ryan White money to support robust services for persons vulnerable to HIV (HIV-negative).

Q5: If you have tried to implement a status-neutral approach in your jurisdiction, please briefly described what has worked and what has not been successful.

Summary

- Not implemented (4)
- Not implemented but working towards it (5)
- Implemented at some clinics (2)
- Fully implementing (2)

Examples of what has and has not worked:

- "Tried to implement but was cited by HRSA-HAB as a finding for doing so. HAB is the biggest barrier, not providers."
- "[State health department] has not consistently engaged us in coordinating funding streams to effectively develop a robust status-neutral approach to HIV in our state and Part A jurisdiction."
- "Creating a case management approach for high-risk negatives with EHE funds to prevention-funded agencies. [They] are not trained to handle flow when there are caseloads to now consider. Likely to try status-neutral case management approach through HIV care case-management with agency used to Ryan White funding."
- "[10% admin cap in Ryan White] made it difficult on the care side to support the necessary subrecipient administrative services for implementing and maintaining status-neutral services. It is helpful to have EHE care and prevention services on the same funding cycle that aligns with RWPA."

Q6. What federal support or resources do you need to successfully implement a status-neutral approach in your jurisdiction?

- Toolkit of best practices, implementation strategies, and training opportunities/ resources for staff.
- Technical assistance; guidance on use of EHE funding.
- Flexibility in PCN 16-02 (ex. for Health Education/Risk Reduction to high-risk individuals)
- Continued guidance on the limitations of each funding silo, and ways around the legislative restrictions to develop a robust status-neutral protocol.
- HRSA funding flexibility for at-risk individuals. (Several respondents stated this and noted strong opposition by PWH community.)
- Reduced administrative/reporting burden.
- Increase linkage to care allowances for RW clients.
- Expand EHE funding beyond Phase 1.
- Funding to incorporate STI/VHep testing into HIV prevention.
- More non-RW/non-HOPWA funding to support services for people vulnerable to HIV.
- Breaking down silos and easing restrictions.
- Direct funding to all 57 jurisdictions by the CDC and for CDC and HRSA to compromise in reporting requirements. Currently, HRSA does not want anything reported that is not related to their funding AND they will not support the [EHE] pillars of Diagnose and Prevent. If we have to keep the reporting separate, it is impossible to integrate.

Q7. What are the key issues or concerns as you consider operationalizing a status-neutral approach in your jurisdiction?

- Siloed funds
- Eligibility limitations
- Buy-in from frontline staff, subrecipient leadership
- Training and TA needs; lack of guidance
- Funding availability and staff capacity
- Administrative difficulty in braiding funding
- Privacy/data collection systems
- Reporting and audit requirements

- Same-day medications
- Lack of clarity on allowable use of funding
- Lack of coordination between CDC and HRSA
- Status-neutral seems limited to EIS services or offering PrEP resources to partners of case management clients.

Q8. Have you received a core medical service expenditure waiver in the last year?

10 = Yes
11 = No

Q9. For Ryan White Part A jurisdictions receiving EHE funding, has that funding helped in any way to facilitate implementation of status neutral? If yes, please describe.

- Fifteen of 21 respondents answered this question.
- 5 = indicated EHE funding **helped** facilitate the implementation of status neutral.
- 10 = indicated EHE funding had **not helped** facilitate the implementation of status neutral.

EHE funding uses for Status Neutral

- Community whole-person education to wider audience.
- "Newly Diagnosed University" for PLWH's networks.
- Low-barrier HIV clinic at SSP with status-neutral direct referral.
- Part A EHE limited to PLWH; need to use Part B EHE.
- Mindset for change to novel strategies.

Q10. Please describe how your jurisdiction incorporated a status-neutral approach formally in their integrated plan?

Summary of Responses

- Syndemic plans/language.
- Routine testing; partner services.
- Provider training for status-neutral goals, strategies, and activities.
- Status neutral included as core strategy.
- Not clearly articulated/minimal inclusion.
- Integrating HIV services in other non-HIV organizations
- Multiple respondents stated that status neutral is included in spirit and structure but not explicitly. Example: focusing on social determinants of health and syndemics, rather than an HIV continuum.

Comments

- "Our integrated plan (IP) includes improved training of providers on the status-neutral care model, patient-centered care, trauma-informed care, as well as cultural humility and competency. The IP includes goals, strategies, and activities to incorporate a status-neutral approach at the point of HIV testing, followed by appropriate linkages to PrEP, partner, and other prevention services or same-day linkages to HIV care and treatment services, depending on the HIV test results. Many Part A subrecipients have multiple services and funding sources to be able to provide appropriate care at a one-stop center, unless client choice prefers care at multiple locations."
- "We used our locally created EHE strategic plan that incorporates all four pillars, combined with any affinity groups' recommendations (created for the integrated plan) that were not addressed in the EHE strategic plan.
- "Integrated planning bodies make implementing a status-neutral approach easier. The trick is to break the silos created by separate grant-funding parameters that have long been the norm."

RYAN WHITE PART A COMMUNITY OF PRACTICE

Discussion on Status Neutral from February 9 Call

The Ryan White Part A COP call began with a brief review of the January 19, 2023, *HAB You Heard* webinar that focused on the release of the joint CDC/HRSA letter to encourage the implementation of status-neutral approaches to HIV care and prevention. The Status-Neutral Framework letter (dated January 17, 2023) described the benefits of status neutral, provided very general examples of braided funding, and outlined a status-neutral approach within the framework of HRSA and CDC goals and restrictions related to HIV funding.

Jurisdictions Participating on the Ryan White Part A COP Call February 9, 2023

Austin, TX - TGA
Columbus, OH - TGA
Ft. Worth, TX - TGA
Hartford, CT - TGA
Jacksonville, FL - TGA
Indianapolis, IN - TGA
Minneapolis-St. Paul, MN - TGA
New Haven, CT - EMA
New York, NY - EMA
Oakland/Alameda, CA - TGA
Philadelphia, PA - EMA
Portland, OR - TGA
Riverside/San Bernardino, CA - TGA
St. Louis, MO - TGA
San Francisco, CA - EMA
San Jose, CA - TGA

The letter and the presentation stressed that Ryan White funds are to be used only for the care and treatment of people living with HIV. In addition, CDC and HRSA encouraged the use of braided funding to reduce barriers and to extend the reach of status-neutral services. They also noted that it was important for grant recipients to identify other funding sources to achieve more robust status-neutral approaches.

In the Zoom chat, attendees expressed frustration in the lack of integration at the federal level.

The Ryan White Part A COP began their discussion, addressing the difficulties of implementing a status-neutral approach when different federal agencies are so siloed in financial, programmatic, and grant-reporting requirements.

- Specific guidance, clarity, and collaboration are needed from CDC and HRSA-HAB to implement status neutral approaches.
- Every Ryan White Part A jurisdiction is different; not all have EHE funding or direct CDC prevention funding. As a result, there will be different challenges in braiding funding and implementing status-neutral programming.
- There is a stark difference in the care and the prevention sides because care is legislatively mandated. As a result, there are rules on how to allocate funds. The prevention side is different. The CDC's priorities can change with new administrations.
- The care and prevention sides have different resources that can be a challenge when trying to braid funding. Housing is a good example. The care side allows funds and resources to stabilize people who are HIV positive and are experiencing homelessness. This care funding can get clients into stable or long-term housing based on their HIV positive status, the prevention side cannot.
- It is difficult to coalesce and match priorities between the care and prevention sides because of the siloed programming and no clear communication mechanisms between the various systems. As a result, jurisdictions are copying seven project officers on one email about one intervention. More integration is needed to improve communication and funding resources.
- Care and prevention are not equal players because of the Ryan White Program's 10% administrative cap.
- More flexible funding criteria are required to embrace a status-neutral approach and to scale it up.
- A broader new funding source is needed to provide and support the flexibility required to implement a status-neutral approach.
- CDC and HRSA support status-neutral approaches, but jurisdictions do not have the funding or instruments to implement it.
- Due to the current political environment, the community does not plan to reauthorize the Ryan White CARE Act, fearing a reduction in funding. The legislation specifies that to qualify for services, clients have a documented HIV-positive diagnosis. Different or additional funding streams need be identified to provide status-neutral approaches in traditionally care-funded programs.
- CDC HIV prevention, in contrast to HRSA-HAB funding legislation, allows for all behavioral risk populations, regardless of HIV status. It is more feasible to implement status-neutral services, including in traditionally HIV-positive care settings, with CDC funding.

- San Francisco focused on braided funding for new EHE programs. The approach was proportional funding, which is to say, if half the patients were positive, half the funding came from Ryan White. With the absence of guidance, this approach helped San Francisco stay in compliance. San Francisco focused its status-neutral approaches on the programmatic level, not provider level. In doing so, an outreach worker could work with everyone.
- With HRSA-HAB eligibility restricted to serving clients with documented HIV, it is difficult to initiate and then stabilize braided-funding streams to support status-neutral programs, particularly determining prospectively the percentage of HIV-positive versus HIV-negative clients in order to assign the correct amount of FTE to each funding source for each employee. To the extent that the client population is variable in terms of the HIV positivity rate over time, this would create a significant challenge and potentially multiple-contract revisions between funding sources to maintain compliance with Ryan White eligibility requirements. For example, a few years ago, New York City used city money to create a status-neutral care coordination program that was integrated with Part A-funded care coordination programs. There were challenges with braided funding at the program level. It was evident that additional technical assistance and guidance were needed to integrate fully because of the different contracts and the inability to "split" funded staff. San Francisco has also experienced this challenge, particularly with attempting to use EHE disruptive interventions to implement status-neutral funding with combined EHE CDC and HRSA funding.
- For agencies that historically have served HIV-positive patients only, a requirement to serve HIV-negative patients may result in a resource-intensive, unfunded-mandate to advertise, identify, outreach, and incorporate to expand services for HIV-negative patients. In New York City, an historically HIV-positive services organization that pivoted to provide status-neutral services was highly challenged to identify a sufficient number of clients to access PEP and PrEP and other types of status-neutral services because they only had HIV-positive clients and did not have the referral source to identify HIV-negative clients.
- Philadelphia has had some EHE programming that straddles CDC-EHE and HRSA-EHE funding sources. The challenge is that these two federal funding sources do not have the same fiscal year, resulting in confusion among CDC and HRSA providers. (It was noted that aligning fiscal years would add to the reporting burden, so no easy answer to this issue.)
- Riverside-San Bernardino noted that in the January 17, 2023 CDC-HRSA Status Neutral Framework letter, HRSA said it was okay to support status neutral as long as a jurisdiction braids its funding. The challenge is some HRSA project officers have been telling jurisdictions not to even mention status neutral in their EHE plans because of the potential perception that Ryan White services are being used for people not living with HIV.

- San Francisco understands status neutral as more than braided funding. It can be the constellation and expansion of services, which is not necessarily funding. This could or could not be related to EHE or other funding. The goal is several one-stop shops that provide all the needed services for both people who are HIV positive and HIV negative. These one-stop sites are tied to syndemics, so a lot of work on STDs and drug user health.
- As jurisdictions discuss a status-neutral approach, it is important to remember the Ryan White CARE Act was developed when people did not want to serve people living with HIV. People with HIV fought long and hard so that local health jurisdictions would use the money to serve only HIV+ clients. In this current political environment, a reauthorization of Ryan White re-opens this discussion and might potentially result in less funding. It is unfortunate that 30 years later, the need to find more flexibility cannot be easily implemented without taking great risk. Several jurisdictions agreed this was an important point, but the last reauthorization was 14 years ago in 2009.
- Marion County reported it had just talked about status neutral with its clinical sites earlier that week and the issues identified in the NACCHO-CAEAR Status Neutral survey were the same ones noted from their clinical sites. Currently, Marion County is trying to help facilitate relationships between clinical sites and other agencies to help provide those status-neutral comprehensive services, but this approach seems clunky. There needs to be a better way. This is still in the idea phase, but Marion County will update the COP when more is known.

What should the Ryan White Part A Community of Practice prioritize?

- Jurisdictions need to gather more information from sub-recipients to better understand what is needed to implement a status-neutral approach at the local level. Specific jurisdictional intel on the care and prevention landscapes is required so that the braiding of funds and services can address the realities on the ground. It is important to know on a local level what services jurisdictions are providing currently on the status-neutral continuum, who is providing it, and where the gaps exist. In gathering this data, jurisdictions can better understand the status-neutral landscape and what is needed.
- In the west region, status-neutral approaches have been organizationally driven for quite some time. There are several reasons for this, including economic survival, diversification of funding, patients going from negative to positive, and many positive and negative patients with the same comorbidities. There has long been a drive towards status-neutral systems, particularly the desire to create one-stop sites. The EHE funding provided the opportunity to look at that approach in a focused way. As more information is gathered, it would be helpful to understand at what point EHE and other mechanisms allowed jurisdictions to take status neutral to the next level. In San Francisco, there has been an integration of funding and services, but this approach was not driven by EHE. It existed before and was based on the needs of the patients and organizational choices on how to maintain funding and to offer constellation of services.

- Requiring employees to know and navigate all the different care and prevention resources and systems is a significant ask. These resources and systems are very different and training and/or hiring frontline workers that have both sets of specialized skillsets and knowledge is challenging.
- Philadelphia worries staff will need to become generalists to implement status-neutral approaches and there is a risk in losing the expertise and depth of knowledge regarding the specific care and prevention funding sources and services. Those who know the care system – what is in it, where things are, and how to navigate it – are different people from those who know the prevention side. How do jurisdictions balance the referrals for the care system versus prevention system. In the case of implementing programming to address drug user health, there are often differences in philosophies and cultural approaches and those differences are strengths that might get lost with a focus on status neutral.
- Medical case managers, navigators, and outreach workers are where status-neutral approaches hit the road. If jurisdictions are going to require a level of expertise on multiple systems for these workers, then a concerted effort is needed to advocate to pay them decent living wages to ensure they are compensated appropriately and remain with the health department. In addition, need to encourage jurisdictions to create career ladders, since many of these workers are disproportionally younger people and people of color. It is important to make these positions attractive and with obvious professional growth opportunities.
- New Haven noted that FQHCs are the entities best suited to implement status-neutral approaches because many of them receive Ryan White Part B, C, and D funding as well as CDC prevention funding. As a result, FQHCs are well positioned to braid funding and services. It is important to engage FQHCs to encourage them to become the one-stop shops for status-neutral systems.
- Chicago implemented a significant status-neutral HIV services portfolio in 2019. The first phase was developing and implementing the program. The second phase is determining if it worked. It took Chicago two and a half years to figure out how to do it, but that does not mean that the effort was effective and successful.
- An in-depth discussion on the steps jurisdictions have taken to implement a status-neutral approach would be helpful. What worked? What did not? What was missed? What adjustments have been made at various points in time? What were the specific internal structural changes that jurisdictions made to accommodate and support status-neutral programming? For example, Chicago asked its funded agencies and community partners, "What does a status-neutral approach look like for the services the jurisdiction provides? What does it look like for partner services programming, for STI clinics, for surveillance programming, and marketing and communications? What does it mean to integrate a status-neutral approach for the planning council, which requires 33% of members to be individuals with HIV who do not work for Ryan White, but receive Ryan White services?

- Implementing status-neutral programming is complicated and more brainstorming is needed. Jurisdictions need to try, fail, succeed, and try some more and be willing to share those lessons learned and best practices. We also need to urge HRSA-HAB to gather and share status-neutral lessons learned and best practices.
- Jurisdictions need to build systems and resources where people can find information in an intuitive way. It is important to note that knowledge of the current systems resides in individuals. The need to be able to easily navigate these two systems must be a priority to successfully create a status-neutral world.
- Jurisdictions that have been responding to significant HIV outbreaks have been forced to figure out how to bring care and prevention together. It would be valuable to learn from their efforts to address outbreaks and how the care and prevention sides worked collaboratively. In addition, there are important general lessons from other outbreaks and the response of the chronic disease system. How did the systems leverage the community and providers to work together to address client needs?
- Need to recognize the need to engage health department leadership. To implement a status-neutral approach, a Ryan White Program is required to ask for changes in staffing allocations, the way grants are managed, and the development of RFPs. Such requests often go above the level of a Ryan White Part A Program Director because such decisions impact the entire health department. Need to recognize that asking for changes to implement status neutral impacts the health department's priorities. How to message status neutral so that health department leadership sees its role in the larger context of this endemic framework is a critical next step.
- New Haven agreed and noted the need to create the expectation that a status-neutral approach is a key component of our work. Rapid ART still receives provider resistance but building it into an expectation via a care standard helped. Need to do the same for status neutral.
- HRSA-HAB leadership may be encouraging the adoption of status-neutral approaches but encounters with project officers have been less than supportive. (One jurisdiction was cited in a site visit report for trying to implement status-neutral programming.) Many project officers are not well informed on status neutral.
- If jurisdictions are leveraging and braiding resources, then these status-neutral efforts need to be acknowledged and supported. Jurisdictions should not be derided for this type of programming or told it is not in line with the Ryan White legislation. Jurisdictions know that Ryan White funding can only be used for care and support services for PWH.

- Status neutral is not owned or governed by HRSA or CDC. It should be owned and governed by the people who are receiving and delivering the services. Several years ago, when Chicago started building its status-neutral approach, it focused on community partners. It took several years and strong engagement of individuals with HIV, individuals on PrEP, priority populations, clinical providers, and case managers to create status-neutral services that addressed the specific needs of the community. Federal funders need to understand that status neutral is not theirs; it belongs to the people delivering and receiving these services.

Communities Advocating Emergency AIDS Relief (CAEAR) Coalition

The CAEAR Coalition's vision is the end of new HIV infections and full, healthy lives for all people with HIV. Its mission is to advocate for robust federal funding and community-based responses to end the HIV epidemic. The CAEAR Coalition is a national membership organization rooted in the Ryan White HIV/AIDS Program. We work to end the HIV epidemic by ensuring equitable access to welcoming, high-quality health care and support services. The CAEAR Coalition advocates for and collaborates with federal partners, impacted communities, administrators, and people with HIV to maximize the allocation and use of federal funding to address local jurisdictional needs.

National Association of County and City Health Officials (NACCHO)

NACCHO's mission is to improve the health of communities by strengthening and advocating for local health departments. It is the only organization dedicated to serving every local health department in the nation. NACCHO serves 3,000 local health departments and is the leader in providing cutting-edge, skill-building, professional resources and programs, seeking health equity, and supporting effective local public health practice and systems.