I. Final FY 2021 Part A Narrative

c. The Atlanta EMA Part A Program implemented strategies to align with the **National Goals to End the HIV Epidemic** to:

- Reduce new infections through partnerships and community planning,
- Reduce HIV-related health disparities through participation in learning collaboratives, and
- Achieve integrated, coordinated efforts that address the HIV epidemic among all partners and stakeholders.

HIV care continuum outcomes were reviewed by the Fulton County Department for HIV Elimination's (DHE) Quality Management (QM) Team and data were shared with stakeholders quarterly.

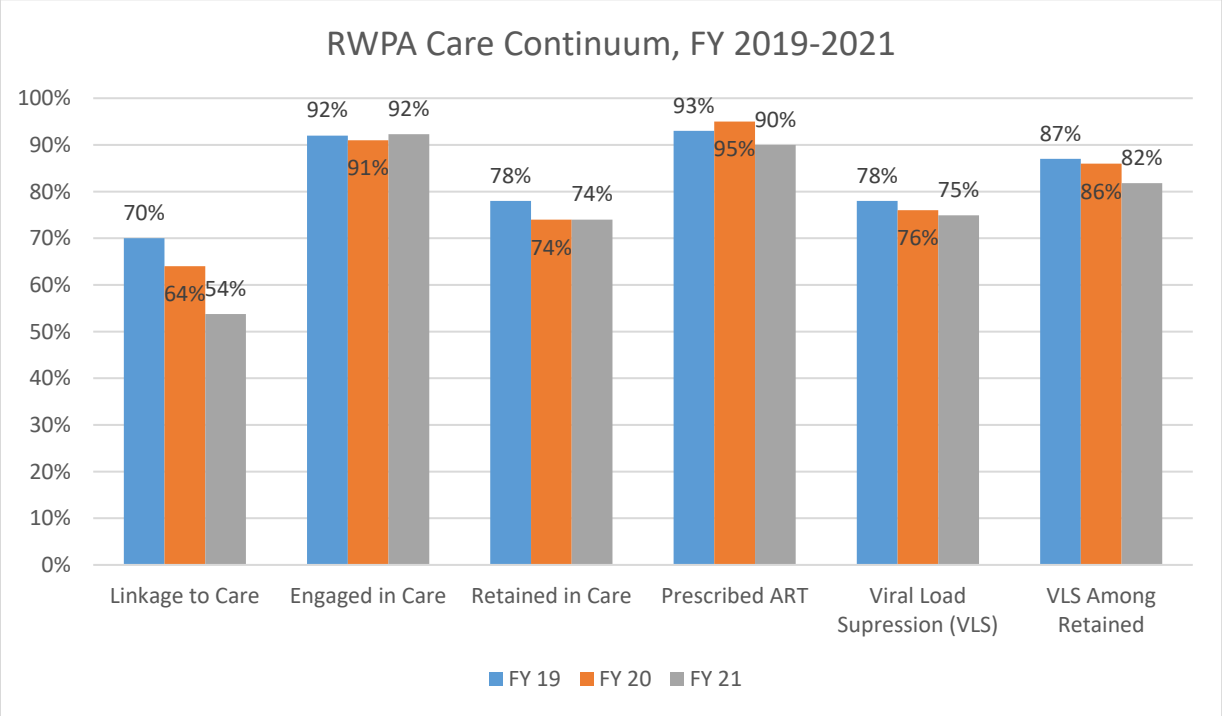


Figure 1: RWPA Care Continuum, FY 2019-2021

During the reporting period, notable data include a 10% reduction in Linkage to Care, presumably related to challenges created by the COVID Pandemic. Engagement in Care rose to 92% with a 1% increase from 2020, and Retention in Care has remained steady at 74% with a 4% reduction from 2019 (78%). Prescription of Antiretroviral Therapy (ART) decreased from 95% in 2020 to 90% in 2021, and Viral Load Suppression (VLS) decreased from 76% in 2020 to 75% in 2021 with VLS Among Retained decreasing from 86% in 2020 to 82% in FY 2021. Thus, the Atlanta EMA is above the HIV care continuum national average[1] for retention in care (50%), viral suppression (57%), and engagement in care (66%). It is important to note that the program is implementing a new client-level database and is still addressing anomalies in the data – until the quality review is completed it is not clear whether these reductions were due to data issues (improperly mapped, missing data, etc.) or actual reductions in certain stages of the continuum.

[1] U.S. Department of Health & Human Services. 2021. *HIV Care Continuum.* June 21. https://www.hiv.gov/federal-response/policies-issues/hiv-aids-care-continuum#:~:text=What%20Is%20the%20HIV%20Care,of%20HIV%20in%20the%20body

DHE experienced notable **program accomplishments** and unanticipated **program challenges** implementing Part A Program services that impacted the HIV care continuum outcomes for people living with HIV in the Atlanta EMA in FY 2021.

Program Accomplishment and Challenge: Part A and Minority AIDS Initiative (MAI) Clients HIV Care Continuum Outcomes

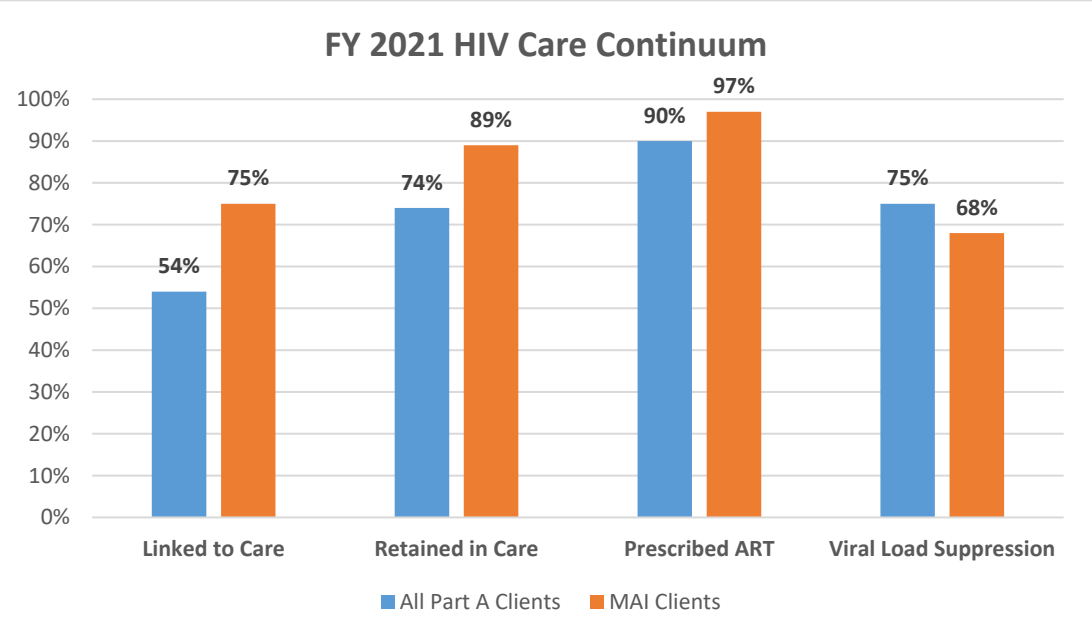


Figure 2: FY 2021 HIV Care Continuum, Part A and MAI Clients

In FY 2021, there was a total of 16,266 Part A clients and 298 MAI clients. When reviewing the HIV Care Continuum, it is noted that the MAI clients were linked to care, retained in care, and prescribed ART at higher percentages compared to Part A clients (see Figure 2) due to concerted efforts to provide extensive follow-up and support. However, Part A clients were more frequently virally suppressed. There was a high percentage of clients in FY 2021 prescribed ART with Part A having 90% of clients and MAI having 97% of clients prescribed ART. The lowest percentages were within those linked to care for Part A clients at 54% and viral load suppression for MAI clients at 68%.

Prevent new HIV Infections

Program Challenge: Decreased Outpatient Ambulatory Health Services (OAHS) Service Utilization
For FY 2021, $8,166,901.98 was allocated for OAHS services to fund 12 primary care sites. Compared to FY 2020 funding of $10,636,358.07 for OAHS (11 sites). Despite this increase in funding, there was a 23% decrease in FY 2021 for OAHS most likely attributed to the effects of the COVID pandemic. One contributing factor was staff vacancies and turn-over at the agency level, including medical providers and administrative staff. As illustrated in the table below, utilization of OAHS services decreased by 2% compared to FY 2020.

Table 1: RWPA Service Utilization of OAHS by Clients and Visits, FY 2019 to FY 2021

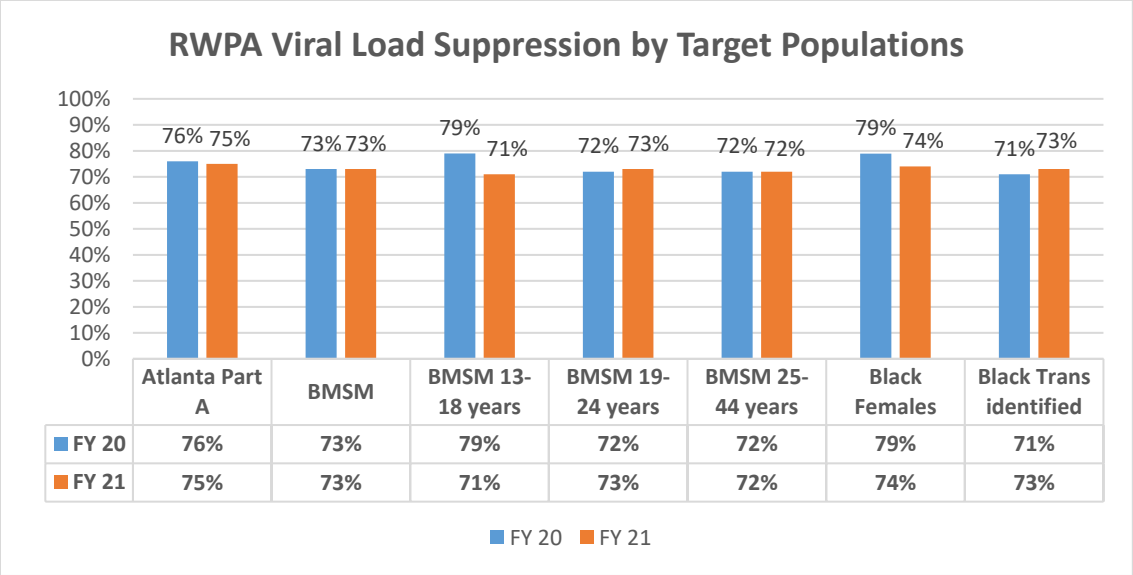
Service Utilization of OAHS by Clients and Visits		
Fiscal Year	**Number of Clients**	**Number of Visits/Units**
FY 2019	15,893	141,231
FY 2020	15,158	153,650
FY 2021	14,853	113,350

Program Accomplishment: Despite COVID-19 and vacant positions, subrecipients were able to continue OAHS service delivery during the reporting period. DHE remained focused on the mission of preventing new HIV infections and improving HIV-related health outcomes of people with HIV by increasing clients' access to care while reducing their exposure to COVID-19. Methodologies used to improve HIV care continuum outcomes (linkage, retention, ART adherence) and service utilization during the pandemic for Part A clients included:

- implementing telehealth services
- providing clients with access to telehealth platforms via video-ready tablets
- administering personal protective equipment
- issuing at-home COVID-19 tests
- providing client incentives
- increased the availability of early morning, evening, and weekend hours by service providers

Improve HIV-related health outcomes of people with HIV

Program Accomplishment: Increased Viral Suppression in Target Populations
From FY 2020, RWPA made improvements in most target populations with several remaining stagnant.



	Atlanta Part A	BMSM	BMSM 13-18 years	BMSM 19-24 years	BMSM 25-44 years	Black Females	Black Trans identified
FY 20	76%	73%	79%	72%	72%	79%	71%
FY 21	75%	73%	71%	73%	72%	74%	73%

Figure 3: Viral Load Suppression by Target Populations, RWPA

In FY 2021, DHE saw improvements in viral load suppression among Black Men who Sex with Men (BMSM) 19-24 from 72% in 2020 to 73% in 2021 and Black Trans Identified individuals from 71% in 2020 to 73% in 2021. Black MSM overall and Black MSM ages 25-44 stayed stagnant at 73% and 72% respectively. The agencies target Black MSM and individuals with trans experience through their quality improvement projects in the two Learning Collaboratives described in the next section.

Reduce HIV-related disparities and health inequities

Program Accomplishment: Innovative Program Model Replication through Learning Collaboratives
Nine subrecipients engaged in University of California San Francisco (UCSF) Learning Collaborative. UCSF's Center for AIDS Prevention Studies was funded by HRSA for a SPNS project: Capacity building in the Ryan White HIV/AIDS Program (RWHAP) to Support Innovative Program Model Replication. The purpose of the project is to build the capacity of RWHAP Recipients and Subrecipients to replicate effective models of care in four RWHAP jurisdictions disproportionately affected by HIV. The EMA began a partnership with UCSF in a learning collaborative to implement multifaceted approaches to reduce HIV-related disparities in health outcomes. The goal of the UCSF Collaborative is to close gaps across the HIV Care Continuum to ultimately improve quality of and retention in care for Black MSM and People of Trans Experience living with HIV in Atlanta. The UCSF collaborative utilizes evidence-informed intervention models including "In It Together" (health literacy intervention), Peer Re-Engagement, TransLife Care, Collaborative Care Model, and Retention through Enhanced Contacts. They also facilitate a Peer Affinity group, which creates a shared space for four agencies with Peers and/or Community Health Workers to share best-practices, hear from experts across the country, and work collectively for the Atlanta jurisdiction. As a part of the affinity group, THRIVE SS conducted a virtual, three-day peer re-engagement training with six peers from multiple agencies, and they plan to hold future sessions open to peers from all agencies in FY 2022. In another example of how UCSF has fostered inter-agency collaboration to expand resources, the two agencies conducting the TransLife Care intervention have cross-agency referrals to Positive Impact Health Center (PIHC)'s new gender affirming program.

Four agencies participated in the RWHAP Center for Quality Improvement & Innovation (CQII) *create+equity* learning collaborative. The goal of the collaborative is "to promote the application of quality improvement interventions to measurably increase viral suppression rates for people with HIV experiencing the impact of social determinants of health related to housing instabilities, substance use, mental health, and age across Ryan White HIV/AIDS Program-funded recipients and subrecipients." The EMA agencies currently participate in two affinity groups: substance abuse and mental health. Their interventions include Trauma Informed Approaches, Optimal Linkage and Referral, and the Use of Peer Navigators.

Agencies have given positive feedback from participating in the learning collaboratives. Providers cite cross-agency partnerships and referrals as well as the quality improvement tools and best practices shared during the learning collaboratives as key benefits of participation. Agencies implemented their chosen interventions using Plan Do Study Act (PDSA) cycles during the action periods and report back during learning sessions. The interventions and PDSA cycles are unique to each agency but have led to both improved processes as well as outcomes for many organizations. For example, through the CQII learning collaborative, NAESM Inc. determined that unidentified substance abuse issues are a contributing factor to decreasing viral load suppression rates in the client population. As one of their PDSA cycles, they introduced a short screening tool to gauge ongoing substance use and determined that the screening tool

was less stressful for clients and assisted clinicians in determining if patients self-identified with having substance abuse issues. As another example from the UCSF collaborative, Grady Infectious Disease Program (IDP) implemented the Retention Through Enhanced Contacts intervention. Grady IDP targeted a cohort of 50 Black MSM patients who were not virally suppressed or not consistently virally suppressed (acutely viremic). As a part of the intervention, Peer Navigators conducted screenings and encouraged eligible patients to utilize the Center for Well-Being (CWB), an in-house mental health service. At the end of the grant year, 66% (n=33) were virally suppressed and 30% were being seen in the CWB. They are continuing to reach out to patients and are looking for innovative ways to integrate mental health into overall care practices.

Program Challenge: MAI-funding Implementation Challenges

MAI funding is currently awarded to two agencies, Grady IDP and Fulton County Board of Health (FCBOH), to respond to unique barriers and challenges faced by minorities and vulnerable populations most severely impacted by HIV. MAI funds were allocated to OAHS, Non-Medical Case Management, Referral for Healthcare and Support Services, and Medical Transportation to improve the health outcomes of minority populations. During the budget period, there were implementation challenges due to procurement delays, staff vacancies (in DHE, in Fulton County's Purchasing and Finance Departments, and among service providers), and COVID-19.

In FY 2021, DHE anticipated serving 1,584 MAI-OAHS clients; however, 298 clients were served. Additionally, due to staffing and implementation challenges (see MAI narrative), MAI funding was unexpended. Due to the limited number of MAI experienced providers (2), it was difficult to reallocate unexpended funds during the programmatic year. Carryover funds will be requested for 19% of the FY 2021 MAI award for labs and medications in FY 2022.

Achieve integrated, coordinated efforts that address the HIV epidemic among all partners and stakeholders

Program Accomplishment: Launched e2Fulton to Replace CAREWare and Client Surveys

In 2021, DHE shifted from CAREWare to e2Fulton, an eCompas product modified for the Part A EMA. This shift has reduced hosting administrative burden. E2Fulton is hosted by RDE Systems, so that all server reboots, updates, etc. can be addressed by the vendor instead of DHE staff. RDE Systems provides off-site hosting and has multilevel security and encryptions to better protect sensitive client data.

E2Fulton has reduced duplication of effort among providers and reduced barriers to care for Part A clients. All subrecipients have entered into Business Associate Agreements and provider domains are now connected in e2Fulton with shared fields and attachments. A client completes eligibility forms once to access services at all Ryan White funded agencies, as providers can share documentation. To provide additional coordinated efforts between subrecipients, service providers can also submit and process referrals within the system, enabling access to all funded services in a timely manner. Previously, case managers would have to contact individual providers at other funded agencies via email and/or phone in order to initiate a referral and follow up regarding completion of the referral. Through the e2Fulton referral module, this is now an automated process. Agency users can see all referrals and client statuses at a glance.

The system also includes enhanced resources for our CQM program and subrecipients including client satisfaction surveys and visual analytics modules. The new standardized client satisfaction survey is being administered through the RDE e2community system, a component of e2Fulton. Any client that has received a service and has a valid email address and/or phone number in their client record receives a survey. A client will not receive more than two surveys in a six-month period per agency and/or service. The client will receive an email or text message with login information, and the survey can be completed on a tablet, mobile phone, or computer. The survey has audio assistance capabilities, and computer-generated audio that will read the questions and answer choices to the responder in English or Spanish with a simple click of the speaker icon. Additionally, the survey utilizes emoticons with every answer choice.

Client Satisfaction Survey results along with all client data can then be analyzed utilizing e2Fulton's visual analytics module. Using the visual analytics module, reporting becomes more dynamic with graphs and pictures to better convey data. The user can add filters and sub-filters regarding various data points including demographics, HAB core measures, services, etc. to better investigate the data and develop a better understanding of disparities and possible interventions.

Program Challenge: e2Fulton Data Quality Issues
DHE experienced the following data quality issues in FY 2021:

- In the moving of data from CAREWare to e2Fulton, data was both lost and duplicated within the new system. We are continuing to validate previous years' data and make corrections as needed.
- Due to the new way in which contracts are set up within e2Fulton, there were several services that were never mapped to the correct service categories. This resulted in incomplete data for various reports. DHE and RDE Systems have worked diligently together to ensure that all necessary fixes be made, all mapping issues should be completely resolved by the end of May 2022.
- Due to massive staff turnover at agencies, there have been data entry delays and a decrease in the quality of data. We continue to address this issue by providing agencies with training videos, step-by step data entry guides, technical assistance, as well as providing technical assistance with individual users.
- There was a delay in the launch of the Ryan White Services Report (RSR) Module resulting in agencies not being able to check their RSR readiness until the report was due. Since the data quality had not been checked monthly as was required by DHE, data completeness and quality decreased. Agencies had to quickly clean a year of data in a new system. DHE is resuming monthly RSR data validation checks to ensure that all agencies will be able to have a successful 2022 RSR submission.
- During the initial roll-out of the Performance Measures in e2Fulton, the previously reported CAREWare percentages did not match with what was reported in e2Fulton. This led to a massive and on-going effort to validate the data by comparing patient-level reports and identify discrepancies in the data. We are continuing to validate and correct the data in this manner.

To address all these needs and develop improvements, DHE meets with RDE Systems bi-weekly regarding the Electronic Contracts Management Module and weekly regarding client level data. We use these meetings to troubleshoot errors, update statuses of various development needs, discuss agency needs, and validate performance measures. With continued communication and system development, we will be able to improve on data quality and automate various processes and reports.

Program Challenge: e2Fulton Electronic Contracts Management Module Issues
There was a delay in the launch of the new Electronic Contracts Management Module in e2Fulton. This module is made up of Procurement and Fiscal tools that allow subrecipients to build their contracted budget and then list expenditures to develop an electronic invoice. Due to the delay, one-third of the expenditure data was entered into e2Fulton while the other fiscal data was still in paper form. This has resulted in challenges reporting on expenditures and assisting agencies with finance questions. There was also not enough training on the Procurement Module when agencies originally entered their budgets, resulting in inaccurate fiscal reporting in e2Fulton, lengthy corrections, and delays in the processing of invoices. We have since provided agencies with technical assistance on the Procurement and Fiscal tools in order to ensure accurate fiscal data entry. We also launched several updates to the module and continue to make additional updates to improve processes.

Expanded/Reduced Resources

Program Accomplishment: OAHS to include Telehealth Services and Video-Ready Tablets
DHE funded additional telehealth communications which include providing laptops, tablets, data cards, phone cards, cellphones, and internet service to clients to increase access to and to improve retention in care. In addition, subrecipients purchased necessary medical equipment to ensure continuity in care during the pandemic for core and support services via Telehealth. Through these efforts over ten thousand service units have been provided to clients in seven service categories.

Table 2: Telehealth Visits by Priority Category, FY 2021

Part A Telehealth Visits by Priority Category				
Category	**Clients**	**New Clients**	**Newly Diagnosed**	**Service Units**
Medical Case Management	269	12	-	570
Mental Health	1,125	95	32	4,966
Oral Health	29	17	3	42
Outpatient Ambulatory Health Services	2,342	235	72	2,972
Psychosocial Support	131	32	10	236
Substance Abuse	182	7	-	1,418
Total	4,078	398	117	10,204

Program Challenge: Client Capacity for Telehealth
After DHE launched telehealth interventions to expand Part A resources during COVID-19, it was observed that several clients did not have internet service and/or no longer had access to Wi-Fi due to the state's Shelter in Place mandate which limited access to free Wi-Fi at libraries, coffee shops, etc. Subsequently, video-ready tablets were awarded to two RWHAP subrecipients to build their capacity to conduct secure telehealth visits with their Part A clients via Ending the HIV Epidemic (EHE) funding. During the reporting period, 8 clients utilized telehealth tablets for OAHS services. In FY 2021, 142 tablets were purchased with EHE funding and are at the agency ready to be distributed to clients receiving OAHS, Medical Case Management, Substance Abuse, and Mental Health services under Part A.

Program Accomplishment: New Priority Service Categories and Expanded Resources
In FY 2021, Ryan White Part A served 16,266 clients across all services, including 1,960 newly enrolled and 509 newly diagnosed clients. RWPA saw increases in core services: Oral Health Care (15%), Mental Health Services (17%), and Substance Abuse Services (2%) compared to FY 2020. There was also an increase in supportive services: Medical Transportation Services (8%), Child Care Services (67%), Linguistics Services (22%), and Other Professional Services (107%).

Additionally, Health Insurance Premium and Cost Sharing Assistance was newly funded in FY 2021. Agencies served a total of 175 clients and provided 208 payments throughout the grant year, and we hope to increase utilization in FY 2022.

Unmet Need

The Unmet Need estimates utilizing HRSA's new methodology indicate that 5,821 (16.7%) people in the EMA are living with HIV but are not in care. Part A aimed to address unmet need amongst target populations identified by the Metropolitan Atlanta HIV Health Services Planning Council (PC).

Table 3: RWHAP Clients not in care by target population

Population	In Care	Not In Care	% Unmet Need	% In Care Not Virally Suppressed
Overall	**28,952**	**5,821**	**16.7%**	**15.2%**
Black Males 25-34	4,586	1,069	18.9%	24.7%
Black Females 25-34	508	148	22.6%	27.2%
Transgender 25-34	172	57	24.9%	27.9%

Linkage and retention are fundamental to achieving viral suppression and viral suppression is key to persons who have an HIV infection not passing the infection to someone else. Successfully improving health outcomes along the care continuum is a continual focus of the Atlanta EMA.

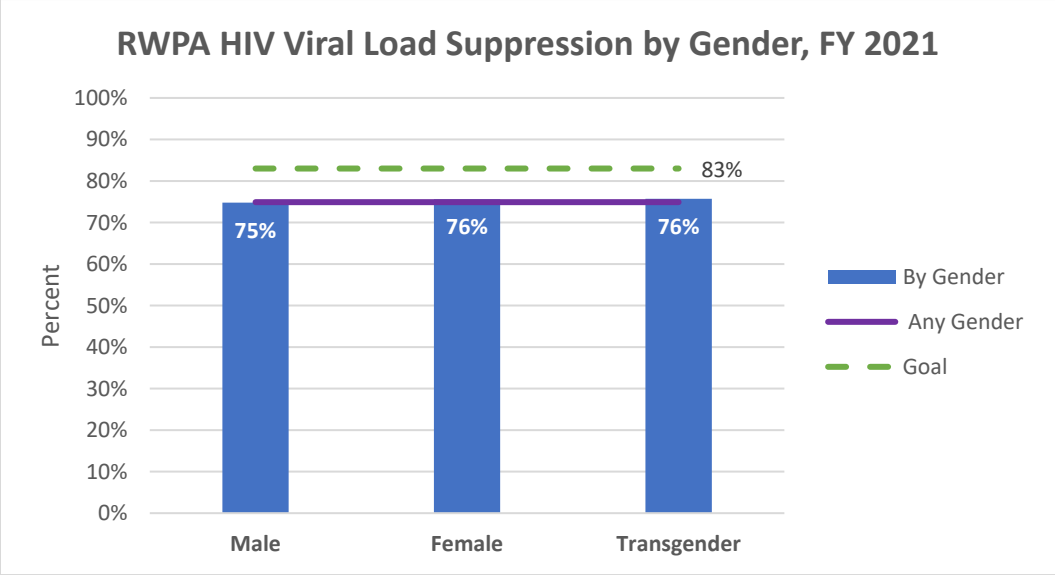


Figure 4: HIV Viral Load Suppression by Gender

In FY 2021, the Atlanta EMA did not meet its viral suppression goal of 83% despite 3% increase from FY 2020. The goal was increased due to notable improvements for the most disproportionately impacted populations the previous year and the EMA-wide quality improvement project focus on viral load suppression among BMSM and transgender clients. Through the CQM Program, agencies will continue to monitor this performance measure each quarter, along with the enhanced interventions to improve health outcomes for Persons Living With HIV (PLWH). The QI project to improve viral load suppression will continue through the next fiscal year.

COVID-19 Pandemic

The State of Georgia currently maintains no "shelter in place orders" and the Public Health State of Emergency has expired. Despite the reduction in confirmed COVID-19 /antigen positive cases in the U.S. and globally, Part A is still addressing issues attributing from the public health pandemic. Factors that have impacted the HIV care continuum outcomes for people with HIV in the 20-county EMA, vulnerable populations, and the Part A service infrastructure include:

1. Reduction in resources: core and support services
2. Initially there were COVID-19 vaccine delays or shortages
3. COVID-19 vaccine hesitancy among PLWH
4. Evictions after the CDC eviction moratorium expired August 2021
5. Inflation and lack of affordable housing

Methodologies to address the ongoing staffing issues during COVID-19 entailed using Zoom recordings to onboard Recipient and Subrecipient new hires in lieu of daily technical assistance. Reallocating unexpended funds to high demand services (e.g., Food Bank/Home Delivered meals, Housing, etc.) and COVID-19 resources for clients from service providers' salary savings proved to be a great strategy. Atlanta Legal Aid Society, the Other Professional Services provider, assisted many clients with applying for Emergency Rental Assistance, provided legal assistance to prevent evictions and solved renter problems for clients. Personal protective equipment and COVID-19 testing kits were also distributed to subrecipient staff and PLWH.

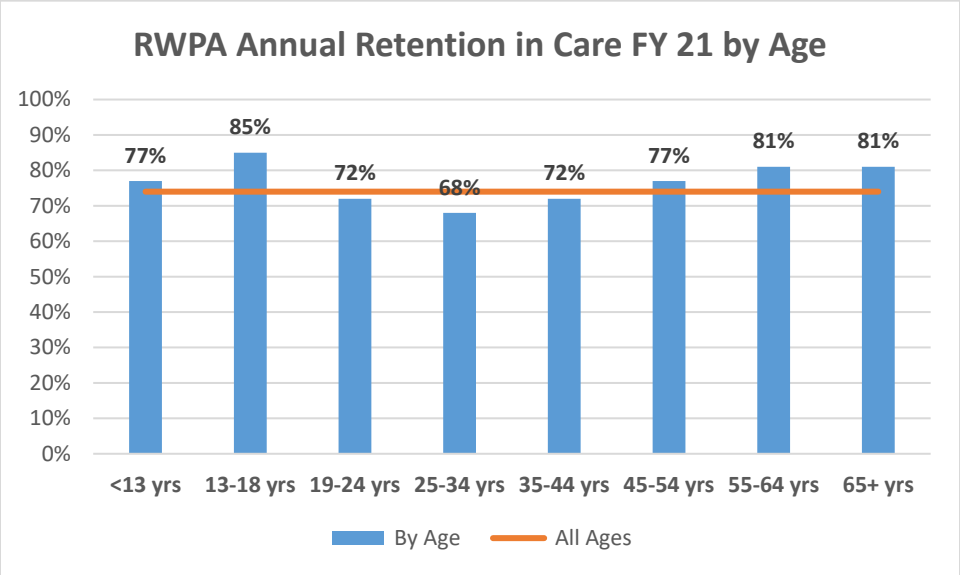


Figure 5: RWPA Annual Retention in Care FY 21 by Age

Ryan White Part A annual retention in care for FY 2021 shows some differences when analyzing the ages and gender of those retained in care. In FY 2021, ages 13-18 years old were among the highest being retained in care at 85%. For ages 25-34 years old, there is a drop in those retained in care where that grouping has a retention of 68%. It is noted that the lowest percentages retained are from ages 19 to 44 years of age and most age groupings are above 70%.

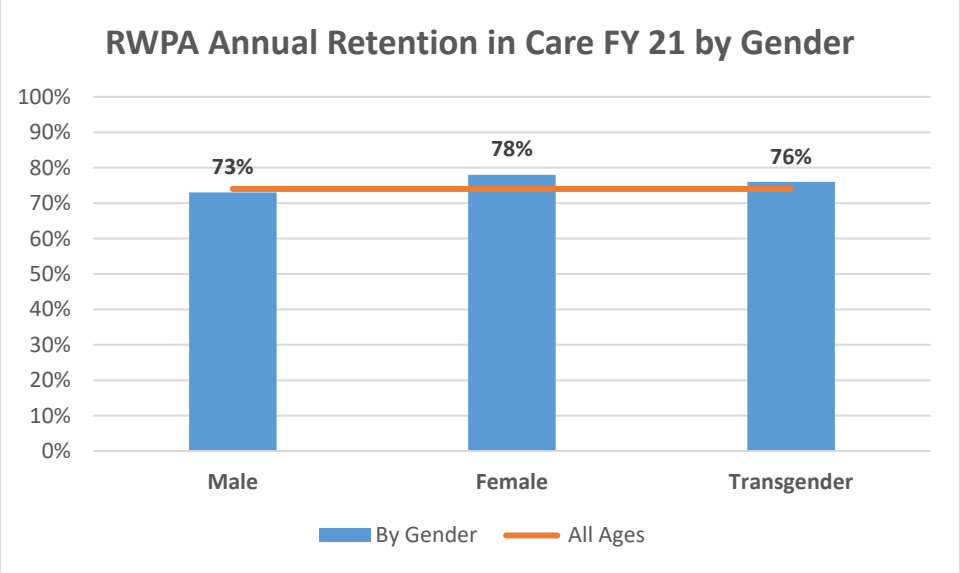


Figure 6: RWPA Annual Retention in Care FY 21 by Gender

Regarding gender, Females were among the highest being retained in care at 78% in comparison to Male and Transgender counterparts. Male and Transgender clients are close in retention percentages as Female at 73% and 76% respectively.

Evolving Healthcare Landscape (e.g., changes in health care coverage options)

In 2021, there were 15 State-based Marketplaces, six State-based Marketplaces using the Federal Platform, and 30 Federally-facilitated Marketplaces. For 2021 coverage, enrollment in plans on Georgia's exchange is up about 11% higher than the prior years. In 2021, 90% of the enrollees qualified for an Advance Premium Tax Credit compared to 87% in 2020. The average health insurance premium is $489 per month in Georgia, only $1 more expensive per month than it was in 2020.

Program Challenge: Georgia Denies Medicaid Expansion
Although the Affordable Care Act (ACA) has made significant progress in Georgia for people having pre-existing conditions, the entire state has suffered from the lack of Medicaid expansion. The State's denial of this expansion left hundreds of thousands of Georgia's most vulnerable residents, including PLWH, without access to affordable coverage in what is called "the Medicaid Gap." Because Georgia also chose not to develop a state-run marketplace exchange, plan prices are higher than those in states that facilitate their own exchanges. These factors created a system that leaves individuals locked out of coverage, particularly those in low-income households or those with strained financial resources. Medicaid is the largest source of insurance for PLWH and offers more healthcare options and access to medication. The Atlanta EMA will continue to monitor the federal and state healthcare landscape to identify changes that could impact delivery of HIV primary care services.

Program Accomplishment: Part A Fills in the Insurance Gaps
Part A serves a large number of PLWH living in poverty, burdened with other medical conditions, experiencing health disparities, lacking health insurance and/or having trouble with insurance deductibles and co-pays. This includes a sizable population of PLWH who are not eligible for insurance under the ACA or many other publicly-funded programs. RWPA funds continue to be used to address service needs and gaps. Funded services to address changes in healthcare include Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals (HIP-CS) and Referral for Health Care and Support Services (including Insurance Navigation). During the reporting period, 7,663 clients were served by 5 providers who were funded for Referral for Health Care and Support Services, and 33 clients (8 new clients) received Insurance Navigation services.

Describe how you share HIV care continuum outcome information with community stakeholders

The Atlanta EMA engages in numerous presentations to share outcomes of the HIV care continuum with community stakeholders. The PC meets seven times per year and provides a forum for community input on the needs of PLWH in the EMA and ways to improve health outcomes as people move along the HIV care continuum. It is during Executive Committee meetings, PC meetings, DHE quarterly staff meetings, and other Atlanta EMA events such as the RWPA Annual Providers Meeting (specifically for subrecipients) where HIV Care Continuum outcomes are shared. Care Continuum data are also shared during the monthly Quality Management meetings. Data are also available on DHE's website. Thus, PC members, providers, staff, and consumers continue to be provided with information throughout the year on service utilization, quality of services, as well as health outcomes of PLWH by target populations.