Austin/Travis County Fast-Track Cities
Prioritization of Action Plan Objectives and Strategies
with Compiled Work Plans

Austin Fast Track Cities – Prioritization

Throughout the month of June 2020, Austin Fast-Track Cities (FTC) priority work groups prioritized objectives and strategies within the action plan for transition into implementation phase of the Austin/Travis County FTC finalized action plan. These next steps allow dictation for grant funding flow and contract writing for the upcoming fiscal year. Prioritization were voted on amongst participants during each meeting utilizing liberating structure tools for organized responses and verbal feedback from participants, followed by discussion on timeline of implementation.

Process for voting within workgroups: Feedback was collected using two means of engagement:

1. *Virtual meetings*: Monthly scheduled workgroup meeting via Microsoft Teams
2. *Liberating Structure*: Waterfall liberating structure tool method to gather votes
    a. Waterfall liberating structure defined: participants type their response in chat box of Microsoft teams, and when instructed, press enter/send to display one's response.

    **In efforts to collect responses fairly, participants were only allowed to display vote once.

Over the course of July 2020 – December 2020, workgroups actively partook in Liberating Structure "Purpose 2 Practice" to provide practices, outputs, and outcomes of strategies and objectives within the 2020 FTC Action Plan.

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Objective 1.1: Prevent New HIV Infections

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2nd	Strategy 1.1.3: Partner with CBOs
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Fast-Track Cities Work Plan Priority Area 1: Prevention
Purpose: Why is the work important to you and the larger community?
Objective 1.1: Prevent New HIV Infections
• We've been living with HIV for too long and we finally have the tools to rid ourselves of this disease. • To help us achieve our Fast Track City Goals of 90/90/90 • We need to have education about the new tools to rid ourselves of the disease. It's an ongoing thing that people continue to say about not being knowledgeable. We still need to be putting that information out there. We have to educate people on what is needed. • Make sure people have access to the information they need to be educated. • Access to medical care along with the information
Strategy 1.1.1: Educate Providers on PrEP
Practices:
➢ Speaker programs, organization programs, community led programs.
Outputs:
• The program that is being provided
Outcomes:
• More providers comfortable with prescribing PrEP
• Percentages/data provided afterwards to show the number of programs provided
➢ Targeted Educational content. Continually updated continuing education or programs
Outputs:
• Educational content and materials that is fully vetted by diverse community representatives
Outcomes:
• Effective materials
➢ In person/virtual/one-on-one/journals and articles to provide information
Outputs:
• HIV Resource Library
Outcomes:
• Providers would be better informed and knowledgeable
• Increase providers within the community outside the traditional administrative services only (ASO)

• Easy access for providers to gain knowledge
➢ Include multiple types of providers such as OB/GYNs, different clinics and offices, providing incentives. Offer a range of topics for providers to choose what best fits their practice sites. Offer to social workers and pharmacy - not just prescribers
Outputs:
• Geographical representation of PrEP providers
• Specific language, training materials that can be used based on geographical makeup
• Collaborative work between different providers
Outcomes:
• Greater knowledge in the female community about risks and prevention
➢ Offering quarterly training to providers
Outputs:
• Given data on different demographics. Visual data of current changes
Outcomes:
• Up to date on knowledge
• Increase PrEP utilization of specific groups
• Decrease of stigma on specific groups
➢ Provider toolkits
Outputs:
• Easily accessible online references
• Providers consortia for just the city to focus on Austin providers
Outcomes:
• Educate more providers so they are comfortable prescribing
Strategy 1.1.3: Partner with Community Based Organizations (CBO's)
Practices:
➢ Developing training materials
Outputs:
• A list of CBO's that practice
• Checking through organizations that have been involved or collaborated with
Outcomes:
• Improved materials and utilization of content and language of materials that are being produced
Strategy 1.1.5: Resource Guide

Practices:
➢ Distribution of the resouce guide to providers throughout the community
Outputs:
• Print multiple copies of resource guide
• Make available on social media
• Leveraging FTC web portal
• Leveraging the HIV Epidemic web portal
Outcomes:
• Print multiple copies of resource guide
• Make available on social media
Strategy 1.1.7: Telemedicine
Practices:
➢ Leveraging existing sources; FTC websites, organizations websites
Outputs:
• Organizations can make sure their information is displayed on FTC SharePoint and frequently updated
• Organizations can make sure links are connected to telemedicine information
• Sharing best practices locally about how organizations have implemented telemedicine
• Partnering with organizations such as Community Action who already interface with many people from more rural areas to increase visibility of telemed services for those who may reside farther away from brick and mortar clinics
Outcomes:
• More people get informed on their telemedicine options of those organizations within the community
• Consumers have clear knowledge of telemedicine access in rural areas
• Increased show rates because of more options to be seen
• Increased program retention in specific areas recognized as increased risk and in which telemedicine is seen as a way to mitigate that risk
• Increased telemedicine options in our community
• Increased uptake of telemedicine services based on zip codes that are more distant from hub services
• Increase number of people who see a provider using telemed who were not in care prior
➢ Telemedicine for home-based HIV and STI testing and risk reductions.
Outputs:
• Number of at home testing kits delivered community wide

• Sharing best practices
• Provide broader availability to those that work different hours and are not able to make regular business hours to get tested
• Easy to use testing packets
• Promote these options within the community by print, web/digital, and ambassador campaigns
• Home based STI and HIV testing offered to all consumers who have had a recent positive STI result in the past 3-6 months (i.e. those at highest risk of re-infection)
• Social network distribution strategies for hard to reach populations
• Area or statewide campaign to increase uptake of home-based testing
Outcomes:
• Increased number of people using home test among those who have not tested
• Increased number of home test kits distributed
• Increased number of home-based HIV/STI testing options in our community
• Increased number of home-based testing programs
• Better data on home testing
➢ Go beyond telemedicine and discuss telehealth.
Outputs:
• Define Telehealth versus Telemedicine
• Share best practices around providing holistic care virtually
Outcomes:
• Better understanding and differentiating between telehealth and telemedicine
Strategy 1.1.4: Suburban and Rural PrEP
Practices:
➢ Expand PrEP education and services to reach outlying areas of Austin and Travis County
➢ Partner with CBOs in rural areas to share information, resource guides, and prevention access methods.
➢ Using data collected to partner with CBOs and other organizations to understand challenges to providing access to care and develop strategies that will address those challenges.
Strategy 1.1.6: Treatment as Prevention (TasP)
Practices:
➢ Collect data on TasP services and activities currently underway.
Outputs:

• Regular review (monthly, quarterly) of patients who are virally unsuppressed and/or out of care and coordinated outreach to get them back into care
• List data points that would measure effectiveness of TasP services and activities
• Survey providers, clients, and community members
• Data coordination across sites
Outcomes:
• Data-informed decisions, promotions, services, funding, and collaborations
• Increased number of contacts / outreach with those consumers who are not virally suppressed.
• 95% of patients in care virally suppressed.
• Obtain data from enough organizations in a reliable, standardized format that can be studied and analyzed and answers data science questions presented
➢ Perform research on TasP activities in other jurisdictions that are not taking place here and can be exploited in Austin/Travis County.
Outputs:
• Reach out at regional/national conferences for best practices. Look for TasP content or tracks at conferences and interview/survey the presenters about their community activities
• Formalize a research network of HIV researchers and providers here in Travis County (and with other regional AIDS Education and Training Centers) to share best practices
• Webinars
• Leveraging existing trainings
• Identify senior HIV researchers to support the efforts of junior researchers and clinicians in this area and others
• Referring to other Fast-Track Cities to see what actions they have taken
Outcomes:
• Implement new activities locally that have high success in other communities, especially in areas that Austin is not seeing traction or success
• Increased funding for research and program efforts. Network HIV/sexual health researchers
Strategy 1.1.2: Educate Health-Services Students on PrEP
Practices:
➢ Health-Services Schools and programs, including Medical, Nursing, and Pharmacy: Research what is currently happening around PrEP education. Can engage Medical and professional societies: Make a sustained systemic policy.
➢ Investigate development of a program or materials that can be used by various universities, public and private, to add to standard curriculum.

Priority Area 2: Testing and Rapid Linkage to Care

Prioritized Objectives and Strategies:

Objectives	Prioritization Order
Objective 2.1: Establish Rapid Linkage Program	1st
Objective 2.2: Testing	2nd
Objective 2.3: Rapid Linkage	3rd

Objective 2.1: Establish Rapid Linkage Program:

Prioritization Order	Strategies
1st	Strategy 2.1.2: Expand and Coordinate Intake
2nd	Strategy 2.1.3: Alignment of HIV protocols
3rd	Strategy 2.1.1: Define "Rapid Linkage to Care"
4th	Strategy 2.1.4: Share Best Practices
5th	Strategy 2.1.5: Expand Community Engagement

Objective 2.2: Testing

Prioritization Order	Strategies
1st	Strategy 2.2.1: Increase Testing Access
2nd	Strategy 2.2.2: CME/CMU for STI/HIV Training
3rd	Strategy 2.2.5: Opt-out HIV Testing in Austin and Travis County Jails
4th	Strategy 2.2.3: Testing for Homeless Population
5th	Strategy 2.2.4: Routine Testing in Area Emergency Rooms

Objective 2.3: Rapid Linkage

Prioritization Order	Strategies
1st	Strategy 2.3.2: Rapid Linkage from Emergency Departments
2nd	Strategy 2.3.3: Rapid Linkage in Area Jails
3rd	Strategy 2.3.1: Advocate for State Drug Assistance Program Improvements

Fast-Track Cities Action Plan Priority Area 2: Testing & Linkage to Care
Purpose: Why is the work important to you and the larger community?
Objective 2.1: Establish Rapid Linkage Program
• Being able to meet the patient where they are at the moment. • Offering immediate medication to that patient to get pill in mouth leads to more positive and immediate response and gets us to our 90-90-90 goals. • Sets the tone for the person's course of treatment, PrEP, antiretroviral therapy (ART), and to make sure we are valuing them as a person and make positive engagements • Honoring choice and self-determination • Those who start treatment early correlates with better health outcomes • Helping community health, rapidly reducing viral load within the community. • Empowering to have something to do immediately that is proactive around their health in the very beginning. • Helping to mitigate the red tape in getting into care. Providing a bridge to prevent screening barriers. • helping people establish trust with providers, especially when trust has been broken in the past.
Objective 2.2: Testing
• To reduce the spreading of the HIV virus, which is beneficial to the larger community • Normalizes routine HIV testing in all medical settings where someone is drawing blood • Enhancing sexual wellness and overall, well being • Testing helps people know their status • It helps people take care of their own sexual health • To reduce stigma and normalize testing • Opens up the door for additional healthcare linkages (for someone who isn't currently engaged in the 'system"
Objective 2.3: Rapid Linkage
• Identifying where tests are occurring and where people are needing our services • Essential to the community as it increases long term engagement in the healthcare system and prolong the life of those living with HIV and their partners
Strategy 2.1.2: Expand and Coordinate Intake
Practices:

➢ Create and maintain list of providers with intake slots available for newly diagnosed individuals, people returning to care, or candidates for PEP and PrEP
Outputs:
• Connecting newly diagnosed to care
• Connecting PrEP candidates to care
• Connecting PEP candidates to care
• Those who have fallen out of care, returning to care
• Connecting the coordination of entities
• A provider/organization actively creates and maintains list ▪ Hot line system, phone numbers to call in i.e. "3-1-1"
• Design session to state what the "3-1-1 hotline system" would look like
Outcomes:
• 90-90-90
• A list is created before December 31st, 2020
➢ Work with multiple agencies to ensure there are as many options as possible for clients to link quickly into care for ART, PEP, and PrEP
Outputs:
• Having a work session on identifying gaps or larger influential organizations that need to be approached to get them more involved
• Engaging larger organizations to ensure they are offering as many options as available
• Work with larger organizations to determine what their needs are to offer more options
• Establish point of contact/liaison with each agency once the list has been made
• Community sessions to identify non-traditional partners
• Community survey to engage/assess needs of non-traditional partners
• Design session to prepare educational package of information for organizations
Outcomes:
• Enhanced linkage to care
➢ Dedicated "walk-in sessions" (e.g. weekends, evenings)
Outputs:
• Survey of what providers currently offer walk in sessions on weekends and evenings
• Identify organizations that do and do NOT offer walk in sessions on weekends and evenings
• Inventory of walk in sessions and when they are available

- Hosting a collaborative effort to get providers to consider to create blanket to offer on different dates
- Work with community pharmacies to make sure they work with providers to have starter packs available at all hours

Outcomes:

- 72 hour linkage to care

Strategy 2.1.3: Alignment of HIV protocols

Practices:

- Rapid starter pack before the patient leaves

Outputs:

- Measure how long patients stay on the medication provided in the starter packs
- Number of starter packs given at organizations
- List of providers who have same day starter packs who we could make referrals/warm hand offs to.
- Development procedures
  - Borrowing best practices from each other in services
  - Connection clients to other services at other organizations
  - Collaborative referral commitments

Outcomes:

- Opportunity to do direct observed therapy.
  - View the patient taking the medication at that time
- Provides education to the patient for pharmacy processes
- Decreases the immediate funding barrier, if one exists
- Getting patients into care and empowering them to start owning their health
- Increasing retention in care
- Reducing negative community impact

- Same day connection to non-clinical services (ie: navigators, peer counselors, social workers) to facilitate linkage to prep or HIV medical care

Outputs:

- Number of connections made to navigators
- Number of connections made to peer counselors
- Number of connections made to social workers

Outcomes:

- More support in connecting clients to care

• Better understanding of the systems that patients need to navigate
• Uptake and acceptance of same day for PrEP or ART
• Retention, reengagement, and rapid viral suppression
• Connecting people in 72 hours or less to services
➢ Warm referral with partner organizations.
Outputs:
• Collaborative referral commitments
• Sharing best practices and protocols, successes and failures throughout FTC and across the country
• Sharing outcomes
• Measuring how many have successfully been connect, how many have come back
Outcomes:
• Providing information to other services and providers on patients to make them feel more comfortable maneuvering through services into the next space
• Data on those successfully connected in services
Strategy 2.1.1: Define “Rapid Linkage to Care”
Practices:
➢ Develop an Austin definition of “rapid linkage to care” across all testing and treatment providers.
Strategy 2.1.4: Share Best Practices
Practices:
➢ Establish quarterly meetings of case managers and navigators
Outputs:
• Sharing best practices on a state and national level
• Common shared definitions and measurements
• Discussions around barriers to providing services. Eg: confirming rapid tests and linkages to programs
• Developing one agreed upon process around testing and rapid linkage
Outcomes:
• Sharing best practices on a state and national level
• Common shared definitions and measurements
• Discussions around barriers to providing services. Eg: confirming rapid tests and linkages to programs
➢ Sharing best practices on a state and national level
• Lessons learned, successes and failures

Strategy 2.1.5: Expand Community Engagement
Practices:
➢ Engage area hospitals and medical providers to actively participate with Priority Groups
Outputs:
• Identify FQHC's receiving funding through ETE and invite them to Testing & Linkage workgroup meetings
▪ 100% of FQHC's in Austin receive funding
• Identify how we are engaging hospitals and medical providers
▪ Hospital leaders involved on executive level
• Confirm what hospitals are currently doing actions wise
• Taking status neutral approach when engaging groups
Outcomes:
• Identify FQHC's receiving funding through ETE and invite them to Testing & Linkage workgroup meetings
• 100% of FQHC's in Austin receive funding
▪ Measure that increase how? Participation in meetings?
▪ Data around viral load, rapid linkage, and follow up treatment
Strategy 2.2.1: Increase Testing Access
Practices:
➢ Encourage primary clinics to do routine opt-out testing for all
Outputs:
• Knowing how many clinics do opt-out testing?
• Providing a clinic on how to do opt-out testing
• Development of a tool kit
Outcomes:
• Measure the opt-out testing of clinics and hospitals
➢ Increase mobile testing capabilities
Outputs:
• Inventory of who is doing mobile testings
• Defining what mobile testing is
▪ Testing not at a stable or fixed location
Outcomes:
• A shared calendar or resource that is fluid and updated by all that are doing mobile testing

• See a proportionate increase in testing in communities that are more impacted via demographics
➢ Increase knowledge of testing locations and treatment
Outputs:
• Shared calendar
• Measuring certain target time frames of testing
Outcomes:
• See a proportionate increase in testing in geographic locations
• People would find testing easier
• Timely testing and interventions
Strategy 2.2.2: CME/CMU for STI/HIV Training
Practices:
➢ CME/CMU for STI/HIV training
Outputs:
• Inventory of what currently exists (e.g. Gilead Cardea)
• Agreement around Core Competencies needed in the field around testing
• Training which is appropriate to a more broad group beyond DSHS service providers.
• Expand training opportunities around testing and how to reduce stigma.
▪ How are you delivering results?
▪ How are you linking to care afterwards
Outcomes:
• People have the skills and knowledge to effectively complete work
▪ They will know core competencies for the field
• Reduction in time between testing and linkage to care
Strategy 2.2.3: Testing for People Experiencing Homelessness
Practices:
➢ Develop community-wide standard for testing area homeless populations
Outputs:
• Programs made for testing the homeless population
Outcomes:
• The homeless population is tested regularly

- Testing being completed for the special populations within the homeless community such as those using drugs and sharing needles
- Importance of connection between persons experiencing and rapid linkage to care

➢ Complete a scan of current resources

Outputs:

- List of current resources
- Baseline understanding of what is currently happening

Outcomes:

- Partnerships made by organizations with efforts towards helping the homeless population
- Offer readily available point of care testing
  - Ex: Austin state camp
  - Access to testing for rapid linkage by giving patients starter packs

Strategy 2.2.5: Opt-out HIV Testing in Austin and Travis County Jails

Practices:

➢ Priority group to research current practices and areas for improvement in opt-out HIV testing in area jails

Outputs:

- Bringing in those who have expertise on this subject to come and speak on testing within jail facilities
- Understanding what linkage already exists as well as what linkage can exist for those exiting out the system
- Identifying partners such as:
  - The local jail
  - Bastrop prison
  - Organization working with people who are preparing for release
  - Getting someone from the local system, state system, federal system
- Systems test those existing the system allowing connection to care once released
- Identify which prison/jail systems test those individuals coming in
- Identify which prison/jail systems test those individuals that are exiting the system
  - Identifying those in need of ART & PREP
- Anticipating patients' needs before release from prison/jail

Outcomes:

- Better awareness and increase knowledge of status
  - The first 95 in the 95-95-95 goals

• Understanding the linkage once individuals are released
• Improve the linkage to care once individuals are released from incarcerated facilities
Strategy 2.2.4: Routine Testing in Area Emergency Rooms
Practices:
➢ Meet with leaders of hospitals in Austin and Travis County to encourage adoption of routine screening for HIV
Outputs:
• Utilizing our Core committee group
▪ Creating a conversation and getting reports on what's occurring in emergency rooms
• T&L workgroup provide panel discussion around this issue in 2021
▪ Identify central health, health equity policy council
• Ie: Brandon Wallerson as a resource
• Identify where routine testing in emergency rooms is currently occuring
Outcomes:
• Grant funded services
• Routine testing occurs in a broad section of emergency rooms across central Texas
Strategy 2.3.2: Rapid Linkage from Emergency Departments
Practices:
➢ Emergency Departments to get navigators and embedded DIS workers to assist in rapid linkage to care (not just social workers).
Outputs:
• Contacting emergency rooms in our local areas to see if they are open to this type of partnership
• Working with the local health department to ensure that disease investigators and services are available
• Add a referral for HIV care in the patient's chart
• Emergency departments collaborate with existing rapid linkage teams and community health worker
• Allow informed HIV navigators and DIS workers to train existing ED staff (i.e. social workers, case managers, others) on HIV navigation protocols and processes
• Opt-out testing
• Help consumers get linked sooner
• Develop a community based on call navigator model
• Connecting this strategy with the opt-out testing strategy
• Study how Florida state implements this model
Outcomes:

• Increased linkage to care rates
• Quicker connection to care
• From the perspective of why a hospital ED would consider: long-term sustainability; cost-savings
• Decreased time to starting treatment
• Emergency departments will be more informed about HIV service providers in our community. The referral network will be more robust
• Increase in PrEP(?)
• Decrease in people falling through the cracks
▪ Establish a measurement baseline of the people who may "fall through the cracks"
Strategy 2.3.3: Rapid Linkage in Area Jails
Practices:
➢ Priority Group to research current practices and areas for improvement in rapid linkage, treatment, and re-entry in Austin area jails
Outputs:
• Contact IAPAC for program models
• Research each system's process for linkage to care and HIV medications, and if some systems are not providing HIV medications to incarcerated individuals, address this issue
• Understand current practices in this area by jails
• Request correctional health HIV diagnosis LTC protocol/process while incarcerated within local jails, state prison and federal prison
• Request correctional health HIV diagnosis LTC post release protocol/process from local jails, state prison and federal prison
• Form task force to research what data is available and what the disparities are and understand the scope of the issues
• Contact appropriate ancillary facilities that provide services to previously incarcerated to assist with LTC
Outcomes:
• Evaluation of policies and understanding what works and why
• Ability to influence protocols and process to ensure HIV LTC while incarcerated and post release
• Ability to identify partnerships that could assist with LTC
• List of facilities in the Austin HSDA and current practices for each
• Increased linkage to HIV medical care and HIV medications, both while individuals are incarcerated, as well as when individuals are released from incarceration
• Support groups for recently incarcerated who are newly diagnosed or out of care
• People have continuity into care, no interruption
• Define point of incarceration: jails, state prison, federal prison, ICE detention centers

Strategy 2.3.1: Advocate for State Drug Assitance Program Improvements
Practices:
➢ Meeting with State re: AIDS Drug Assistance Program (ADAP)
Outputs:
• Understanding the resources and budget cuts that have been affected due to pandemic COVID-19
Outcomes:
• Maintain efficiencies in systems post COVID-19

Priority Area 3: Retention, Reengagement, & Viral Suppression (RRVS)

Prioritized Objectives and Strategies:

Objectives	Prioritization Order
Objective 3.1: Defining Terms	Completed
Objective 3.2: Minimize Burden on Clients	1st
Objective 3.3: Bundling and Co-locating Services	2nd

Objective 3.2: Minimize Burden on Clients Strategies

Prioritization Order	Objective 3.2: Minimize Burden on Clients Strategies
1st	Strategy 3.2.5: Engage Pharmacists
2nd	Strategy 3.2.3: Transportation
3rd	Strategy 3.2.2: Promote Education Around Benefits and Enrollment Assistance
4th	Strategy 3.2.1: Strategic Decentralization Plan
5th	Strategy 3.2.4: Childcare

Objective 3.3: Bundling and Co-locating Services

Prioritization Order	Objective 3.3: Bundling and Co-locating Services
1st	Strategy 3.3.1: Co-locating City/County Services
2nd	Strategy 3.3.2: Utilizing State Strategies related to Achieving Together plan to widen the circle of involvement in FTC

Fast-Track Cities Work Plan Priority Area 3: Retention, Reengagement, & Viral Suppression (RRVS):
Purpose: Why is the work important to you and the larger community?
Objective 3.2: Minimize Burden on Clients:

- Help people we serve to receive those services and continue to receive those services and be retained in the delivery of those services.
- People remain on medication each day.
- Burdens that hinder individuals from receiving medication
- Agree on the bundle of services that we want for clients
- Coordinated approach for case management.
    - Orient organizations on a coordinate approach
    - Assessment of social determinants of health
        - Transportation and so on to help with providing of services
- Distinguish differences between barriers and burdens.
- We are closer today to having this disease being manageable, but in order for it to be MANAGED, then we MUST reduce the burdens to our shared community members, then we must address the barriers that keep it from it being managed. That is why I feel this is important.
- Build in systems that solicit and identify what those burdens are, and then try to do something about what the consumer identifies as a burden.
    - Identify customized options to provide to consumers/clients
    - Figure out array of services that they need, especially their individualized needs
    - Make sure we have the resources to provide.
        - ex: valid identification cards to receive services
        - Seems like process mapping may be a to do here... like if you come in without an ID here is the process of getting you what we can... then you go down the next process of getting an ID... then a process of rapidly getting a person who has been waiting an ID into services.
- Looking at processes that screen people into services instead of intaking people into services. Intake clients, and then help them navigate their unique needs (rather than starting with screening)

Objective 3.3: Bundling and Co-locating Services

• Clients having to repeat their story/repeat trauma. Bundling services would minimize this and allow them to get everything that need at 1 place feeling satisfied on moving towards progress.
  ○ Co-locations make sure everything is covered and minimizes fear.
  ○ Bundling services broadly in a concept form.
  ○ Transportation
• Coordination and integration of care and services across programs and agencies
  ○ Ex: housing, emergency services
• The need for systems that talk to each other, the relay of information to create an atmosphere for communication and coordination
• A team of people ready to embrace and assist.
• Consider telemedicine/telehealth to reach out to other agencies to benefit the client in ways of connecting with providers.
• Teleservices
  ○ Ex: Food banks, mental health assessments for tele-psychiatry
• Provide kiosks at locations that could be used for televisits due to lack of privacy at home

Strategy 3.2.5: Engage Pharmacists
Practices:
➢ Assisting clients with programs to help connect them to get immediate information on getting their medications.
Outputs:
• Clients leave their appointment with information
Outcomes:
• Increase number of clients being able to access their medications within a reasonable timeframe or with speed
• Increased engagement with patients
• Adherence - access, patients stay more compliant, pharmacies stay in business
➢ Use opportunity when client is interacting with pharmacist to help with providing other bundle of services
Outputs:
• Providing information
• Compile a one pager to provide to pharmacists with bundled services of information. Would need continuous updating
• Pilot program with case managers and nurses
Outcomes:
• Adherence
▪ Better patient engagement
• Higher retention in care

• Viral load suppression
➢ Pilot program that do large bulk managing HIV medications, complete a meeting before pharmacy opens. Looking at pharmacies that serve specific populations.
Outputs:
• Information documents
• Quick/short training for pharmacies and clinician meetings
• Continuing getting valuable information and build out
• Providing laminated/front and back index cards to clients, making easy conversation for them to be engaged and get information they may need. Fits in wallet, has link on card. Informational card for pharmacists to help them engage with clients.
• Gather input from pharmacies and clients to determine usefulness
Outcomes:
▪ 90-90-90
Strategy 3.2.3: Transportation
Practices:
➢ Providing multiple option for patients to get access to services via transportation as needed.
o Examples: Keep a stack of gas cards at the clinic. $20 gas cards give patients flexibility. Funding pilot for rideshares. Also, funding bus cards.
Outputs:
• An assessment or analysis to be completed to determine if the following outcomes are made to be goal baselines
• Community wide access program. Any patient can access this program through any agency.
• Inventory of current transportation options with recommendations for making improvements
Outcomes:
• Increase your patient show rate
• Increase viral suppression
• Increase patient retention
• What improvements were made from previous transportation practices
• Discounted rideshare rates for medical visits
➢ Using telehealth as a means to address transportation as a barrier but also minimize contact for staff and patients during a global pandemic.
Outputs:
• An assessment for telehealth on the need to provide transportation.

Outcomes:
• More patients being seen
• More flexible accessibility for patients
• Creating as many options as possible for the patient in terms of what works best for them
➢ Mobilizing healthcare. Taking the healthcare to the patients via mobile unit. o Examples: Healthcare concierge and technology devices provided for us
Outputs:
• Determine what services should be provided remotely
▪ Examples: Mobile hotspot to securely access bandwidth to connect for information.
• Research best practices globally and nationally.
▪ Examples: Provide minutes for cell phones
Outcomes:
• More patients being seen
• Increased flexibility and accessibility for patients
Strategy 3.2.2: Promote Education Around Benefits and Enrollment Assistance
Practices:
➢ Online enrollment learning program for patient navigators and case managers
Outputs:
• More patients more readily accessing and being enrolled
• Increased knowledge and awareness on benefits available
• Satisfaction on access of benefits
• Answering the question of is the patient getting the right benefits for them?
• More easily accessed medication
• Pre and post survey to question if satisfactions and benefits went up or down for measurables
• “Cheat sheets” provided with possible insurances as well as benefits
• “Cheat sheets” for questioning which services are being accessed the most, also showing the least accessed as well
Outcomes:
• Increased retention, linkage to care, and viral suppression
• By 2021, accessible program provided for patients and navigators
• Measurements of pre and post optimizations on burdens on providers and patients
• Measurements on efficiency and decreases in time to accessing appropriate medications and accessing care
➢ Information to patients on their needs for services so they can make decisions on enrollment.

➢ Community based live document with information of resources to help navigate HIV care
➢ Training information for navigators with the systems to better help the patients during enrollment
Strategy 3.2.1: Strategic Decentralization Plan
Practices:
➢ Determine what larger service providers are doing to decentralize services
Outputs:
• Promote the sharing of data
▪ Barrier: Individuals may not want to share personal data
• Less travel time to get needed care
• Decreasing barriers
• "One stop shops" for all services
• Funding following the patients
• More options of services and locations of those services
• Promote the sharing of data
Outcomes:
• Higher level of engagement with appointments
• Patient feels more welcomed and informed which would lead to keeping that patient in care and engaged
• More people to receive PrEP
Strategy 3.2.4: Childcare
Practices:
➢ Improve childcare options for clients to access care
Outputs:
• Provide childcare services during sessions
• Encouraging providers to ask about childcare for patients to be able to attend appointments
• Implementing a voucher programs
▪ Vouchers for transportation
▪ Vouchers for local school boards with after care
▪ Vouchers for having a neighbor or family member to watch child
▪ Vouchers for community orgs such as YMCA
• Establishing relationships with some daycare/childcare providers that will take vouchers for drop in availability
Outcomes:

• Services located all in one spot for utilization
• Data to be provided displaying if childcare is an issue for trying to attend appointments
➢ PAL Program - Pediatrics AIDS League
Outputs:
• Childcare availability for drop-in services for patients to utilize
• Scheduled appointments
Outcomes:
• Receiving services while child is being taken care of
**Note that COVID-19 has affected all childcare

Priority Area 4: Ending Stigma

Prioritized Objectives and Strategies:

Objectives	Prioritization Order
Objective 4.1: Inclusion	2nd
Objective 4.2: Advocacy and Education	1st

Objective 4.1: Inclusion:

Prioritization Order	Strategies
1st	Strategy 4.1.3: Ensure Future Medical Providers are Adequately Trained on Gender Affirming
2nd	Strategy 4.1.2: Incentivize Participation
3rd	Strategy 4.1.1: Respectful and Inclusive Language

Objective 4.2: Advocacy and Education:

Prioritization Order	Strategies
1st	Strategy 4.2.3: Establish Leadership of Community Advocacy Council
2nd	Strategy 4.2.1: Implement the People Living with HIV Stigma Index
3rd	Strategy 4.2.2: Empowering and Uniting Through Story Sharing and Promoting Community

Fast-Track Cities Action Plan Priority Area 4: Ending Stigma
Purpose: Why is the work important to you and the larger community?
Objective 4.1: Inclusion
• For awareness and informing the community • Helps to reduce potential discrimination • Help normalize HIV testing, living with HIV, accepting PREP and PEP services • Improve mental health by reducing stigma and isolation • Sexual Wellness • Integrating sexual health care • Normalize in health care settings • Helps to explore and build resources • Helps with treatment options
Objective 4.2 Advocacy and Education
• It reduces the stigma that's associated with HIV screening • It fosters awareness and informs people about services and topics. It can reduce fear. • Decrease the violence against the community • Helps to identify the various determinant of health for those particular populations that we serve • It educates parents and young people on facts about HIV/AIDS and testing • Promotes the health of the community at large and explains why we serve them • Consider education in provider context as well, unless provider is educated on population they serve, they are unable to provide the services to the people who need HIV care the most. • Gives them a better understanding of the needs of the community as a whole. Status neutral • It educates the community on PrEP and PEP access • Clarify HIV services to include HIV testing, status neutral referrals to Prevention and HIV care services • Help build more community advocates to foster the abilities to help them find purpose by getting involved impacting community health • Influences overall knowledge and behavior of health and wellness. The more knowledge acquired, more ability to take an active role in healthcare in general. • Build and increase trust in the community
Strategy 4.2.3: Establish Leadership of Community Advocacy Council
Practices:
➢ Access the current leadership or Community Advocacy Council to determine what resources already exist - part 1

Outputs:
• Recruiting members of the community to participate
• Developing a distribution list of current community leadership advocacy council
• Having a wider reach for identifying community councils and leaderships to speak for populations that have smaller numbers
• Asking already participants to make nominations or provide names of people who have the capacity to help
• List of ACTIVE resources for education, advocacy and access to care on HIV/AIDS in Travis County
• Have people identify key informants
• Identify gaps of resources
• Recruiting members of the community to participate
• Developing a distribution list of current community leadership advocacy council
• Having a wider reach for identifying community councils and leaderships to speak for populations that have smaller numbers
• Asking already participants to make nominations or provide names of people who have the capacity to help
Outcomes:
• Increase access to accurate medical information, health care and policy advocacy on HIV/AIDS
• More engaged community actively working together to end the epidemic.
• Number of people regular receiving emails through our distribution list
▪ "Email open rate" and "Open and response rate" (ie. link click throughs)
▪ Those that we do know, can open and receive emails and add people that we don't know who can be brought to the table
• The resources needed are identified
➢ Access the current leadership or Community Advocacy Council to determine what resources already exist - part 2
Outcomes:
• Provide value and be intentional in outreach efforts; be people centered
➢ Leverage current leadership or community advisory council to be leaders in advocacy for ending stigma in the healthcare setting
Outputs:
• More systems designed to support gender affirming services that are specific to HIV for trans masculine people (currently a huge gap in services for this population)- this may involve changing the narrative and language around how we handle engagement
• Workshops/presentations by potential young leaders (adolescents -up 24 years of age) to health care providers and council leaders on challenges experienced by young people diagnosed with HIV and challenges experienced by the LGBTQIA community (can be done with non-profit groups like Changing Lives, like a play or real stories and experiences of young people with stigma)
Outcomes:

• increasing awareness, education, and tools for communities not historically considered high risk populations
➢ Provide training around Transgender, sexual minorities and gender affirming care.
• Provide value and be intentional in outreach efforts; be people centered
➢ Leverage current leadership or community advisory council to be leaders in advocacy for ending stigma in the healthcare setting
Outputs:
Strategy 4.2.1: Implement the People Living with HIV Stigma Index
Practices:
➢ Coordinate with HIV Planning Council's efforts to support bringing the index to UT Austin and Huston-Tillotson and other academic institutions
Outputs:
• Table with outreach materials and implement the survey
▪ Drive in movies during this pandemic time
• Coordinating with Dell Medical School and Stigma Index
• Implementing electronic surveys
Outcomes:
• Feedback from individuals
• Broader community involvement and engagement
Strategy 4.2.2: Empowering and Uniting Through Story Sharing and Promoting Community
Practices:
➢ Create or add to calendar of local events within our community
Outputs:
• Social media, i.e. facebook, twitter, instagram
Outcomes:
• More people would be informed for participation and involvement
➢ Support these events by promotion and involvement
Outputs:
• Support the Hill Country Ride for AIDS
• Support AIDS Walk
• Story sharing series
▪ Collaborating on multiple methods such as blogs, in writing, in video, podcasts. Hear the stories from people that are doing well.
• Audio recordings and video production
• Leveraging existing blogs and podcasts.

▪ i.e. Achieving Together, CHE podcasts, Story Corps, APH radio station
Outcomes:
• More outreach
• Promotional material with positive story lines
➢ Supporting the efforts of utilizing the stigma index
Strategy 4.1.3: Ensure Future Medical Providers are Adequately Trained on Gender Affirming
Practices:
➢ Develop or identify a training or curriculum focused on Transgender, sexual minorities and gender affirming care.
Outputs:
• Implement sexual health curriculum and trainings.
• Training focused on providers or future providers and incentivizes providers to participate.
• On-going quarterly training with evaluation component
Strategy 4.1.2: Incentivize Participation
Practices:
➢ Identifying key populations to ensure they are included in events and decision making.
Outputs:
• Power mapping of key groups updated yearly
• We need to bring family planning organizations into the fold to better target populations that are slow to adopt PrEP and are disproportionately impacted by HIV.
• We also need to bring in organizations that focus on sexual health with cisgender/heterosexual/women of color.
• We need to make the Austin transgender community more visible and bring members to the table.
• When engaging the community, provide gift cards, meals, or mileage reimbursement
• Surveys, round table discussions, and advisory committees with members who represent the populations you want to reach
Outcomes:
• Get the LGBTQIA+ Black BIPOC community engagement response up to at least 25% participation in events and action increased before 2022
• Increased participation in planning groups such as FTC, HIV Planning Council from groups which are trust leaders for those populations experiencing disparities.
• Increased awareness of planning efforts within same organizations and communities.
• By the end of next year a non-ASO organization adopts a campaign to expand HIV education/prevention/testing/treatment.
• At least 2 nontraditional partner organizations participate in planning activities by June 2021. By June 2021 we have a viable incentive to engage parents in planning activities - childcare.

• See a significant increase in trans individuals, people of color, and cisgender men and women who are screened for HIV and linked to status-neutral care
➢ Identifying resources and funding to incentive participation of key populations.
Outputs:
• Pursue foundation funding to support incentives - work with corporate sponsors (Avita Pharmacy/Walgreens/CVS)
• Develop stipends for participants under any funding. For instance create an emerging leader position or program and appoint a representative from key populations to participate regularly and use funding to support their time.
• Allow organizations to have an opportunity to be the topic of conversation for a function or event. Highlight their work.
• Stipend level payments and giveaway incentives direct to leadership in organic engagement positions for use in community calls to action in their own way. Give the group leads the budget freedom to be creative with the funds. Collaborate with groups already in action and effective.
• Knowledge is a tool for motivation. Campaigns educating folks on the disproportionate impact HIV has on black MSM, black cis women, and the trans community will motivate grassroots-level participation in ending the epidemic.
• Looking to provide services that motivate participation such as childcare and transportation. Studying what barriers to participation are actually occurring then addressing them.
• Connecting with existing change
Outcomes:
• Per the CDC opt-out guidelines, making sure every individual is screened for HIV at least once in their lifetime (and at least once per year for more at-risk patients)
• Decrease the reports of poverty level earnings in the trans community by connecting them to higher level pay opportunities within these programs (get us closer to cisgender numbers of under or unemployed)
• By September 2021 create a funding prospecting blast to post on the SharePoint and push to users
• By September 2021 recruit sponsors to host Fast track cities meetings
• By 2022, once report which has top five recommendations of how to better encourage participation for groups experiencing disparities. At least two public forums focused on community based organizations or held at CBO meetings.
➢ Implement and engage peer education
Outputs:
• Create a Fast-Track Cities Student workgroup or chapter to include participants from all colleges/universities in Austin, TX.
• Identify what universities are doing related to COVID-19
Outcomes:
• Increase condom distribution sites in the community and have condom distribution sites expand to include masks and hand sanitizer for covid prevention.
• Have representatives from 3 of the 4 universities in austin participate in Fast Track cities

• A permanent internship program with 2 interns per semester
▪ Interns would (ideally) pursue full-time careers in sexual health/public health
Strategy 4.1.1: Respectful and Inclusive Language
Practices:
➢ Develop/find appropriate language document (Glossary of Terms) and share outputs
Outputs:
• Each of our respective organizations should collaborate closely with HR, our health care providers, and other key staff to disseminate meaningful, impactful training on inclusive language.
▪ This includes people-first language, gender-inclusive language, and other nuances in communication of which staff may not be aware
• Work with various organizations and review terms used within those organizations that don't appear inappropriate
• Create a community campaign that brings in all organizations (APH, Kind, CHE, CUC, AshWell, ect.) Have resources posted online with all organizations. Increase certified health equity index (HEI) organizations
Outcomes:
• Trauma-informed content
• Reach more members of the community. Especially those members who may have previously felt excluded by the public health care system
• Opportunity to improve cultural competency
• Increase inclusiveness/participation with all groups represented
• Providers better informed on respectful and inclusive terms

Priority Area 5: Cross Cutting Strategies

Objectives and Strategies:

Objectives
Objective 5: Cross Cutting

Objective 5: Cross Cutting:

Strategies
Strategy 5.1: Peer Advocate Program
Strategy 5.2: Being Grant Ready
Strategy 5.3: Universal Messaging
Strategy 5.4: Provide Diversity Training for the Workforce
Strategy 5.5: Normalize HIV Testing

Cross cutting strategies have not yet been voted on for prioritization

Fast-Track Cities Action Plan Priority Area 5: Cross Cutting
Purpose: Why is the work important to you and the larger community?
Objective 5: Cross Cutting Strategies
Strategy 5.1: Peer Advocate Program
Practices:
➢ Gather models of peer advocate programs from other disease states (cancer)
➢ Develop system of peer navigators and support for newly diagnosed individuals to help them get into and stay in care.
Strategy 5.2: Being Grant Ready
Practices:
➢ Compile a list of Request for Proposals (RFPs) to share with organizations
Strategy 5.3: Universal Messaging
Practices:
➢ Establishing city-wide participation, consistent information, and a universal message (not organization-centric)
Strategy 5.4: Provide Diversity Training for the Workforce
Practices:
➢ Identify areas of diversity to address; with special consideration to equitable and inclusive language
Strategy 5.5: Normalize HIV Testing
Practices:
➢ Activities will give special consideration to efforts around Ending Stigma and Prevention

Acknowledgements of Participants and Organizations:

Thank you to the Austin/Travis County community that informed this Fast-Track Cities Initiative. We value your collective insights and professional knowledge that guide this important work.

The dedication and expertise of the following agencies and people have made Austin/Travis County Fast-Track Cities a collaborative and engaging initiative that will lead our planning efforts moving forward. Thank you!

Executive Committee

Name	Organization
Akeshia Johnson-Smothers	APH
Ana Lidia Almaguel	Travis County Health and Human Services
Anjelica Barrientos	APH
Barry Waller* (Testing and Rapid Linkage Co-Chair)	HIV Planning Council
Chip House	AVITA Pharmacy
Christopher Hamilton	Texas Health Action
Dr. Colette Burnette* (Ending Stigma Co-Chair)	Huston-Tillotson
Colt Woods* (Prevention Co-Chair)	Walgreens Specialty Pharmacy
Danielle Houston	Gilead Sciences
David Evans	Integral Care
Donald Wilkerson	St. David's
Earl Maxwell	St. David's Foundation
E Marks	St. David's Foundation
Emma Sinnott	CommunityCare
Greg Hartman	Seton
Jaeson Fournier	CommunityCare
Jay Fox	Baylor Scott and White
Jerry Purcell	AVITA Pharmacy
Juan Troy* (Former Testing & Rapid Linkage Chair)	CHE
Larry Wallace	Central Health
Lesley Varghese	City of Austin, Mayor's Staff
Maninder Kahlon	Dell Medical
Mark Erwin* (Prevention Co-Chair)	Texas Health Action

Mel Mcleroy	Texas Health Action
Nicolas Yagoda	CommunityCare
Norman Chenven	Austin Regional Medical Clinic
Paul Scott* (RRVL Chair)	Vivent Health
Richard Waite	CommUnityCare
Ronald Pierson	Gilead
Salman Ghassan	Austin Diagnostic Clinic
Scott Lyles* (Testing & Rapid Linkage Co-Chair)	APH
Sherri Fleming	Travis County Health and Human Services
Stephanie Hayden	APH
LJ Smith	HIV Planning Council
Dr. Valerie Agee* (Ending Stigma Co-Chair)	Center for Health Empowerment

Core Committee

Name	Organization
Adrienne Sturrup	APH
Akeshia Johnson-Smothers	APH
Alberto Barragan	Vivent Health
Aliza Norwood	CommunityCare/Dell Medical School
Ana Lidia Almaguel	Travis County Health and Human Services
Barry Waller* (Testing & Rapid Linkage Co-Chair)	HIV Planning Council
Brandon Wollerson	Texas Health Action
Brenda Mendiola	APH
Cassandra DeLeon	APH
Chip House	AVITA Pharmacy
Christopher Hamilton	Texas Health Action
Colette Burnette* (Ending Stigma Co-Chair)	Huston-Tillotson
Colt Woods	Walgreens Specialty Pharmacy
Cynthia Brinson* (Key Opinion Leader)	Red River Family Practice
Danielle Houston	Gilead Sciences
Darrell Barnett	APH
Emily Johnson	Integral Care
Emma Sinnott	CommunityCare
Flor Hernandez-Ayala	APH
Glenn Selfe	APH
Hailey de Anda	APH
Isabel Clark	DSHS: HIV/STD Prevention and Care Branch
Janice Gold	HTU
Jenna Burt	DSHS
Jenny McFarlane	DSHS
Jaseudia Killion	APH
Jessica Haskins	Walgreens Specialty Pharmacy
Jessica Howard	Gilead Sciences
Juan Troy* (Former Testing & Rapid Linkage Chair)	CHE
Laura Still	APH

Marcus Sanchez* (Social Media Co-Chair)	THA/Kind
Mark Erwin* (Prevention Chair)	Texas Health Action
Megan Cermak	Central Health
Nicholas Yagoda	CommUnity Care (David Powell Clinic)
Paul Scott* (RRVL Chair)	Vivent Health
Phillip Schnarrs	UT Austin
Rashana E. Raggs	APH
Renue Jones	APH
Richard Waite	CommUnityCare
Ruth Dalrympe	APH
Scott Lyles* (Testing & Rapid Linkage Co-Chair)	APH
Stephanie Eaton	APH
Taylor Stockett* (Social Media Co-Chair)	Hill Country Ride for AIDS
Ted Burton	Central Health
Vanessa Sarria	Cardea
Valerie Agee* (Ending Stigma Co-Chair)	Center for Health Empowerment
Laura Still	APH

Austin/Travis County Fast-Track Cities Workgroup Members

Priority Area 1: Prevention

Workgroup Members

Name	Organization
Alberto Barragan	Vivent Health
Anjelica Barrientos	APH
Antonio Menchaca	Vivent Health
Aurelia Lopez	APH
Cassandra DeLeon	Austin Public Health
Christopher Hamilton	Texas Health Action

Claire Adkins	Texas Health Action
Colt Woods* (Co-Chair)	Walgreens Specialty Pharmacy
Cynthia Brinson	Red River Family Practice
Danciel C. Montoya	Gilead Sciences
Danielle Houston	Gilead Sciences
Elijah Allen	Texas Health Action
Flembrick Wright	Vivent Health
Hailey de Anda	APH
Halana Kaleel	Austin Public Health
Heran Kidane	Gender Health Equity Lab at UT Austin
James Baker	APH
Jenna Burt	DSHS
Jeremy Teel	Texas Health Action
Jessica Haskins	Walgreens Specialty Pharmacy
Jessica Howard	Gilead Science
Juan Troy	CHE
L Young	CHE
Laura Still	APH
Lee Miranda	unknown
Mel Mcleroy	Texas Health Action
Mark Casstevens	Vivent Health
Mark Erwin* (Co-Chair)	Texas Health Action
Mehran Massoudi	US Dept. of Health and Human Services
Melanie Pokluda	Texas Health Action
Meredith Vinez	Texas medical association
Miguel Sierra	CHE
Nicole Schmid	APH
Paul Scott	Vivent Health
Peter Magallanez	APH
Joanna	CHE
Rashana E. Raggs	APH
S.D. Butler	CHE
Samuel Goings	Texas Health Action
Sandra Chavez	Ashwell

Sandra Ford	AIDS Healthcare Foundation
Sarah Alvarado	CommUnityCare
Scott Lyles	APH
Steve	CHE
Steven Tamayo	Texas Health Action
Susan Campion	AIDS Services of Austin (Vivent Health)
Valerie Agee	Center for Health Empowerment
Virginia Pearson	HTU

Priority Area 2: Testing & Rapid Linkage

Workgroup Members

Name	Organization
Akeshia Johnson-Smothers	APH
Alberto Barragan	Vivent Health
Ana Herrera	AIDS Services of Austin (Vivent Health)
Anastassia Mitchell	Central Health
Anjelica Barrientos	APH
Aurelia Lopez	APH
Barry Waller* (Co-Chair)	HIV Planning Council
Brandon Wollerson	Texas Health Action
Brenda Mendiola	APH
Bruce Gilbert	ViiV Healthcare
Chip House	AVITA Pharmacy
Colt Woods	Walgreens Specialty Pharmacy
Danciel C. Montoya	Gilead Sciences
Danielle Houston	Gilead Sciences
Darren McCulloch	ACARE Program
Elijah Allen	Texas Health Action
Emily Johnston	Integral Care
Emma Sinnott	CommunityCare
Evelio (Ricky) Astray-Caneda III	Friends of the David Powell Clinic

Hailey de Anda	APH
Heather Hill	CHE
Isabel Clark	DSHS HIV/STD Prevention and Care Branch
Jason Craven	Johnson & Johnson
Jenna Burt	DSHS
Jeremy Teel	Texas Health Action
Jessica Howard	Gilead Sciences
Juan Troy* (Former Chair)	CHE
Laura Still	APH
Martha Breck	Vivent Health
Mehran Massoudi	US Dept. of Health and Human Services
Meredith Vinez	Texas Medical Association
Nancie Putnam	APH
Paul Hurlburt	CommUnityCare
Roy Wenmohs	Integral Care
Samuel Goings	Texas Health Action
Sandra Ford	AIDS Healthcare Foundation
Sarah Alvarado	CommUnityCare
Scott Lyles* (Co-Chair)	APH
Stacy Kanehl	ViiV Healthcare
Susan Campion	Vivent Health
Vanessa Sarria	Cardea
Laura Still	APH

Priority Area 3: Retention, Re-engagement & Viral Suppression

Workgroup Members

Name	Organization
Ana Herrera	Vivent Health
Andrea Sosa	Vivent Health
Andrew Martin	Vivent Health
Anjelica Barrientos	APH
Anthony Kitzmiller	APH

Barry Waller	HIV Planning Council
Bart Whittington	Texas Health Action
Benjamin Steele	Vivent Health
Brandon Wollerson	Texas Health Action
Caitlin Simmons	Vivent Health
Chip House	AVITA Pharmacy
Claire Adkins	Texas Health Action
Colt Woods	Walgreens Specialty Pharmacy
Danciel C. Montoya	Gilead Sciences
Danielle Houston	Gilead Sciences
Darren McCulloch	APH
Elijah Allen	Texas Health Action
Emma Sinnott	CommunityCare
Evelio (Ricky) Astray-Caneda III	Friends of the David Powell Clinic
Hailey de Anda	APH
Jeremy Teel	Texas Health Action
Jessica Haskins	Walgreens Specialty Pharmacy
Juan Troy	CHE
Dr. Julie Zuniga	The University of Texas - School of Nursing
Leah Graham	Vivent Health
Lynne Braverman	Vivent Health
Mark Erwin	Texas Health Action
Marlene Rodriguez	CommUnityCare
Melissa Rios	Vivent Health
Meredith Vinez	texas medical association
Nancie Putnam	APH
Norah Maposa	Vivent Health
Paul Scott* (Chair)	Vivent Health
Rachel Luebe	Vivent Health
Rashana E. Raggs	APH
Richard Waite	CommUnityCare
Roy Wenmohs	Integral Care
Sandra Chavez	Ashwell
Sandra Ford	AIDS Healthcare Foundation

Sarah Alvarado	CommUnityCare
Scott Lyles	APH
Stephanie Eaton	APH
Stephanie Guerra	Vivent Health
Tarie Beldin	Vivent Health

Priority Area 4: Ending Stigma

Workgroup Members

Name	Organization
Alan Washington	APH
Alberto Barragan	Vivent Health
Ana Lidia Almaguel	Travis County Health and Human Services
Anjelica Barrientos	APH
Anthony Kitzmiller	APH
Aurelia Lopez	APH
Ben Soriano	APH
Brandon Wollerson	Texas Health Action
Chase Calvert	UT Dell School of Medicine
Claire Adkins	Texas Health Action
Dr. Colette Burnette* (Co-Chair)	Huston-Tillotson
Danciel C. Montoya	Gilead Sciences
Darrell Barnett	APH
Dorothy Jenkins	Austin Outreach
Elijah Allen	Texas Health Action
Emily Johnston	Integral Care
Emma Sinnott	CommunityCare
Ena Ganguly	Allgo
Evelio (Ricky) Astray-Caneda III	Friends of the David Powell Clinic
Fernanda Santos	APH
Hailey de Anda	APH

Hector Campos	Cardea
Isabel Clark	DSHS HIV/STD Prevention and Care Branch
Janice Gold	HTU
Jaseudia Killion	APH
Jeremy Teel	Texas Health Action
Joe Anderson Jr	Texas Health Action
Juan Benitez	Vivent Health
Juan Troy	CHE
Lane Strickland	Vivent Health
Laura Still	APH
Mehran Massoudi	US Dept. of Health and Human Services
Norah Maposa	Vivent Health
Paul Scott	Vivent Health
Peter Magallanez	APH
Pooja Srikanth	UT Dell School of Medicine
Renue Jones	APH
Rashana E. Raggs	APH
Sandra Chavez	Ashwell
Sandra Ford	AIDS Healthcare Foundation
Sarah Alvarado	CommUnityCare
Savannah Low	Vivent Health
Scott Lyles	APH
Shelley Lucas	DSHS
Steph Adler	Vivent Health
Stephanie Hayden	APH
Sylvia Lopez	Vivent Health
Tarik Daniels	What's In the Mirror?/CHE
Taylor Stockett	Hill Country Ride for AIDS
Dr. Valerie Agee* (Co-Chair)	CHE
Virginia Pearson	HTU