Rural HIV/AIDS Prevention and Treatment Webinar 11/2/17

Kristine Sande: Good afternoon, everyone. I'm Kristine Sande and I'm the program director of the Rural Health Information Hub, I'd like to welcome you to today's webinar on rural HIV/AIDS prevention and treatment.

Before we begin the webinar, I just need to run through a few housekeeping items. We do hope to have time for your questions at the end of the webinar. If you do have questions for our presenters, please submit them at the end of the webinar using the Q&A section that will appear on the lower right-hand corner of the screen following the presentation.

We have provided a PDF copy of the presentation on the RHIhub website and that's accessible through the URL that's on your screen right now or by going to the RHIhub webinar page at www.ruralhealthinfo.org/webinars and clicking on today's presentation. If you do decide to go download those slides during the webinar, please don't close this webinar window or you'd have to log back into the event.

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Now, it is my pleasure to introduce our speakers for the webinar.

Alycia Bayne will kick off today's webinar, Alycia is a senior research scientist at the NORC Walsh Center for Rural Health Analysis. She will introduce the rural HIV and AIDS prevention and treatment toolkit that's available on the RHIhub website.

Our next speaker, Daniel Wakefield, is the interim director of the Ursuline Sisters HIV/AIDS Ministry in Youngstown, Ohio. He will share details about the ministry's successful clinical and nonclinical strategies to reach people and to help those they serve achieve better health outcomes.

Finally, Lisa McKeithan is the director of Positive Life and the North Carolina Rurally Engaging and Assisting Clients who are HIV positive and Homeless or NC-REACH Project at CommWell Health, which is a federally qualified health center in Dunn, North Carolina. Lisa will share innovative strategies to improve patient outcomes and enhance qualities for individuals living with HIV in rural communities.

Now, I will turn it over to Alycia.

Alycia Bayne: Thank you, Kristine, and thank you all for joining the webinar. Today, I'm very happy to be able to introduce the Rural HIV/AIDS Prevention and Treatment Toolkit. The toolkit was developed as part of the Rural Health Outreach Tracking and Evaluation Program, which is funded by the Federal Office of Rural Health Policy. The project is conducted by the NORC Walsh Center for Rural Health Analysis in partnership with the University of Minnesota Rural Health Research

Center. We're also working with the National Organization of State Offices of Rural Health and the National Rural Health Association to disseminate findings from this study. The Rural Health Outreach Tracking and Evaluation Program is designed to monitor and evaluate the effectiveness of different programs that are funded under the Outreach Authority of Section 330A. These grantees seek to expand access to care, coordinate resources, and improve quality. Grantees work as part of the consortium with different providers, schools, tribal health programs, and community-based organizations.

A key focus of our work has been on establishing a rural evidence base, which includes developing evidence-based toolkits based on the experiences of grantees and other rural communities. Our toolkits have three aims. First identifying evidence based on promising programs, studying the experiences of these programs to figure out what's working in rural communities and why, and then disseminating best practices from their experiences through evidence-based toolkits so that future grantees and other rural communities can learn from these experiences and replicate them.

We recently completed a toolkit on evidence-based practices for preventing and treating HIV/AIDS in rural communities. HIV prevalence rates in some rural communities are nearing the rates of more populated urban centers. One recent example of HIV in rural communities made headlines last year when a rural town in Indiana had 190 new HIV cases in a community of 4,000 people. This outbreak was linked to injection drug use of opioids. In addition to the outbreak in rural Indiana, rural communities in Southern states have also seen notable increases in new infections since 2008. Still, the effects of HIV/AIDS made be underestimated in rural communities due to a lack of screening, and that not everyone agrees to be screened.

Many factors converge to complication treatment and prevention in rural communities. These include stigma that prevents people from being tested or treated, challenges in seeking services privately in a small community, a lack of awareness that HIV is a problem in rural communities, limited access to providers who specialize in caring for people with HIV/AIDS, and cost. The Ryan White program provides subsidizes or free treatment, but some rural communities do not have a Ryan White provider, making cost of treatment a barrier.

Many rural communities have developed innovated programs to prevent new infections and provide treatment for people living with HIV/AIDS. These programs aim to increase access to treatment and support, increase collaboration among organizations in the community, provide education and reduce stigma. Their experiences suggest promising practices that can be adapted in other communities. We developed a toolkit to share these experiences and evidence-based in promising practices and resources.

Our activities including reviewing the literature and grantee applications, conducting interviews with programs, including Ryan White grantees and

experts in the field, and then developing a toolkit that includes resources about how to implement programs focused on HIV/AIDS prevention and treatment. This toolkit is not available if you go to the Rural Health Information Hub community health gateway website.

So next I want to show you how to navigate through the toolkit. This is a snapshot of the main page. The toolkit is organized in to different modules so you can easily find information. So if you take a look at the menu on the left-hand side of the screen, you will see that we have a content for planning programs, implementing, evaluating, sustaining and disseminating programs in rural communities.

Each module contains information and resources. There's also a program-clearing house that contains information about promising rural health programs if you want to find out more. Module two is our programs model section, and that's what I really want to focus on now. It describes evidence-based and promising program models that are implemented in rural communities. So next I'm just going to briefly describe each model, and then you can go to the toolkit to find more information about models that you might be most interested in.

The first set of models focus on preventing new infections and how public health agencies and community organizations can prevention new infections. First behavioral interventions can promote behavior change at the individual, group, or community level to reduce the risk of HIV infections, and comprehensive risk-reduction for adolescents is one example. Prevention with positives reduces HIV incidents by engaging people living with HIV as active participants in prevention efforts. Preventing transmission through the use of HIV medications, which is known as comprehensive pre-exposure prophylaxis or Pr-EP, is when HIV negative individuals take antiretroviral medication to prevent transmission. Codom distribution programs may be available at health departments, clinics, bars, or clubs and other organizations. Education about condoms is another mechanism to prevention HIV transmission. Harm-reduction is a strategy that aims to reduce the harms associated with the use of drugs, including the risk of acquiring HIV or other blood-borne infections, and these can include syringe-exchange programs. And finally socially marketing interventions use strategies to target specific populations, such as high-risk adolescents or other populations that may be difficult to engage in prevention.

Next are models for identifying people who are unaware of their HIV status. Approximately 15% of people living with HIV in the US did not know they were infected. People who test positive during screening can be linked to treatment and counseling services, so these models are very important. The first is routine HIV testing and treatment for people age 15-65 in healthcare settings. This includes urgent care settings, primary care offices, and the screening can be provided on an opt out basis. It can reach people like pregnant women, for example, who may not otherwise seek out HIV testing, but are visiting the clinic for care. In interventions that use provider-referral partner notification, people with HIV voluntarily disclose information about partners. Providers or other

public health professionals notify partners that they were potentially exposed to HIV. And then finally community HIV testing and screening can help reach people who are at risk, and maybe less likely to visit a clinic for a test. These programs take place outside the clinic setting in the community.

Once people with HIV infections have been identified, it's important that they receive high-quality care. In addition, these programs can include efforts to connect people to treatment support resources and education. Two models that I wanted to talk about are TeleHealth and other technologies that can improve access to care for people living with HIV/AIDS. TeleHealth can connect people to specialists or other providers. Technology is also being used to deliver trainings and support to providers serving patients in rural areas. Provider education and training can also help prepare rural healthcare providers to address complex cases, provide peer-learning opportunities, and offer specialized recommendations for providers that may have a small patient population living with HIV/AIDS.

And then finally models to improve retention adherence and management. Medication adherence is a major determinant of disease progression and health outcomes. Adherence may be difficult depending on factors including housing, employment, substance use, mental health, transportation to care, and providers and other types of organizations can play an important role in helping people access and adhere to treatment. Models include case management and patient navigation programs that are designed to increase retention in care. Services can include connecting patients to care and facilitating access to transportation, medication, counseling and other services. One-stop HIV/AIDS programs provide prevention and treatment as well as other non-clinical services like food and housing assistance, to provide a comprehensive support system. And then medication management programs are designed to increase medication adherence. These programs can increase privacy by mailing medications directly to the patient and also involving local pharmacy teams as care coordinators.

I just want to conclude with some of the lessons that we learned in developing this toolkit. The first is that stigma is really one of the greatest barriers to treatment in rural communities. People are concerned that their family, friends, or acquaintances might learn that their seeking prevention or treatment services and therefore they do not seek help. Rural programs are trying to address these concerns by co-locating HIV services with other services that are not HIV-specific, and that are located in places that people frequently go. Rural HIV/AIDS programs must consider the needs of the whole person. Programs reported the importance of social support services for people living with HIV/AIDS to ensure that people stay in care and take their medication. Many programs provide services related to nutrition, education, transportation, housing, and financial assistance. People living with HIV/AIDS in rural areas may be especially likely to experience challenges accessing and staying in care. Barriers include a lack of access to transportation, or not being able to access services in their community. Peer-navigators can play an important role by

working with individuals who are living with HIV/AIDS and are struggling to adhere to treatment.

And then finally, patient-centered strategies are vital to creating a safe environment for people seeking treatment. These practices can include providing culturally and linguistically appropriate services, providing education and using positive encouragement. Our toolkit includes considerations for implementing programs for many different populations in rural communities. So I urge you to check it out.

Thank you so much for your time today. Here's our contact information. I want to acknowledge the wonderful work of the team that worked on this toolkit and now I'm going to turn it over to Daniel Wakefield.

Daniel Wakefield: Thank you very much. I appreciate it, and I'm very excited to be here presenting to you guys this afternoon. My name is Daniel Wakefield. I'm the interim director of the Ursuline Sisters HIV/AIDS Ministry. We are located in Youngstown, Ohio, which is in northeast Ohio. It's about equidistant between Cleveland, Ohio and Pittsburgh to kind of give you some sense there of our geography. And so, our ministry primarily serves our tri-county area of Mahoning County, Trumbull County, and Columbiana Counties, although it also includes some individuals who live outside of that area as well, in some of the more rural parts of our region.

Our particular organization got started actually by the Ursuline Sisters in Youngstown, Ohio, and the Ursuline Sisters had community presence dating back to 1874 in our area and they started a variety of different types of programs and different types of ministries throughout their history in our community. Primarily at first it focused a lot on education, and so they began the formation of an all-girl's high school, Ursuline High School, as well as Ursuline Preschool and Kindergarten, and then they also expanded later on to include other programs focusing on disadvantaged women and children, which is called Beatitude House. Then in 1993 started our HIV/AIDS ministry.

The beginning of our HIV/AIDS ministry actually got its start because of four Ursuline Sisters had experienced working in the community with HIV positive individuals. What they began to notice is that the people who were HIV positive typically felt very isolated. They felt alone. In many cases they were not treated very kindly in healthcare settings or in other settings in which the Sisters associated with them, and so what they decided to do was begin a ministry that really started as a support group. It was an effort to try to meet the needs of the people that they interacted with and worked with, to try to provide them with a sense of community, a sense of safe-space, and a sense of feeling welcomed and loved. So that's kind of where we got our start initially, and since 1993 our ministry has expanded to include programs to include men, women, and children living with HIV or AIDS.

So here's kind of a timeline of our ministry and how it got its start. So you can see back in 1993 was officially the start, and then what we see is the addition of programs throughout the years. As people began coming to the support group that the Sisters established in 1993, what they saw was people began to say, "Well, it would be really nice if maybe we started to feed people, or provided a meal for people." That would lead to the next type of programs that they developed. Really the Ursuline Sisters were really great at doing that. Of really listening to what the needs were, and responding to those needs, and trying to identify those gaps.

As part of my presentation today, I'll kind of take a look at these different programs that comprise our ministry and explain a little bit more about them in detail. One of the earliest programs is what we call "Our Café." Really this kind of was the evolution of the support group. Our support group in 1993 was really for individuals who were HIV positive and their loved ones, and it consisted really primarily just of a support group. Once they divided to add the component of providing a meal to people, we made things established a little more regularly. Our Café is held once a month. It's held the third Saturday of the month, and individuals who are HIV positive are invited to attend. When they arrive, they basically ... it serves the purpose of not only being a social support group, but also again we have a congregate meal together.

So as people arrive they get to interact with one another once a month, they get to talk about any concerns that they have, they get to enjoy a warm meal. At this particular event we also distribute items from our pantry. So we distribute two bags of groceries each month to the individuals to attend as well as one bag of household products or personal hygiene products to them. So they get to take that home with them. Again, that's primarily because although we are an HIV/AIDS ministry, we do primarily serve individuals who are living in poverty. We're trying to address all of their needs, not just specifically their needs associated with HIV.

A common quote that we'll hear with our Cafés by the people who attend is that they enjoy having the support of friends, they know that they're not alone, that they know there's a safe-space because as many of you in the field of HIV/AIDS know, many people chose not to tell maybe their family members, their parents, their brothers and sisters, that they're HIV positive. Both for fear of rejection or just because of shame or because of guilt. So for many of them, they carry a sense of burden with them, so having a safe-space where they know they're accepted, where they know that they're loved, they can be themselves, they can let their guard down a little bit, has really kind of assisted and helped us.

What's also neat about our Café is our staff members also attend. It kind of provides a different light for them to interact with the people served by our ministry. Rather than just be specifically just a clinical setting, this provides them an opportunity to kind of engage and interact with clients on another level as well.

So as people began to come to our Café, what we saw is that in many cases they began to bring their children. That was because they didn't have child care options and so we quickly identified that as something we needed to address. In 1997, we began the Children's Program. And the Children's Program at first was pretty much exclusively at the Café. So as people brought their children in, we would separate the children from the adults and we would have games and activities for the children as the adults were having their support group and their meal together. As we did that, we quickly identified that a lot of the children that we were working with had a lot of unmet needs. So that developed into a full-fledged Children's Program.

Our Children's Program is for children who are infected or affected by HIV or AIDS. So in some cases it might be the children in the program have a sibling or their parent is infected. In some cases it is the child themselves. During the school year we do tutoring three nights a week. We actually provide transportation, we have a ministry van. We go and pick up the children either from their home or their school, and we bring them to our programming sight and we do tutoring three nights a week with them. The tutoring really consists a lot of times of homework help or assistance like that, but we also provide dinner. So we serve kind of a dinner family-style together each of those nights.

We also have a summer program during summer that we try to provide field trips and special events with them as well, because again, we recognize that ... And actually all of our children who are a part of our children's program live in poverty. So it's 100% of the children in our program live in poverty. And so because of that, as we all know or might be aware, in the poverty sometimes your world is really confined to the street you grow up on. If you don't adequate transportation, if your parent's working multiple jobs, if you just lack the financial resources ... so part of our Children's Program really strives to get kids out in the community, to show them museums, to show them special events, take them to our local Youngstown State University games, things like that. Really provide kind of those opportunities for them.

One quote that I always like came from a young woman who went through our program. Our tutoring program is pretty much K-12, so we do have some children that come to us in kindergarten and stay through twelfth grade in tutoring, and she was one of them. She left after twelfth grade and I ran in to her and she said, "You know Dan, it was like Christmas every day there." And I thought, that's such a nice sentiment to the ministry and to the programs but it also reminded me too of things that I might take for granted personally. Things like having a meal, having someone help me with my homework, were things growing up that I personally took for granted. But for these kids it really does mean a lot to them.

A newer phase of our ministry is our housing program. Our housing program came about because of as we were serving people in the clinic, we began to see that more and more people had housing instability or histories of homelessness. Again there was kind of an unmet need there. In 2015, we actually expanded

our programming to include housing for HIV positive individuals and families. Currently we have three scattered-site houses, we have one emergency shelter, and one four-unit apartment complex I'll show you on the next slide. We have a photo of our apartment complex. It was a newly-constructed one. This also has tried to identify what the needs are of our community, what the needs are within the population that we're serving and then try to address those needs as well. So our housing program is the newest program of our ministry.

And then of course we have our clinic. Our clinic got its start because the ministry was actually approached by some local officials because our local HIV clinic was closing. People asked if the Ursuline Sisters would actually consider opening a clinic. Our clinic opened in 2001. It's an adult and pediatric HIV clinic. At our clinic we do testing, counseling, case management, patient education ... And again, common quote that we frequently hear is that it doesn't feel like it's a normal doctor's office, it feels like people are with family ... We really strive to provide that compassionate and welcoming atmosphere within our clinic.

We've seen a lot of success within our ministry. One of them would be the growth of our clinic, our comprehensive care center, that we started with a full-time clinic director and a part-time nurse. That's now expanded to include our clinic director, one full-time nurse, two part-time nurses, two social workers. So it's greatly expanded. We've also began peer-navigation a few years ago, and so we currently have a very active peer group that helps with providing some transportation if there's some transportation issues with getting people to doctor's appointments. We have someone that does translation for people who are English language learners so they can better communicate with their doctor. The peers also go out and do some HIV testing within our community, HIV education within the community, and so they've been a true asset for our agency and for our clinic.

Ohio is also part of the H4C Project and the H4C collaborative, so our clinic was a participant in that and we saw great strides with our viral-load suppression rates. Our viral-load suppression went from a little over 56% in December of 2012 to most recently in October of 2017 our rate now is at nearly 87%. That's in large part because of the individualized approach that we've taken. Rather than a one-size-fits-all, what we do is we actually have our clinic staff kind of get together and meet at a meeting once a month. They take a look at people that might be struggling with being medically adherent and work with them, basically. They try to work with them personally to identify what barriers they might have in getting to their appointments and try to overcome those barriers so that they can be successful. In some cases what we've found is the biggest barrier is that people felt that nobody cared for them. So once they had somebody checking in, once they had someone asking them about their health, we kind of saw that that lead to in some cases all the change that was necessary. We've seen some success with our uninsured rate. Ohio does have expanded Medicaid. We went from 60 people being uninsured in 2012 to 3 in 2017.

Primarily our ministry has been successful because we've really strived to provide as many wraparound services for people as we can. So again, identifying what the needs are, and recognizing what those needs are. The idea that, again ... The idea of Maslow's Hierarchy that if you're not addressing those basic needs, then people can't really advance or move beyond that. By providing our housing and by providing things even like food or their personal hygiene products, by having child care and our tutoring program, we're really striving to make a difference in that fashion.

Our clinic and our ministry has also really been fortunate in the sense that we've also had very low staff turnover. We just recently ... Two of our clinic nurses, one of them we just had a little lunch celebration for her because she's been with us for fifteen years, and the other one just yesterday, was with us for fourteen years. The same goes with our social workers, the same goes with other ministry staff. We don't really necessarily see staff turnover, which speaks volumes I think about how they feel committed to the mission of our agency. But also it really has helped, I think too, as we've been working with the clients that we serve because people feel like they now know them. They have in many cases known them for over a decade, so that really has also I think been a key to our success, is having those long lasting relationships with people.

Our collaboration with community agencies has been really pretty good, especially with our Ryan White social workers, our [inaudible 00:29:32] program. We've had great success as well with our clinic nurse Terry Mitchell, who's an ACRN. She's received awards for her work, our social workers have received rewards for their work. So again, that idea that they're very committed to the mission of our ministry and the programs has really made all the difference. I think that that's kind of the biggest lesson that we've kind of learned is that hiring the right people, finding the right people who are really committed really kind of helped set the tone for the ministry and set the tone for the programs in our ministry.

That is basically our program. Once again thank you so much for allowing me to participate here. We do have a video that's up on the Rural Health Information Hub website, so if you're ever interested in checking out our video you can feel free to do so. They did a wonderful job and we appreciated that too. But I'm going to go ahead and turn it over to Lisa now for the next part of our presentation.

Lisa McKeithan: Thank you Daniel. Good afternoon. My name is Lisa McKeithan and I'm grateful for this opportunity to talk with of you about CommWell Health and the NC-REACH program. CommWell Health opened its doors in 1976 as a part-time migrant health program. We've grown from one single healthcare center to 16 locations serving over 22,000 annually throughout a six-county region of Southeastern North Carolina. Just recently we added a dental mobile unit. We are not-for-profit Federally Qualified Health Center and we're Joint Commission and dually accredited in ambulatory and behavioral health. We're certified by

the Joint Commission as a Patient Centered Medical Home for each of our primary medical, dental, and behavioral health practice locations.

Our target population is the low income and uninsured, and migrant and seasonal farm workers. The counties in our service area are all designated as a medically underserved area and health professional shortage areas for primary care and behavioral health. The economics of our service area are driven by agriculture, tourism, healthcare, utilities and education, but many of our citizens are underemployed and unemployed. Also in rural communities there's a lack of permanent, affordable housing. Homelessness is a present and important issue for many rural families, especially the hidden homeless. They're either living in their cars, doubling up with friends or family, or living in substandard housing. There's no public transportation in our service area. Our service area is largely rural, and we have thousands of miles of secondary roads, and often do not have direct access from one location to another. Even if you have a car, the travel time from your home to your primary care provider could be over 30 minutes. Let's not even talk about if you had a specialty appointment. That could be 60 to 70 minutes away. Many of the individuals who attend our clinic care in Dunn drive, or we provide transportation and they're at least 60 minutes from their home.

Here at CommWell Health, we are committed to our communities thriving. We go beyond traditional healthcare and we are concerned about the social determinants of health of our patients. It's in our DNA, it's our core values, it's our culture that we have a solid mission to increase access to comprehensive primary and preventive healthcare and to improve the health status of our community. Because of the HRSA and the SPNS Initiative, we were able to address the gaps that we found in housing in our community through the NC-REACH program. NC-REACH is a model of a medical home developed and implemented by CommWell Health to provide comprehensive primary care and supportive services to homeless and unstably housed HIV positive with mental health and substance abuse disorders.

It's an innovative intervention for improving healthcare and supporting service delivery as well patient outcomes. The essential program element is having a network navigator who coordinates behavioral health services while also integrate housing and health services through a comprehensive care coordination team, we call the Positive Life program. The network navigator is also able to provide tailored services to address the individual barriers to housing for our participants.

The network navigators are able to educate the clinical staff and the participants about housing instability and how that can affect retention and care and medication adherence. You know, we say, "How can you expect a patient to take their medications as prescribed and attend their behavioral health appointments and their HIV infectious disease appointments if they don't have housing?" Our network navigators they were able to educate our providers and

our staff about homeless, about medical literacy, and also about cultural sensitivity because we all know that rural America has its own culture.

The network navigators continue to provide transportation for a patient. They were able to provide resources for support services for our clients to maintain housing and then they were able to go out in the community and build these partnerships. Some were formal and informal, through community engagement as well as outreach. As you can see here, the network navigators were addressing the unique needs of this population, while serving as a bridge between the client, the healthcare system, housing, and employment. We know that addressing the social determinants of health, and being supporters of health and healthy choices is an innovative way to improve population health.

At CommWell Health, we understand the value of connection and we believe together we can achieve more. We build strong and innovative partnerships with supportive services agencies to meet the unique needs of our community, through integration of HIV care and housing in a coordinated intervention. We were able to provide community-based education about hidden homeless, about HIV, about discrimination and definitely about stigma. Also, we were able to make those community partnerships, engagement, and advocacy to help reduce the duplication of services for a patient.

More than just building community partnerships, what was most important and one of the lessons learned was we were able to build community systems to help move the public health system to the next level. We know that this is extremely significant and needed in rural communities. We know supportive services can be difficult to access. They can also be spread over large areas, over different counties, and they often are not structured. What we did is we created a community housing coalition and our strategy in the beginning was just to identify resources within our communities that could help our patient. We contacted the homeless shelters, UnitedWay, Salvation Army, Veterans Affairs, the Incarceration Centers, and it became a unique venue for presentation. It became a regular forum for local providers to get together and share what we know about housing and other support services.

The meeting provided a critical opportunity for us to increase transparency, but also give people the opportunity to share information to collaborate, and implement strategies for our communities to thrive. It was an opportunity to have conversations with key stakeholders regarding the social risks and the needs of our communities. Most importantly we were able to discuss long-term solutions. This meeting continues to be an ongoing educational and technical assistance for community partners regarding "best practices" and evidence-based research.

Let me tell you a little bit about the patients that we served. We enrolled 80 clients into the NC-REACH program. After 18 months, 83% of our patients were virally suppressed. 74% of those patients were transitioned back to sustainitive care, so they were transitioned back to our Positive Life program. We only lost 3

people who lost to follow-up. 3% of our population was lost to follow-up, and all 80 were referred and completed at least one behavioral health and substance abuse referral. 87% of participants were virally suppressed after 12 months. Here you can also see that the unmet needs of our participants decreased. 60% of our participants were stably housed, and the HIV medication adherence from baseline to 18 months increased. We're grateful that this is the "best practice" model that can be replicated in any rural community and that it will have a lasting value.

Our agency CommWell Health is committed to quality and to better understand our patients social determinants of health. We know that we can transform the modern healthcare system by integrating services and community partnerships, by advocating for change for our communities, and demonstrating the value of empowering our patients, our colleagues, and our communities. But as our CEO Pam Tripp said, "We need to ignite a fire of transformation in healthcare to revolutionize the way we operate daily, beginning first and foremost with our healthcare organization culture."

Unfortunately many organizations, the way they lead healthcare has been more traditional and generic. But for better patient outcomes and improving the quality of health in our communities, our healthcare system needs a transformation. That's why we're going to continue to incorporate network navigators in our future care strategies, we're going to maintain community systems through partnerships with our local community organizations, and we're going to continue our community housing luncheon. At CommWell Health, we want our excellence tomorrow to be better than our excellence today.

I want to thank you all for this opportunity to talk about the work I love, improving the lives of rural America is my passion and it's my purpose. I'm grateful for the opportunity to value and empower rural communities. Additionally, I want to thank everyone listed on this slide, and if you would like to contact me, my information is noted above. Now we're going to play a video about the NC-REACH program, and I would like ... So you'll have a better understanding of the NC-REACH program.

Video: I was diagnosed in 2010 with HIV. I didn't tell a soul and it's 2016 and none of my family and friends still know. I've had some bad experiences with people just bringing the subject up and how we ought to be all shipped off on a boat and be forgotten. So tried dealing with it by myself at first, and they didn't tell me a lot about it, they just told me I had it. I did some medicine for it. So not knowing was scary. The thing that we have to get out today is that it's not a death sentence if we only take our medicine, and we're just like anybody else. You can't get it from drinking behind me. We need awareness. We need information. The reason why people are out there acting like that is they don't know, and what they don't know scares them. My HIV doctor left and went to Georgia, and I told him, I said, "I need someone closer."

The people and family at CommWell Health are awesome. I can be myself. I can just walk in and have a bad day, y'all know it. Y'all know how I act, y'all know what I feel. I wish that they had talked many times about my problems, and what I should do about it. I met Crystal in my first interview at CommWell Health. She's outgoing, she's a hard-worker. I don't care what the problem was, I could call her, she'd fix it. I even call her on Friday and she's like, "Now, Tammy, you know I don't work." Y'all are just everything rolled up in one. Friends, you're family, you're my number one supporter, you're information. Anything that I need, I can get from y'all. I don't have to go outside of CommWell Health and that means a lot.

Took me roughly about two years to find a place to stay. I lost my husband August 9th 2014, of cancer, but I was living with my daughter. I didn't have income coming in but now I do, so we just looked. Because I have a criminal record and because I have a felony, a lot of people wouldn't rent to me, and because I have an animal, it was either both or either one, or either or. She continued to look for me and if I'd call her and be upset or crying, she said, "I don't want to hear none of that. We're going to do this, one way or the other, we're going to find you a place." I've been here a little over two months, and I love it. It's quiet, I can see anybody coming in and out. I've had several things, well not several, one or two things break. Call him, and he was right here. Says and long as I do what I'm supposed to do, I'll have a place for life.

Kristine Sande: Wow, what a great video. Thanks for sharing that Lisa. I believe at this point we are ready to open the webinar up for questions in just a minute ... Oh, right now, you will see the Q&A box in the lower right hand corner of your screen, and that's where you can enter any questions that you have for today's presenters. As you enter those questions, I would just ask that you please select the option to send the question to all panelists so that your question doesn't get overlooked as we do the Q&A. I would just mention while we're waiting for some of those questions to come in, Dan mentioned that the RHIhub produced a video featuring the Ursuline Sisters program, which was really a great experience for us here at RHIhub. We learned a lot about what they do and were really inspired. If you want to view that video, we did provide a link to that in the right hand column of the webinar page back on our website. So that's at www.ruralhealthinfo.org/webinars and then click into today's webinar and you can find that on the right hand column. We have a question about will the audio of this webinar be available also. We will provide a video recording as well as a transcript of the webinar.

Alright, the first question is, "I am working on a research project for my MSN program. My topic is the health intervention for rural underserved population. I'm interested in what the presenters see as the biggest impediment to medication adherence in the rural population." So Daniel or Lisa?

Lisa McKeithan: I personally feel that access, many of our patients have difficulty getting access to their medications, but also housing. As I mentioned in my webinar, it's

difficult for patients to take their medications as prescribed if they don't have a safe place to stay.

Kristine Sande: That's a good point. Daniel, do you have thoughts on this one?

Daniel Wakefield: Yes. I would just add, kind of along a similar lines, I think that I would say we have seen in our experiences stigma as well. We've had some patients, especially those from rural areas, who are fearful that they might be seen coming into the clinic or going in to the support groups. We've had some who when prescribed medication have asked if their medication can be put in a separate container so that nobody could google or search what the medications are for. We've had a lot of that experience too. So I would probably say that in our experience, I would echo what Lisa said, I think housing is important, I think access is also important, but for us stigma as well plays a big role.

Kristine Sande: Thank you. The next question is, "How many of the patients that you serve have mobile phones?" Lisa or Daniel, do you have thoughts on that?

Lisa McKeithan: I think about 80% of our patients have mobile phones. However, not all of them have a working mobile phone. We have some patients, they may go to a place like McDonald's or somewhere that has free Wi-Fi so that they're able to call us or send an email once they're hooked to a Wi-Fi. But I'd say at least 80% of them have a cell phone, but probably only 50 to 60% of those have a working cell phone.

Daniel Wakefield: Yeah, that's about what we see here too. I would say a lot of times if our clinic staff is calling or we're calling as a ministry, we'll find that the phone is no longer in service or they're out of minutes for the time being. So I would say a vast majority of the people in our ministry do have cell phones, but whether they're at any given time able to be reached on them is a separate kind of issue.

Kristine Sande: Alright. The next question is, "How many community members were informed and engaged in these projects?" Daniel and Lisa?

Lisa McKeithan: Well we had ... Initially when we first started the community housing luncheon, I think we invited about 25 or 30 different agencies, from the six county radius, but we still have at least 15 to 18 who consistently participate in the coalition and who faithfully attend the meetings.

Daniel Wakefield: For us, I our ministry, considering we kind of run a gambit of serving children to serving adults, we've really tried to make partnerships within our community and strengthen those. For example, like with our Children's Program, one of the things we've done is work with the local university. As the university has a need to place students who might be going into education or social work or the healthcare field in to some field experience work, we've been a placement site for them both at our clinic and both at our Children's Program. We've done similar outreach events and things with our local hospitals as well. So we've had

... Our peer group for example, each semester they will do an HIV one-on-one healthcare presentation with nursing students from two local universities, to try to again get the word out, engage, and actually inform people that are going to be going in to the healthcare field. We definitely strive to get the community as involved and as educated as possible.

Kristine Sande: Alright. A question for Lisa, "Lisa can you tell us about how your organization partnered with others to pursue the HRSA funding support, and did you approach others to garner the support for this funding partnership, or were you approach by say, university-based medical centers?"

Lisa McKeithan: We were actually approached. Here at CommWell Health we have actually several different HRSA-funded grants and I believe on some of them we were approached, but on others we were able to go out and approach the different universities in our area.

Kristine Sande: Alright. Another question for you Lisa, "Does CommWell Health have a mobile medical unit as well as the dental unit?"

Lisa McKeithan: Oh. Okay, so at the current time we only have a dental unit, but it's part of our strategic plan that we are looking at having a mobile medical unit. In the meantime, we do attend local festivals, fairs, and we partner with different organizations and different employers that we can go out and help with their employees, with their health screenings.

Kristine Sande: Great. Thank you.

Lisa McKeithan: So that's part of the plan.

Kristine Sande: Let's see. It looks like there's one question that maybe got cutoff. The question says, "We are in the early phases of developing a needle exchange program and there's such a stigma inherent in that." So the rest of the question maybe missing, but any comments on that as far as ways to overcome that stigma?

Lisa McKeithan: What helped us the most was education. Going out in the community, explaining what it is, talking about it, we even partnered with our faith-based community, and we were able to go out and do trading sessions. I believe education is the best way to help reduce stigma, especially in rural communities.

Kristine Sande: Thanks, Lisa. Any other thoughts on that? Alright. One other question for Lisa, "At CommWell Health, what kinds of housing providers did you seek out and eventually find? Was it publicly supported and funded or private housing providers, section 8 or subsidized?" The person who submitted the question said they noticed a spike in those housed in the last 12 to 18 months, wondering if it took time to get there, I guess.

Lisa McKeithan: It did. In the beginning, what we did is we went and partnered with the public sector, but also the private sector. And even we started off with the homeless shelters, building those partnerships, fostering those relationships. So when someone came in to our agencies and they were unstably housed or homeless, we were able to call a case manager at the local shelter, to just make sure we could expedite our patient getting in. We also had partnerships with UnitedWay, with Veterans Affairs, with HOPWA, which is housing for individuals who have HIV assistance, and other housing providers. Most importantly, we partnered with the faith-based community. They were able to help us find housing for some of our patients.

Kristine Sande: Great, thanks so much. I'm not seeing any other questions at this time, so I think we'll wrap it up at this point. On behalf of the Rural Health Information Hub, I just want to thank all of our speakers for the great information and the great insights that you've shared with us today. It is truly inspiring and it's very obvious that the Ursuline Sisters and the NC-REACH Project are both extremely mission-based, so thanks for all the great work you do. Also, thank you to our participants for joining us today. A survey will automatically open at the end of today's webinar. We would ask that you please complete that survey to provide us with some feedback so that we can do even better in hosting future webinars. The slides used in today's webinar are currently available at www.ruralhealthinfo.org/webinars. In addition, a recording and transcript of today's webinar will be made available at the RHIhub website and sent to you by email in the near future. That will give you an opportunity to listen again, or share the presentation with your colleagues.

So thanks so much for joining us, and have a great day.