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The PrEPARE Mobile Program for HIV Prevention in Washington D.C.

Gabrielle Cochran
University of Kentucky, gabriellecochran1409@gmail.com

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The document mentioned above has been reviewed and accepted by the student's advisor, on behalf of the advisory committee, and by the Director of Graduate Studies (DGS), on behalf of the program; we verify that this is the final, approved version of the student's capstone including all changes required by the advisory committee. The undersigned agree to abide by the statements above.

Gabrielle Cochran, Student

Richard Crosby, Committee Chair

Dr. Sarah Wackerbarth, Director of Graduate Studies

The PrEPARE Mobile Program for HIV Prevention in Washington D.C.

Gabrielle M. Cochran

College of Public Health

University of Kentucky

April 25, 2023

Specific Aims

Incidence rates of HIV have decreased in the United States in the past decade, but the southern United States has higher rates of HIV than other regions, and cities in the south, like Washington D.C., have some of the highest rates of HIV incidence in the nation. Risky sexual behavior, needle sharing, and substance use increase the risk of transmitting or acquiring HIV, and these behaviors are more common among unhoused people (CDC, 2021; CPPH, 2022).

Expansion of community resources in cities with high levels of HIV have allowed for many people at high risk for HIV to comply with the CDC's suggestion to receive regular HIV testing and adhere to PrEP, a medication or shot that prevents HIV. Still, unhoused populations may face additional barriers, such as cost and transportation, that prevent the use of these services and leave them vulnerable to HIV (Epps et al., 2022). Mobile vans offering HIV testing and PrEP have been one strategy used to reach people experiencing unstable housing.

The PrEPARE program will use evidence-informed strategies developed in scientific literature and community partnerships with stakeholders to develop a culturally competent program to address HIV incidence among the unhoused population in Washington D.C.

The Specific Aims of the PrEPARE program are as follows:

1. Establish community partnerships to form a Community Advisory Board and create culturally relevant program materials;
2. Train and mobilize a diverse and culturally competent staff;
3. Implement mobile HIV testing and PrEP vaccination at housing partner sites;
4. Evaluate the impact of the program on the HIV incidence rate of unhoused individuals in Washington D.C.

Target Needs and Population

Human immunodeficiency virus (HIV) is an incurable virus that weakens the immune system and lowers the count of white blood cells over time. Once the immune system is severely weakened a person will be diagnosed with acquired immunodeficiency syndrome (AIDS) and infections are more likely to lead to death (HIV.gov, 2022). The first signs of HIV typically occur more than a month after the date of infection and can include flu-like symptoms such as muscle aches, night sweats, rash, fatigue, and more. These effects are short in duration, and, without regular testing, people may go years without being aware of their status (Cleveland Clinic, 2022). In fact, people can have HIV for over a decade before their white blood cell count reaches the standard set for an AIDS diagnosis (HIV.gov, 2022). Ultimately, people do not die from HIV or AIDS, instead death is caused by infections that the weakened immune system can no longer fight off (Cleveland Clinic, 2022).

HIV incidence rates have slowed in the decades since the 1980s HIV epidemic in the United States following the introduction of pharmacological options to prevent HIV transmission and acquisition. The incidence rate for HIV in the United States is 13.2 per 100,000 people and the prevalence rate is 379.7 per 100,000 people (HIV Surveillance Report, 2019). The difference between these rates is due in part to Antiretroviral Therapy (ART), a combination of medications that work by reducing the viral load of the HIV virus to under 200 at which point HIV is deemed undetectable. When undetectable, HIV is considered untransmissible during sexual contact and the risk for transmission is significantly lower during breastfeeding and injectable drug use. ART also prevents the weakening of the immune system which allows HIV-infected individuals to live long, relatively normal lives as long as medicine is taken consistently. Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP) work to prevent the acquisition of HIV among people at risk of HIV. People at high risk for HIV can take PrEP to prevent the

transmission of HIV. It can be taken in two forms: a daily pill or a shot taken every two months. People who were exposed to HIV within the past 72 hours can take PEP daily for 28 days to reduce their risk for HIV (CDC, 2020).

Aside from pharmacological options, there are a number of protective and risky behaviors that can affect the acquisition of HIV. Preventing HIV transmission and acquisition can be done through engaging in protective behaviors such as condom use, regular HIV testing, and the use of clean needles. Latex male and female condoms are over 90% effective at preventing HIV transmission when used correctly (USAID, 2015). Additionally, knowing HIV status can allow protective steps to be taken if the status is positive. Therefore, the Centers for Disease Control and Prevention (CDC) recommends that those at high risk for HIV get tested every 3 to 6 months (National Institutes of Health, 2021).

HIV acquisition is highest among individuals engaging in risky sexual behavior, those engaging in substance use, and among unhoused populations. Unprotected sex is the most common way that HIV is transmitted between people, and the risk is highest for the receptive partner in anal sex. Substance use also increases the chances of engaging in risky sexual behavior through practices such as unprotected sex, sex work, and multiple sexual partners. The CDC also lists injection drug use as a high risky activity for transmitting HIV, accounting for 10% of HIV diagnoses across the nation (CDC, 2021). Substance use, particularly of injectable drugs, occurs commonly among unhoused populations which increases the risk for HIV transmission, indicating that unstable housing is another risk factor for HIV acquisition and transmission (Community Partnership for the Prevention of Homelessness, 2022; Schafer, Blanchard, & Fals-Stewart, 1994). This is particularly relevant because there are an estimated 580,000 unhoused individuals across the United States on any given night (United States Interagency Council on

Homelessness, 2021). People experiencing homelessness are more likely to have adverse experiences that lead to worse health outcomes than people in stable housing. Unhoused people are more likely to experience social exclusion, victimization, discrimination, harsh living environments, and trauma than people with stable housing. Furthermore, competing health and safety priorities can lead to risky health behaviors and difficulty adhering to medication. This leads to a greater risk for heart disease, respiratory conditions, infectious disease, and uncontrolled chronic disease (Liu & Hwang, 2021).

HIV incidence and prevalence occurs at inconsistent rates across regions and between communities indicating past and present health disparities for HIV acquisition (HIV.gov, 2022). Disparities in HIV incidence are found based on region, sex, race and ethnicity, and sexual orientation. HIV incidence is highest in the southern United States as the incidence of HIV is 12.4 cases per 100,000 people compared to 7.6 cases per 100,000 in the Northeast, 6.0 cases per 100,000 in the Midwest, and 8.0 cases per 100,000 in the West (CDC, 2022a). HIV incidence is also more common among Black and African American individuals (42% of new HIV diagnoses) than White individuals (26% of HIV diagnoses) even when controlling for sexual orientation. Lastly, male-to-male sexual contact accounts for the transmission of 66% of new HIV cases, while heterosexual contact accounts for 22% of cases, indicating disparities by sexual orientation (CDC, 2022b).

Washington D.C. is home to over 670,000 individuals across a mere 61 square miles, still there is great variety in quality of life despite the close proximity. In D.C., 45.9% of residents are White alone, while 45.8% of residents are Black or African American. Additionally, 11.5% of the population is Hispanic or Latino. In terms of education, 91.9% of adults have a high school degree or higher and 59.8% have a bachelor's degree or higher. The median income is \$90,842.

Still, 16.5% of people live in poverty. Part of this reason is the significant disparities that exist within the community (United States Census Bureau, 2020). One example of this is the differences in the average and median income based on race. In D.C., the average household income for White individuals was \$161,221 compared to \$74,728 for Black and African American individuals. Similarly, the median household income for White individuals was \$160,914 while it was \$53,629 for Black/African American individuals (DC Health Matters, 2022).

Washington D.C is uniquely affected by HIV with some of the highest incidence rates of any city in the United States, significant health disparities, and common engagement with risky behaviors. The incidence rate of HIV in Washington D.C. is 31.5 new cases of HIV per 100,000 people (Atlas Plus, 2019). This is comparable to cities such as Philadelphia, Pennsylvania and Atlanta, Georgia which have incident rates of 26 and 36 new cases of HIV per 100,000 people respectively (AIDSVu, 2020). There are also significant disparities for HIV in Washington D.C. as 76.5% of new HIV cases were diagnosed in Black individuals compared with 11.8% of cases among Hispanic and Latinx individuals and 7.5% of cases in White individuals. So, Black or African American individuals account for over 3 in 4 new cases of HIV in Washington D.C., despite making up less than half of the overall population (AIDSVu, 2020).

The most common form of HIV transmission in Washington D.C. is through sexual contact, though there are other risk factors for HIV that contribute significantly to HIV incidence. Sexual contact was responsible for almost 90% of new cases of HIV among females and over 72% of new cases of HIV among males. Among males, 16.7% of cases were attributable to a combination of sexual contact and injection drug use (AIDSVu, 2020). Unprotected sex plays a large role in this incidence rate as almost 60% of adults in Washington

D.C. did not use a condom the last time they had sex (DC Health matters, 2019). Injection drug use alone accounts for over 10% of new HIV cases among both males and females in Washington D.C. (AIDSVu, 2020).

Unstable housing is also an important factor to consider with HIV as 15.3% of individuals living with HIV in Washington D.C. do not have stable housing and people with unstable housing have high risks of HIV infection (Aquino et al., 2021). There are around three to six thousand people living in transitional or emergency shelters or completely unsheltered in Washington D.C. on any given night. In fact, D.C. has the highest rate of unstable housing when compared to states, as the rate of homelessness is more than twice as large as that of the highest states, New York and Hawaii (National Alliance to End Homelessness, 2022). The majority (91%) of unhoused people are people of color (POC). Specifically, 85% of unhoused people are Black, African American, or African, while only 9% are White. In Washington D.C., 22.6% of individuals with unstable housing report using illegal substances and 22.4% have at least one chronic health problem. Additionally, 2.3% of unhoused individuals in Washington D.C. have been diagnosed with HIV or AIDS, making the spread of HIV more likely (Community Partnership for the Prevention of Homelessness, 2022).

Previous studies indicate the ability to reach high numbers of unhoused individuals despite barriers. Studies conducted in non-traditional settings across the United States indicate that thousands of unhoused individuals can be reached within a couple of years. Specifically, in Washington D.C., researchers were able to reach over 4,500 people via mobile clinic in just three years. Given the high numbers of people experiencing homelessness each night and previous research, it can be expected to reach at least 700 to 1,000 unhoused people over the course of a year (Bowles et al., 2008).

Program

Goals developed for Healthy People 2030 indicate a continued need to eliminate health disparities and address factors related to HIV through the use of evidence-informed strategies. Goals related to HIV include increasing knowledge of HIV status, HIV viral suppression, and linkage to HIV medical care and reduction of HIV incidence (Healthy People 2030, 2019). A variety of evidence-based strategies have been shown to be useful for achieving these aims. Harm reduction programs, also known as needle or syringe exchange programs, are one option that reduce the possibility of transmission and furthermore, people who utilize these services are more likely to stop injecting drugs and seek treatment (CDC, 2019a). Reducing barriers, such as cost and transportation, to condoms and medications can also increase the utilization of these preventative materials (Choopanya et al., 2013). For unstably housed individuals in particular, recommendations for HIV treatment include a combination of multiple HIV prevention efforts, street outreach, and the removal of community-specific barriers (NHCHC, 2019).

Many of these recommended services are available in Washington D.C., including access to free condoms, syringe exchange locations and mobile units, mobile HIV testing sites, and more through non-profit organizations, healthcare organizations, and faith-based institutions. Still, significant health disparities exist, particularly among African American men, indicating that barriers to utilization of HIV services need to be addressed (DC Health, 2022). Collaborating with existing programs can allow for HIV services to be expanded and adapted for individuals experiencing unstable housing while being mindful of limited resources. One such program is the Family and Medical Counseling Service Inc. (FMCS) which provides a mobile needle exchange program and other health services specifically to underserved and marginalized communities. Collaboration with programs such as this could allow for a greater reach into at-risk communities

and strengthens the ability to provide additional low-cost services through culturally competent programs (FMCS, n.d.).

The PrEPARE (PrEP for those At-Risk of Exposure) program will use evidence-informed strategies to provide HIV testing and PrEP access to the unhoused population in Washington D.C. This program will be based on evidence-informed strategies that will expand and adapt the D.C. Whitman-Walker Health program to regularly bring HIV testing and monthly PrEP shots to three low-barrier housing sites for a three-year period. Program components will be based on a review of current literature and global and national health organization recommendations.

The use of a mobile program stems from global and national health organizations that recommend mobile outreach programs that offer HIV services, rapid HIV testing, and prescription of PrEP shots for high-risk and mobile populations. The World Health Organization (WHO) is one such organization which recommends mobile outreach as a complement to standard testing sites (World Health Organization, 2020). Another organization, the Health Care for the Homeless (HCH) Clinicians' Network, recommends outreach and community-based services similar to on-site mobile units (HCH Clinicians' Network, 2019). Furthermore, these strategies have shown evidence of effectiveness in the southeastern United States. In a Tennessee pilot study, individuals with unstable housing were willing to utilize HIV testing services that were offered on site outside of traditional health settings with a utilization rate of 89% (Pichon et al., 2021).

Additional programs across diverse communities in the United States, including unhoused populations and people who inject drugs, show the versatility of mobile HIV testing. One literature review for mobile health clinics found advantages to the mobile design, including cost-effectiveness and adaptability, which increased the ability to reach underserved groups.

Mobile programs also helped to enable self-efficacy and address disparities in social determinants of health (Yu, Hill, Ricks, Bennet, & Oriol, 2017). Further studies show that mobile HIV testing has high acceptance rates among unhoused and unstably housed people compared to traditional settings. They were more likely to reach POC, people who had never tested for HIV, people with substance use and injectable drug use, and people engaging in risky sexual behavior than health departments or standard facilities across a variety of regions in the United States (Ellen, Bonu Arruda, Ward, & Vogel, 2003; Pichon et al, 2021; Spielberg et al., 2011). The implementation of regular, on-site HIV care reduces barriers often seen with multi-step processes commonly used for HIV care. These multistep processes are less likely to have patients achieve the full benefits of the medication because of poor adherence or low prescription fulfillment. Conversely, having care in one place can reduce barriers to PrEP adherence (Cironi, Jones, Hauser, Olsen, & Kissinger, 2021).

Findings across studies consistently show that there is large uptake of HIV testing among high-risk populations. The San Francisco program had a 75.2% testing rate among unstably housed individuals with 46% reporting injection drug use, 38% being men who have sex with men (MSM), and 33% reporting risky sexual behavior. In a multi-site study, many high-risk populations were reached including MSM, people who inject drugs (PWID), those engaging in risky sexual behaviors, and POC. A study in Maryland found that the proportion of results found to be HIV positive was over twice as high among people attending mobile units compared to traditional settings, demonstrating the need for mobile services for at-risk populations (Ellen et al., 2003; Pichon et al, 2021; Spielberg et al., 2011).

The mobile PrEPARE program will be based on an on-site HIV testing program based in San Francisco that aimed to reach populations at high-risk for HIV. Collaboration was a critical

component of the program as the program directors at the local shelters, food programs, and temporary housing services where the testing took place had to agree to let the study take place in their facilities before the program could begin. Once services were approved, four to six program staff members recruited and screened participants on-site from Friday through Sunday to determine their desire and eligibility for HIV testing. To participate, participants had to be over 18 years of age, speak English, and be able to make decisions for themselves. Once eligibility was determined, staff members explained the process of HIV testing and helped to schedule appointments. This recruitment period lasted 8 months from August 2003 to March 2004. Testing took place on Mondays on-site, if there was enough space to ensure confidentiality, or at a nearby testing facility (Buchér et al., 2007).

Staff members obtained participant consent for HIV testing and conducted pre-test counseling. Structured interviews were conducted among participants to collect survey information and then trained staff administered a rapid HIV antibody test. If results were negative, no further actions were taken, and participants received a \$15 incentive. If results were positive, participants were referred to community resources and asked to return. Positive results were confirmed via enzyme immunoassay and western blot, and positive results indicated a confirmed HIV infection. Participants testing positive received \$15 at the time of testing and \$15 at test confirmation. Ultimately, over 1,200 participants (75.2% of those invited) were tested in an 8-month period with 30 participants being newly diagnosed with HIV (Buchér et al., 2007; Bowles et al., 2008).

Mobile HIV services have been implemented similarly throughout the country to diverse audiences. Mobile HIV testing programs have been implemented across a range of geographic locations, including Washington, California, Missouri, Massachusetts, Illinois, and Michigan.

Across the programs, between 4-6 staff members tend to be employed at each site, including HIV counselors, recruitment staff, testing staff, and program coordinators. Typically, at least one staff member has extensive training in HIV testing and may be a registered nurse or phlebotomist. Mobile HIV programming has been implemented among a range of audiences, including as general outreach to the community and as tailored outreach for high-risk populations such as MSM, PWID, and unhoused individuals. Mobile HIV services have often achieved programs goals as high rates of testing lead to increased awareness of HIV status. Once HIV status is known, participants can be directed to resources based on the results of the testing. Those with negative test results can be given prescriptions for PrEP and those with positive results can be given information for free or low-cost HIV confirmatory testing and ART (Ellen et al., 2003; Pichon et al, 2021; Spielberg et al., 2011).

Based on the successes of previous programs and further evidence from national organizations, the PrEPARE program will aim to increase HIV testing and access to PrEP among unhoused individuals at high-risk for HIV exposure in Washington D.C through mobile testing sites (see Figure 1 and Figure 2). Similar to the San Francisco program, the first step of the PrEPARE program will be to establish collaborative partners at the testing sites and create a community advisory board (CAB). Testing will take place at 3 different sites: the Community for Creative Non-Violence (CCNV), Catholic Charities' St. Elizabeth's East Campus Men's Shelter, and the Patricia Handy Place for Women. Testing will take place weekly in a three-week cycle, where the location of services rotates so that each site offers on-site testing every three weeks for an 8-hour period. These sites were selected because they are designated as "low barrier" shelters which means that people of any background can seek shelter. Other shelters may require sobriety, brief background checks, or commitment to treatment programs. This would filter out

people who may be more likely to engage in risky behavior and ultimately may have higher needs for HIV testing, PREP, and connections to community services.

Each shelter has core values that indicate a willingness to offer HIV services to residents who have the need. CCNV has the capacity to serve 511 unhoused persons. Their mission includes protecting the rights of those they serve and establishes a commitment to providing access to medical care (CCNV, n.d.). The Pat Handy Place for Women has a capacity for 213 unhoused women. This organization has previously partnered with organizations in Washington D.C. that provide shelter specifically to women living with HIV or AIDS. Furthermore, 41% of the women they serve have a mental disorder, substance dependence, or both and 4% are currently living with HIV or AIDS (N Street Village, n.d.). Lastly, the St. Elizabeth's East Campus has a capacity for 396 men. This organization's mission highlights a desire to provide culturally competent services to an inclusive and diverse population. Furthermore, this organization has experience collaborating with foundations to provide health services to residents (Catholic Charities, n.d.).

Once the location of the program has been settled, staff for the PrEPARE mobile van and the CAB can be determined. Staffing will follow the precedent of the aforementioned mobile programs as one program director, two program coordinators, and six part-time mobile staff members will be hired to work in the mobile vans. The program director will be hired internally through Whitman-Walker Health as an expansion or transfer of responsibilities. The program coordinators will be new hires that must meet qualifications set by the program director and Whitman-Walker Health. This will include experience managing programming and staff members and working with diverse populations. Program coordinators can have one of two roles: evaluation or mobile clinic management and community outreach. The mobile staff will be hired

by the program coordinator for mobile clinic management and community outreach preferably through the transfer of current staff to mobile vans on testing days. Each mobile staff member must demonstrate values of inclusivity and have experience working with diverse populations due to the diverse population expected to be served by the program. Additionally, all mobile staff members must have a current certificate that will allow them to administer shots. Since, only four staff members will be required to work at a time, staff members will only be expected to work two, 8-hour shifts every three weeks.

Once hired, all mobile staff members will receive extensive training from the program coordinator for evaluation for the first month of the program over research practices and ethics, inclusivity, program values and objectives, CDC protocol, HIV test kits, and community services. Research practices and ethics will be certified using The Collaborative Institutional Training Initiative (CITI) program courses titled Human Subjects Research, Information Privacy and Security, and Responsible Conduct of Research. These programs will provide guidelines to protect the confidentiality of sensitive participant data by requiring staff members to complete modules related to Health Insurance Portability and Accountability Act (HIPAA) standards, the principles of research, and the protection of human participants (CITI Program, n.d.). Inclusivity training will be completed through edX which provides a course titled “Leading With Effective Communication (Inclusive Leadership Training)” which includes methods for testing assumptions, exploring case studies, and learning how to communicate across differences (edX, n.d.). Mobile staff will also be trained using protocols adapted from the CDC guide for nonclinical rapid HIV testing which will be utilized during patient testing to increase efficiency and accuracy (CDC, n.d.a). This protocol will be used as a checklist (see Figure 3) for providers to track program fidelity. The checklist will be included in the patient file and providers will

mark each step that occurs during the visit or immediately after to ensure the accuracy of the information. Mobile staff will be trained to use the rapid HIV test kits and administer PrEP shots as part of this process. During training, a script will be provided to staff to ensure that every participant receives similar care and support (CDC, n.d.b). Lastly, health department and social work representatives will introduce staff to the available services in Washington D.C. and surrounding areas. These resources will include information on how to receive free at-home STD testing kits and contraceptives, how to apply for programs that provide free or reduced-cost programming, and how to access free syringe exchange programs. The Washington D.C. Department of Health (DOH) will also be responsible for compiling information on additional locations for confirmatory testing and providers for HIV care that are low-cost and in close proximity to testing sites. The social work department at the University of the District of Columbia will also help to provide resources to program participants. These resources will consist of programs and services through which participants can apply for government aid and insurance and access additional services such as violence prevention, counseling, and community advocates. In addition, they will work to verify the level of cultural competence seen in the providers recommended by the DOH.

All staff members will meet weekly for the first month of the PrEPARE program for training and every three weeks for the first year of program rollout to address challenges and successes during each cycle. At these meetings, the program coordinator of mobile clinics and community outreach and the program coordinator of evaluation will lead mobile staff in a review of progress, challenges, and protocols for the period. They will also review the latest data on HIV research, protocol for HIV testing and PrEP shots, and updated community resources. Lastly, any participant feedback will be discussed. Importantly, the first quarter will revolve

around the determination of additional resources or support for the mobile staff and receptivity to PrEP shots.

These staff meetings will be supplemented by quarterly meetings between the program coordinator for mobile clinics and community outreach and the CAB which will further review progress and challenges and work with community partners to ensure program success. CAB meetings will be used to review progress over the quarter, keep resources up to date, maintain relationships, and approve program changes. These meetings will further highlight progress and challenges in the program and provide potential solutions for gaps in care. Suggestions from mobile staff meetings will be posed to CAB members and approved upon a majority vote. Recommendations from the CAB will be implemented with majority approval of the program director and coordinators. Each member of the CAB will get \$50 for meeting attendance or members can choose to have the money donated to the National Minority AIDS Council in their name.

The CAB will include the program coordinator for mobile clinics and community outreach, program coordinator for evaluation, a representative from each of the three low barrier shelters, a representative from the Washington D.C. DOH in the area of HIV care and services, a social work representative from the University of the District of Columbia, and an unhoused person elected from each site for a total of ten members. The program coordinator for mobile clinics and community outreach will serve as a bridge between the mobile staff members and community partners. The program coordinator for evaluation will present quarterly data reports on the progress of the program. Representatives from the shelters will address specific successes and barriers at each site and make sure the program is tailored to the needs of their participants. The health department representative will provide updated information about the services

available to the program and bring back knowledge about the needs of the unhoused to the health department. The social work representative will provide connections in the community to support unhoused persons across a variety of needs. Lastly, elected unhoused persons will provide direct insight into the needs and receptivity of the people served. Their perspective will help partners to understand the needs of participants, test cultural competence, and learn what can be done to improve care beyond the program.

After training, the first order of business will be to disseminate information about the PrEPARE program to residents at the shelters through flyers posted throughout the living spaces and at community resource locations. This dissemination will mimic the strategy used by the multi-site mobile program which used signage and posted materials, distribution of flyers, client referrals, and community gatekeepers. Additionally, walk-ins will be permitted for anyone (Bowles et al., 2008). These developed materials will be approved by the CAB at the first meeting. Online, social media, and text-based advertising will not be prioritized due to potential barriers this may pose for unhoused populations.

In the mobile PrEPARE van, trained staff members will follow the CDC protocol to offer HIV testing to consenting adults using rapid HIV antibody tests and PrEP shots to anyone with a nonreactive HIV test. All participants will be referred to community services that are relevant to their needs based on disclosed information and test results. Gift cards worth \$15 will be offered to participants who complete testing, and an additional \$15 gift will be offered to patients with a reactive test who return for confirmatory results. Studies on unhoused populations in Canada have shown that providing incentives is an effective strategy to recruit and retain unhoused individuals in healthcare services. Furthermore, qualitative research suggested that using financial incentives helped to ease financial stress which allowed for focus to be turned to other

needs (Reid et al., 2022). In Washington state, they also found that even nonmonetary incentives were helpful for engaging participants when compared to programs not offering incentives (Spielberg et al., 2011).

Rapid, blood HIV testing will be used due to recommendations from the CDC, HCH Clinicians' Network, and findings from past studies. These rapid tests use blood from a finger stick to provide test results in under 30 minutes (CDC, 2022c). The HCH Clinicians' network recommends rapid HIV testing be used to provide fast results to individuals rather than the use of other tests which can take several days to confirm and require blood taken from a vein. In Washington state, rapid HIV testing was shown to allow for more people to receive their test results when compared with HIV testing that required a follow-up visit (Spielberg et al., 2011).

While waiting for test results, mobile staff will screen participants for demographic characteristics, acute HIV infection systems, risky behaviors (injection drug use, needle sharing, risky sexual behaviors), and needs which will be logged in an excel spreadsheet shared by PrEPARE staff. Collected patient data will include a randomized participant ID, the data and time of the test, key demographic information, a record of consent, risky behaviors, and test results. Unlike in previous programs, pretest and posttest counseling will not take place as the CDC no longer recommends this practice. Instead, information sheets and referrals to community services will be provided after test results are received (CDC, 2019b). Test results will be delivered to patients in the confidential testing rooms.

If the test is nonreactive, the patient is assumed to not have HIV and at this point, the CDC recommends PrEP use for high-risk populations (CDC, 2022d). Furthermore, the United States Preventive Services Task Force (USPSTF) grade for injectable PrEP is an A which means that the service is strongly recommended for eligible patients (USPSTF, 2022). Injectable PrEP

is a recently approved version of PrEP that only needs to be given every 6-8 weeks and reduces barriers to medication adherence and prescription costs (CDC, 2022d). A global systematic review found that the majority of high-risk populations, such as injection drug users, were willing to take PrEP if it was offered and effective. This same review also found that many people were unaware of PrEP as a preventative option for HIV (Koechlin et al., 2017). A study in Washington D.C. further found that PWID were willing to take PrEP if it was offered without cost, even though many of them did not know what PrEP was (Kuo et al., 2016). A second study in Washington D.C. found that most MSM were willing to take a long-acting injectable PrEP shot (Levy et al., 2017).

If the first test is reactive, a second rapid test will be conducted, and if the second test is reactive, the person is assumed to be HIV-infected. If the second test is negative, the result is considered inconclusive. In both cases, the participants will be referred to the closest Whitman-Walker locations for confirmatory testing (CDC, 2015). To record the results of tests, mobile staff will continue to record data on the shared spreadsheet. After the column for test results, the data that is collected for participants will differ based on whether the results are HIV nonreactive or HIV reactive. Data for participants with a nonreactive test result will include a section to indicate if a PrEP shot was given, the date of its expiration (if received), and referral to community services. Data for participants with a reactive test will include the results of a confirmation test, indication of referrals to community resources, and a scheduled date for a follow-up visit.

After HIV testing and PrEP shots, mobile staff will schedule follow-up visits for all participants at either the mobile van or a main Whitman-Walker location. Mobile staff workers will ideally also be employed through the main Whitman-Walker program, so they will be able

to schedule a follow-up appointment with the participant and set up any services that are needed through the main Whitman-Walker program with the same provider. In this way, a version of a “warm handoff” will occur as the mobile staff workers will be able to speak to the competence of the organization and be a familiar face in a potentially unfamiliar setting. The goal of this is to establish a relationship between the program participants and a staff member of Whitman-Walker Health to encourage continued treatment even after the program is completed or the participant moves (Epps et al., 2022). The locations of the low-barrier housing sites also allow for easy access to the main Whitman-Walker health locations as each is within a 35-minute walk.

Participants with nonreactive results will be tested for HIV at every visit and then can receive another PrEP shot, which lasts for six to eight weeks (CDC, 2022d). Participants with reactive results will schedule an appointment where they will confirm the results of their test and can enroll in HIV services provided through the health department or Whitman-Walker Health. In either case, participants will be given an information and community resource sheet that identifies organizations, services, and providers that provide safe spaces for diverse and dependent people in the area. These will be regularly updated by the CAB. At the end of each visit, participants will be asked to complete a brief, anonymous feedback survey that will be used to make modifications to the program along the way.

Despite barriers to retention among the unhoused population, the PrEPARE program is designed to facilitate continued care through staff and participant connections, considerations of competing needs, and managed care practices. With a highly mobile population, providing continued care is often more challenging due to difficulties maintaining communication, competing needs for food and shelter, cost for services, and transportation. While these barriers will undoubtedly be faced, key components of the program have been structured to promote

retention and relationship building. Recent studies of people experiencing homelessness have found that brief interventions that connect unhoused people to long-term care promote continued retention and utilization of health services (Lamanna et al., 2018). Furthermore, connecting patients with a service provider that will be present at follow-up appointments further reduces barriers to continued care (Epps et al., 2022; Lamanna et al., 2018). Additionally, connections to Whitman-Walker Health and community social work resources can help participants utilize additional resources that address needs. Lastly, the PrEPARE program seeks to address competing needs by reaching participants who already have shelter and by providing gift cards that can be used to purchase food (Lamanna et al., 2018).

Even after program completion, the effects of the PrEPARE program will persist through the connections made throughout the community, the effects of testing and PrEP, and a greater awareness of the needs and challenges faced in the unhoused population. After three years of continued communication, the Washington D.C. Health Department, the University of the District of Columbia social work program, and community organizations should have developed a relationship that will continue after the PrEPARE program. Residents at the shelter can still be referred to services made available by the health department and community organizations. There will also be a greater understanding among these partners about the depth of needs and challenges faces by the unhoused population. Ideally, partner organizations will expand their services to address gaps in care that are identified. The CAB will also provide an opportunity for unhoused individuals to speak directly to influential people who can make changes in the community outside of the program and its funding. Lastly, connections to services for HIV-infected individuals will still be available as they are not provided directly by the PrEPARE program and the effects of the PrEP shots will last an additional five to seven weeks after the end

of the program. There are also organizations through which participants will be connected to get continued access to PrEP services at little to no cost, including Whitman-Walker Health.

Evaluation and Measures

The PrEPARE program aims to increase access to HIV testing and PrEP among at-risk individuals experiencing unstable housing in Washington D.C. to ultimately reduce HIV incidence among this population. To evaluate these aims, the PrEPARE program will use a combination of recordkeeping processes, feedback surveys, and trends in epidemiological data. The evaluation will be done in three distinct parts. The first phase will occur simultaneously with program implementation to monitor program fidelity and address program components as needed. The second phase will take place during the program and immediately following the end of the PrEPARE program to evaluate the utilization of program services and overall barriers and challenges to programming. The third and final phase will include a follow-up several years after program completion which will measure the overall program outcomes on HIV rates among the unhoused population in Washington D.C.

PrEPARE program staff members will be trained to use recordkeeping processes to record participant data collected during testing services using practices that protect patient confidentiality. Before staff members are given access to the data files, they must have completed the CITI training which will teach staff how to properly handle personally identifiable information (PII) and follow regulations related to data management and security (CITI program, n.d.). Any data shared with partners and stakeholders will be de-identified and shared in summary reports to limit the number of people with access to identifiable information and prevent stakeholders from identifying participants. Furthermore, information collected on the data sheet will be secured using the protocol identified in the CDC's Data Security and

Confidentiality Guidelines for HIV, Viral Hepatitis, Sexually Transmitted Disease, and Tuberculosis Programs. To do this, the PrEPARE program director will be named as the overall responsible party (ORP) for maintaining data security and ensuring data collection procedures follow national recommendations. This will include the use of password protection on the excel sheet. This will also entail the development of confidentiality agreements to be signed annually by all staff members who have access to PII. As per CDC recommendations, confidentiality and data protection practices will be reviewed annually by team members at staff meetings. Additionally, the only PII that will be collected is participants' names which will be used to track continued utilization of program services such as PrEP shots (CDC, 2011).

Trained staff members on-site at the PrEPARE program mobile van will use internal recordkeeping on a shared excel spreadsheet to track five main objectives for program fidelity. The questions that will be evaluated for program fidelity are as follows: 1) Were HIV testing services offered every 3 weeks at all sites? 2) Were PrEP shots available at all HIV testing events? 3) Was an average of six, CDC rapid testing protocol steps for nonclinical sites completed during patient visits? 4) Were 80% of patients referred to community services? and 5) Was the program culturally competent?

To analyze these questions, data will be pulled from internal records related to the location of the PrEPARE mobile van such as variables related to the dates and locations of testing and the services offered. This data will be logged by on-site staff on a spreadsheet at the end of each shift. On this spreadsheet, summarized data will be recorded for the number of HIV tests given, the number of nonreactive and reactive HIV tests, and the total count of PrEP shots administered for the day. This data will be useful for providing summary reports to stakeholders

on the progress of testing and PrEP administration and it can be used to quickly assess program fidelity for objectives 1 and 2.

To assess objectives 3 and 4, the shared database of patient data will be assessed for the variables recording completion of the CDC protocol steps during patient visits. Providers will mark the steps that were completed during the visit or immediately after to ensure the accuracy of the information. The completion of the checklist will then be summed in a separate variable on the overall data sheet to provide an overview of how much of the protocol was used. The mean and median of this column can then be used to determine how often patients received the care that was intended and if there were any differences in how patients received care. The summarized data will also be used in staff and CAB meetings to determine progress and challenges to program implementation. Particularly, utilization of CDC protocol can be used to determine which steps of the protocol are working and which need to be modified. If steps are consistently skipped or missed, additional training or modifications may be needed.

To assess the final objective, an anonymous feedback survey adapted from The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Cultural Competence (CC) survey will be used to assess cultural competence and the quality of patient care (see Table 1). The CAHPS CC survey is a 26-item survey that assesses eight domains of cultural competence: doctor communication-positive behaviors, doctor communication- negative behaviors, doctor communication- health promotion, doctor communication- alternative medicine, shared decision making, equitable treatment, trust, and access to interpreter services. Three of these domains (doctor communication-positive behaviors, doctor communication-negative behaviors, and trust) will be used in the feedback survey for a total of 12 items. Multiple regression results looking at the validity of the association between overall doctor rating

and the CAHPS CC ratings found a significant positive association between each domain. Each of the three domains that will be utilized were found to have internal consistency with an alpha higher than 0.70 (Weech-Maldonado et al., 2012). The last section of the survey will be an open-ended question that will allow participants to write in any additional information about the program. The findings from the feedback survey will be used to assess staff members' ability to provide adequate treatment to the unhoused population. Consistent low scores on survey items will be addressed at monthly staff meetings to determine what changes need to be made to better provide for patients. Upon completion of the survey, participants will receive a \$15 gift card to a local grocery store.

The participant data collected will also be used for the impact evaluation that will determine the reach of the program and the utilization of services. The questions that will be used to evaluate the objectives are as follows: 1) Did 60% of residents living at the housing sites over the course of the program receive HIV testing? 2) Did 50% of participants with nonreactive HIV tests get a PREP shot? 3) Did 85% of participants with a reactive HIV test return for follow-up testing? These objectives were set based on national statistics and outcomes found in previous programming (CDC, 2018; Kuo et al., 2016; Bowles et al., 2008).

Participant records tracked on the shared excel sheet will be used to determine if these objectives have been met by program end and can further be used to track progress along the way. As described, participant records will log each date of HIV testing, results of tests, and PrEP utilization. If participants have a reactive test, follow-up visits will also be recorded. From this data, the percentage of participants choosing to partake in testing and receiving the PrEP shot will be determined. This data will be further used in collaboration with demographic data pulled from participants. Records will track demographic data such as race and ethnicity, age,

sexual orientation, gender identity, housing facility of residence, and duration of housing instability which can be used to determine the population that is being reached by the PrEPARE program. Participant demographic questions will be asked by PrEPARE staff during the waiting period for the HIV test results to ensure that data is received. Scripts and checklists will be used by staff members to ensure that data is collected using the same methods to avoid influence on responses. Summary reports of this data will be discussed at every other CAB meeting to determine which groups of people have lower utilization of PrEPARE services and brainstorm how to better reach and serve them. Since data will be collected using a shared spreadsheet, data can be updated and analyzed in real-time, so reporting progress can be simple for the program coordinator for evaluation.

The final piece of evaluation will focus on the long-term program outcome: did the incidence of HIV decrease among unstably housed or unhoused people in Washington D.C.? This outcome will be more difficult to assess since this question is not directly measured. To infer the long-term outcome of the program, the use of secondary data is necessary. Two different data sources will be used for this purpose: the Point-in-Time (PIT) Count and AIDS Vu. The PIT Count is an annual, nationwide count of individuals experiencing homelessness that is conducted by each Continuum of Care (CoC) in the last 10 days of January. The PIT Count is required by the United States Department of Housing and Urban Development (HUD) and maintains a set of minimum standards to ensure data quality. One of the questions asked in the survey is related to the health conditions of participants, including current HIV status (US HUD, n.d.). This question can then be used to assess the prevalence of HIV among the unhoused over time. AIDS Vu is the other dataset that can be used to determine the incidence of HIV as it collects the HIV incidence and prevalence rate for Washington D.C. by zip code (Sullivan et al.,

2020). The combination of data from these two sources can allow inferences to be made about the change in prevalence of HIV among the unhoused population, while giving context to the incidence rate of HIV in Washington D.C. overall.

Capacity and Experience of the Applicant Organization

The Whitman-Walker Health program is a program based in Washington D.C. that focuses on providing inclusive and culturally competent health and quality of life services to a diverse population with a special emphasis on HIV care. Since Whitman-Walker Health was founded, our goals have prioritized the provision of necessary care and services to underserved populations, particularly those in the LGBTQ+ community. This was evident when we became the first organization contracted by Washington D.C. to provide AIDS services to the community in 1983 (Whitman-Walker Health, n.d.a). This is also evident in our mission statement which emphasizes our commitment to culturally competent care which we provide to an ever-expanding community through continually evolving services (Whitman-Walker Health, n.d.b). Today, we continue to work toward this mission by annually serving over 2,000 transgender and gender non-conforming patients, providing low-cost HIV services based on patient's ability to pay, helping enroll patients into programs and benefits for which they are eligible, and reaching patients experiencing unstable housing or homelessness (Whitman-Walker Health, 2019a).

Our work extends beyond the services we provide as we are also advocates for people living with HIV, the LGBTQ+ community, and immigrants and we are proud members of the D.C. Community Anchor Partnership (DCCAP) which aims to support minority-owned businesses in Washington D.C. (Whitman-Walker Health, n.d.b). As part of this work, we have garnered annual support from over 100 corporate sponsors, hundreds of donors, and several hundred volunteers (Whitman-Walker Health, 2019a). This includes the Washington D.C. DOH

and St. Elizabeth's East Campus. This work has allowed us to maintain steady communication and expectations with these partners through the development of a donor bill of rights and the dissemination of annual reports (Whitman-Walker Health, n.d.b). Furthermore, all staff are held to the highest standard of inclusivity and professionalism as we require continual professional development on a variety of topics including LGBTQ cultural competence, substance use and harm reduction, and mental health (Whitman-Walker Institute, n.d.)

Beyond the commitment to our community, Whitman-Walker Health has extensive experience managing and attaining program funding and planning and implementing programming. We have been involved in HIV/AIDS prevention since the initial AIDS epidemic in Washington D.C. during the 1980s. Since then, we have expanded our locations and services, serving over 20,000 unique patients each year on-site and performing over 13,000 HIV tests of which 3,000 tests are free each year (Whitman-Walker Health, 2019a). Furthermore, Whitman-Walker Health was selected by the Washington AIDS Partnership to pilot the Mobile Outreach Retention and Engagement (MORE) program which aimed to provide free, mobile HIV services to patients throughout Washington D.C. and reduce barriers to care. Following the pilot, Whitman-Walker expanded services to include a mobile HIV testing van that provides free, rapid HIV testing to the community several times a month (Whitman-Walker Health, n.d.c).

In addition to these services, we work with the National Institute of Health (NIH), the CDC, pharmaceutical companies, and other local organizations on research related to services offered. On average, Whitman-Walker Health manages 20 to 30 drug trials a year and in 2019 alone was involved in 18 active NIH-funded studies, 14 of which focused on HIV and 3 of which focused on PrEP (Whitman-Walker Institute, 2020). In addition, Whitman-Walker Health is funded in part by The Ryan White HIV/AIDS Program Part C (TargetHIV, n.d.). In 2019,

Whitman-Walker Health received over \$11 million from contracts and grants and managed over \$92 million in operating expenses (Whitman-Walker Health, 2019a). To maintain this level of involvement, we employ an extensive staff, including multiple infectious disease specialists, staff members dedicated to grant proposals, and American Academy of HIV certified providers (Whitman-Walker Health, 2023). We also strive to ensure that our patients receive the highest quality of services and care which we verify through feedback surveys. These feedback surveys are distributed to about 1 out of every 20 patients that receive care at our facilities and provide information related to the quality of care they received. This information is then publicly reported to ensure accountability to our mission of care (Whitman-Walker Health, 2019b).

Partnerships and collaborations

The PrEPARE program will be supported by partnerships with reputable, district-level organizations in the Washington D.C. community whose various responsibilities and connections will enable successful program implementation. One of these organizations is the Washington D.C. DOH which will play a role in the compilation of culturally competent resources that will be provided to the unhoused population at the time of HIV testing. The University of the District of Columbia's (UDC) Division of Education, Health, & Social Work will share some of the responsibilities with the Washington D.C. DOH in providing resources to program participants. These two organizations will provide their expertise on community resources to ensure PrEPARE staff and participants are aware of necessary program resources that can address additional needs of the unhoused population in Washington D.C. and provide culturally competent care. Finally, a representative from the HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA) and a faculty member from the UDC's social work program will sit on the PrEPARE CAB (D.C Department of Health, n.d.; UDC, n.d.).

Partner organizations were selected due to their reach and expertise in the unhoused community in Washington D.C. which aims to further the impact of the PrEPARE program. The Washington D.C. DOH and UDC are key community partners due to their connections to community resources that extend the level of care available to the unhoused population. Additionally, social workers are trained to assess individual's needs to provide them with appropriate care and likely have pre-established relationships with organizations in the community that provide low-cost services for a variety of needs (NASW, n.d). Both of these organizations are committed to helping the intended audience of the PrEPARE program as the DOH's mission statement directly states a commitment to health equity and has a specific department dedicated to addressing HIV/AIDS, while UDC is a land-grant university that will have the opportunity to collaborate on research publications. Both of these organizations have an extensive staff with a variety of specialties and, ultimately, they have the capacity and experience to partner on prevention programming in the community. For example, the DOH provides services for a variety of health concerns including HIV, adolescent health, heart disease and stroke prevention, rabies prevention, and many more. Similarly, UDC is involved in countless projects through faculty members with a greater focus on research and evaluation. The combination of these two skills, implementation of prevention programs and evaluation of research programs, will be instrumental in the PrEPARE program (D.C Department of Health, n.d; UDC, n.d.).

The three low-barrier housing sites and FMCS are additional community partners that will enable the implementation of the PrEPARE program. Housing sites will provide space in the parking lot for the mobile van to reduce barriers such as access and transportation to HIV services. Each housing site will also select a representative from the staff and from the shelter

residents to participate in the quarterly CAB. At these meetings, they will represent the unhoused population and strengthen cultural competence by providing direct insight into the needs and experiences of the community. Additionally, the housing sites and FMCS will aid in the dissemination of program materials to expand the reach of the program. In particular, housing sites will be used to directly access the unhoused population in temporary housing through the use of flyers in community areas and FMCS will give access to high-risk and unhoused people without any shelter. Since FMCS provides mobile needle exchange throughout Washington D.C., flyers distributed at these sites may reach a larger portion of the unhoused population. These four organizations, along with the Whitman-Walker program, have specialized interest in either HIV or the unhoused population or a combination of both. This insight will allow for the development of tailored resources and recruitment and retention strategies that are relevant to the intended audience of the program (FMCS, Inc., n.d.; CCNV, n.d.; N Street Village, n.d.; Catholic Charities, n.d.).

Project Management

The PrEPARE program will be managed across various levels with the highest level of responsibility falling on the program director, and the program coordinators being the next highest level of authority with more interaction with partners and staff members (see Figure 4 and Table 2). As the highest-ranking staff member on the project, the program director will be responsible for controlling and monitoring progress toward the overall goals and objectives set for the program. This will largely involve managing the budget, evaluating program data, attending high-level staff meetings, ensuring rigorous program practices, and maintaining partner relationships. The program director will also work with the program coordinators to address staff, partner, or population needs identified in meetings or evaluation.

The two program coordinators will split the daily responsibilities required to manage the program based on the area of need. Specifically, each program coordinator will be responsible for one of the following components of the program: evaluation or mobile clinics and community outreach. The program coordinator for mobile clinics and community outreach will be the primary contact for community partners and CAB members as demonstrated by their role as the leader of quarterly partner meetings. They will also be responsible for relationship development with partners at the onset of the program and maintenance of these relationships throughout the program. Additionally, the program coordinator for mobile clinics and community outreach will be responsible for the recruitment of participants for the program based on the ideas identified in the CAB meetings. The other aspect of their position will be to lead the daily running of the PrEPARE mobile van and supervise the mobile van staff. They will be the main contact for mobile van staff members, and their role will include leading staff meetings, as well as coordinating staff and mobile van schedules. The program coordinator for evaluation will lead staff training at the onset of the program and ensure that continuing education occurs for staff throughout the program. They will also help with the development of reports on program progress that will be used in internal meetings and CAB meetings. Furthermore, they will lead evaluation efforts to ensure both program fidelity and proper data collection methods that will help ensure high quality data upon program completion. It will be the staff members on the PrEPARE mobile van that will engage with the intended audience of unhoused individuals and carry out weekly activities of the PrEPARE program (see 2).

With the scope of responsibilities required for program staff, competitive wages and benefits will be offered based on the current job market in Washington D.C. Additionally, staff members will be awarded bonuses and the standard 3% raise at the end of every full year of

employment with the program to encourage staff members to build relationships among themselves and with community partners and participants and furthermore, to prevent high staff turnover rates. In addition to monetary incentives, monthly staff meetings with the program coordinator for mobile clinics and community outreach are intended to provide a platform for staff members to speak openly and honestly about challenges to programming or changes that need to be made. At these meetings, feedback surveys completed by program participants will be addressed to provide accountability for relationship building and culturally competent care.

To prepare staff members to provide appropriate care to unhoused individuals, rigorous training must be completed prior to contact with program participants. This training is described in detail previously and includes training on responsible practices when working with sensitive data and human participants and inclusivity training provided by CITI and edX (CITI Program, n.d.; edX, n.d). Prior experience working with diverse populations, especially those similar to the intended audience, will be prioritized during the hiring process to further promote the compatibility of staff members with program participants. Lastly, PrEPARE staff members will work with the CAB to continually assess mobile staff's use of the HIV testing script and other program materials to ensure their relevance to the unhoused population in Washington D.C.

Monitoring of the PrEPARE program will further be used to track utilization and receptivity of program services to determine if the complex needs of the unhoused population are being met. As noted before, unhoused populations tend to have higher rates of chronic health problems, illegal substance use, discrimination, and trauma than stably housed individuals which can pose unique challenges to regular HIV testing and PrEP adherence (Liu & Hwang, 2021). Therefore, one of the roles of the program coordinator for evaluation will be to compile internal reports tracking service utilization and return rates of participants to determine program

facilitators and barriers. These internal reports will be discussed at quarterly CAB meetings and at every other staff meeting to identify ways to strengthen continued adherence to PrEP with the guidance of community stakeholders. Additionally, incentives for utilization of program services are currently planned due to evidence for the use of incentives to increase program retention and overall utilization of HIV services in previous HIV programming (Spielberg et al., 2011).

Budget Justification

Program director

This position is responsible for the initial hiring of program coordinators and mobile clinic staff. Their responsibility is to oversee the duties conducted by the program coordinators and ensure that the program is moving toward the achievement of program goals. Additionally, the director will work with program coordinators to monitor national guidelines on HIV testing and PrEP, manage the budget, maintain partner relations, and evaluate the program (Indeed, 2023a).

	Pay*	Time	Fringe**	Amount Requested
Year 1	\$90,000	40%	\$9,074	\$45,074
Year 2	\$92,700	25%	\$5,842	\$29,017
Year 3	\$95,481	25%	\$6,017	\$29,888
			3-year total	\$103,979

*Pay increases reflect an average raise of 3% per year
 **Fringe is calculated in Table 3

Program Coordinator- Mobile Clinics & Community Outreach

This position will lead the program’s outreach efforts in the community and communication with the intended audience. They will be the connection between partners, mobile staff workers, and the program director. Main responsibilities will include the supervision of work conducted by mobile staff workers, the running of program meetings, and initial partnership and community outreach (Indeed, 2023b).

Pay	Time	Fringe	Amount Requested
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Year 1	\$60,000	100%	\$15,123	\$75,123
Year 2	\$61,800	100%	\$15,577	\$77,377
Year 3	\$63,654	100%	\$16,044	\$79,698
			3-year total	\$232,198

Program Coordinator- Evaluation

This position will lead the training of staff members and overall evaluation efforts for the program. Main responsibilities will include the creation of internal reports related to program objectives to be presented at quarterly CAB meetings and monthly staff meetings. Additionally, they will monitor program fidelity and aid the program director with external reports (Indeed, 2023b).

	Pay	Time	Fringe	Amount Requested
Year 1	\$60,000	50%	\$7,562	\$37,562
Year 2	\$61,800	50%	\$7,789	\$38,689
Year 3	\$63,654	50%	\$8,022	\$39,849
			3-year total	\$116,100

Mobile Staff

A total of six staff members will be hired to work on the PrEPARE mobile van. This van will run 8 hours a week for every week of the year. Each week, 4 staff members will be present on the van, so staff members will work 2, 8-hour shifts every 3 weeks. Their main responsibilities will entail providing culturally competent HIV testing and PrEP shots at low-barrier housing sites (Indeed, 2023c).

	Pay	Time	Fringe	Amount Requested
Year 1	\$6,000	<i>16 hours every 3 weeks</i>	\$1,512	\$7,512
Year 2	\$6,180	<i>16 hours every 3 weeks</i>	\$1,558	\$7,738
Year 3	\$6,366	<i>16 hours every 3 weeks</i>	\$1,597	\$7,963
			3-year total	\$23,213
			6 staff members	139,278

Travel

Travel expenses will cover the Annual Project Director’s meeting in Washington D.C. for each year of the program and Regional Training for both program coordinators for the second and third year of the program. This budget will include mileage costs, hotel expenses, and meals per diem. Travel will also include expenses calculated for the cost of gas, maintenance, and general repairs for the mobile van. The total budget for the mobile van will be \$720 (see Table 4).

	Mileage	Per Diem (Meals)	Hotel	Amount Requested
Annual Project Director’s Meeting				
Year 1	\$50	\$100/day	\$150/night	\$400
Year 2	\$50	\$100/day	\$150/night	\$400
Year 3	\$50	\$100/day	\$150/night	\$400
Regional Training				
Year 2	\$50	\$100/day	\$150/night	\$400
Year 3	\$50	\$100/day	\$150/night	\$400
Year 2	\$50	\$100/day	\$150/night	\$400
Year 3	\$50	\$100/day	\$150/night	\$400
			3-year total	\$2,800

Incentives

Incentives worth \$15 will be used to encourage participation in the PrEPARE program and the completion of study surveys. With an estimated 1,000 participants a year and the potential to earn two \$15 incentives, a total of 6,000 incentives will be budgeted. Therefore, \$90,000 will be reserved for program incentives for participants. The CAB will receive an incentive for participating in each CAB meeting. Each member will receive an incentive worth \$50 for each of the four meetings held annually. The total cost for this is estimated to be \$6,000. The overall incentive budget is then \$96,000.

Training

Training costs will be incurred through the purchase of qualified programming on Citi and edX. Citi has a one-time fee of \$4,000 for non-profit organizations and edX has a \$49 per person fee

(Citi, n.d.; edX, n.d.). The total cost for these programs will be \$4,392. An additional \$2,000 will be budgeted for the cost of food for staff during training. The total training budget is then \$6,392.

Supplies

The remainder of the budget will be spent on the supplies needed for the mobile van. These supplies include the HIV testing kits, personal protective equipment (PPE), office supplies, resource pages, flyers, condoms, and PrEP shots. Costs for HIV testing kits, resource pages, PPE, and condoms are calculated based on an estimate of 5,000 participants using the supplies, or slightly above an 80% success rate (if 2,000 people are reached about the program a year). Costs for program information are calculated based on the ability to reach 6,000 people. Cost for PrEP is based on a 50% acceptance rate of participants with non-reactive tests (estimated 2,500).

	Cost per person	Amount Requested
HIV test kits	\$8*	\$40,000
PPE	\$0.49**	\$2,450
PrEP shots	\$0***	\$0
Condoms	\$0****	\$0
Office Supplies	\$0.30	\$1800
Dissemination materials	\$0.15	\$1800
	3-year total	\$46,050

*(Shrestha et al., 2008)

** (Eggman, et al., 2014)

*** (DC Health and Wellness Center, n.d.; Apretude, 2023)

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Appendix

Figure 1: Logic Model for the PrEPARE mobile program

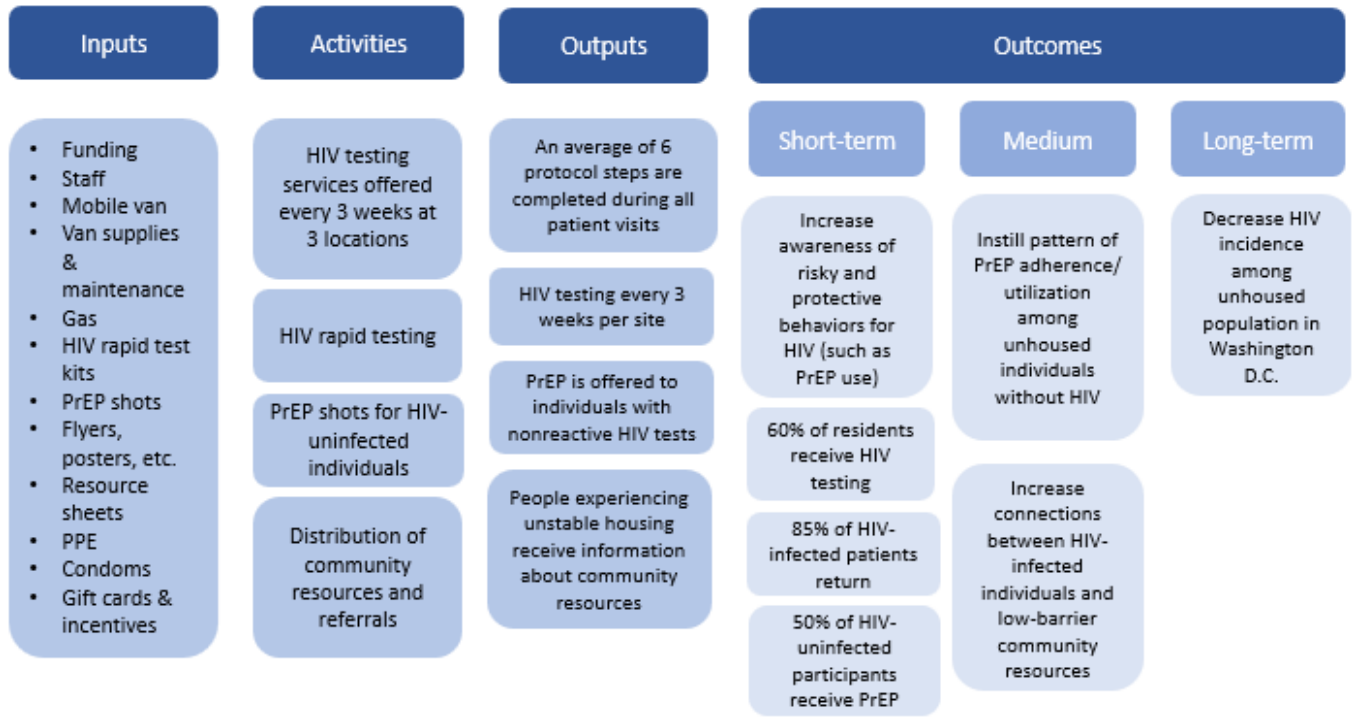


Figure 2: GANTT Chart for the PrEPARE mobile program

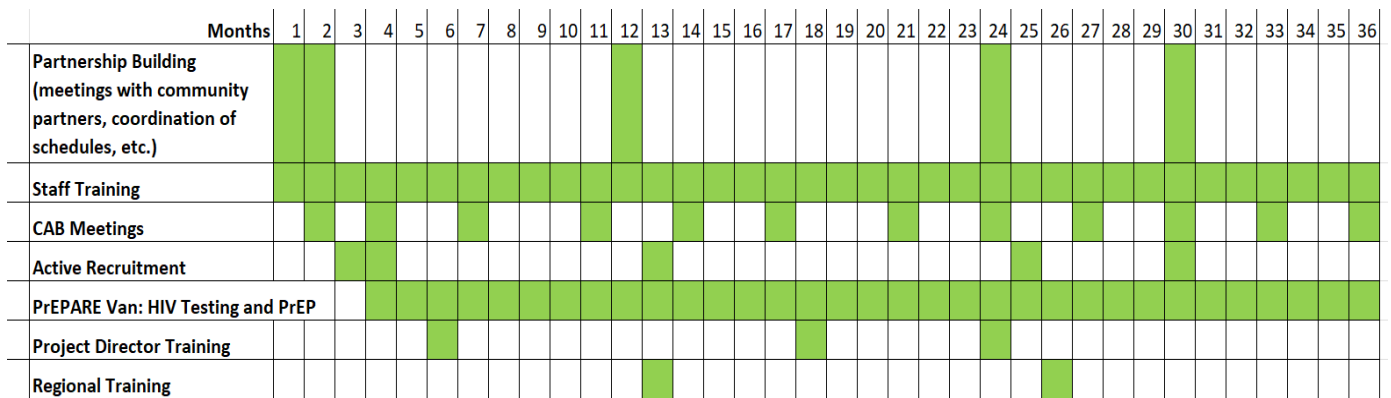


Figure 3: Rapid Testing Checklist for Mobile Clinic Staff

Step 1: Provider-patient introductions and testing information

Step 2: Preparation for HIV testing and consent collection

Step 3: Rapid test administration

Step 4: Risk Screening and data collection

Step 5: Results reading

Step 6: Develop care, treatment, and prevention plan

If negative, offer PREP shot.

If positive, confirmation test.

Step 7: Link to community services

Adapted from the CDC's Protocol for Rapid Testing

Table 1: Feedback survey to assess cultural competence and the care quality

Domain	Item	Responses
<p style="text-align: center;">Doctor communication- positive behavior</p>	<p>At your last visit, how often did your tester explain things in a way that was easy to understand?</p>	<p>never-sometimes- usually-always</p>
	<p>At your last visit, how often did your tester listen carefully to you?</p>	<p>never-sometimes- usually-always</p>
	<p>At your last visit, did your tester spend enough time with you?</p>	<p>yes, definitely- yes, somewhat-no</p>
	<p>At your last visit, how often did your tester show respect for what you had to say?</p>	<p>never-sometimes- usually-always</p>
	<p>At your last visit, how often did your tester give you easy to understand instructions?</p>	<p>never-sometimes- usually-always</p>
<p style="text-align: center;">Doctor communication- negative behavior</p>	<p>At your last visit, how often did your tester interrupt you when you were talking?</p>	<p>never-sometimes- usually-always</p>
	<p>At your last visit, how often did your tester talk too fast when talking with you?</p>	<p>never-sometimes- usually-always</p>
	<p>At your last visit, did your tester use a condescending, sarcastic, or rude tone?</p>	<p>yes, definitely- yes, somewhat-no</p>
<p style="text-align: center;">Trust</p>	<p>Do you feel you can tell the person who tested you anything?</p>	<p>Yes-no</p>
	<p>Do you feel the person who tested you always tells you the truth about your health?</p>	<p>Yes-no</p>

	Do you feel the person who tested you cares as much as you do about your health?	Yes-no
	Do you feel the person who tested you really cared about you as a person?	Yes-no
	What else would you like to share about your experience with the PrEPARE program?	O/E

Adapted from The Consumer Assessment of Healthcare Providers and Systems Cultural Competence survey.

Figure 4: Organizational Flow of the PrEPARE mobile program

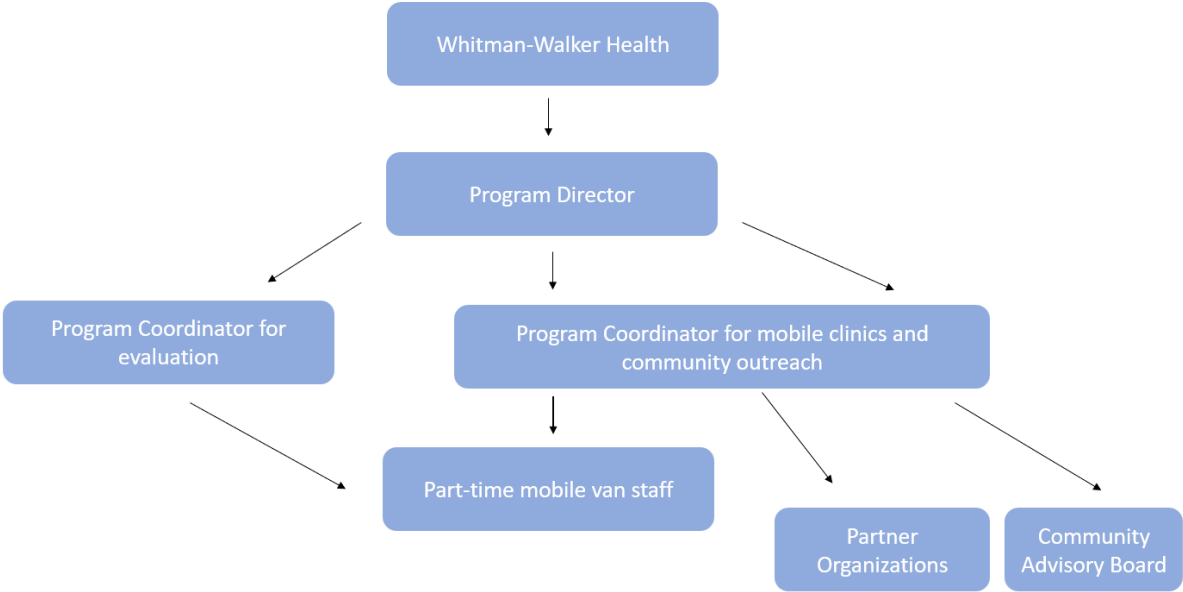


Table 2: Identification of staff and community partner responsibilities for the PrEPARE program.

PrEPARE staff or partner	Responsibilities
Program director	<ul style="list-style-type: none"> - Hire program coordinators and purchase training materials and programs - Attend monthly staff meetings (on a quarterly basis)

	<ul style="list-style-type: none"> - Attend quarterly partner meetings - Work with program coordinator for evaluation to monitor and update programming based on changes to HIV testing or PrEP guidelines - Manage program budget - Maintain partner relationships - Program evaluation
Program coordinators	<p>Community Outreach</p> <ul style="list-style-type: none"> - Dissemination of program information - Plan and lead quarterly partner meetings <ul style="list-style-type: none"> o Bridge staff and partner meetings by communicating key ideas addressed in either meeting o Maintain partner relations <p>Mobile Clinics</p> <ul style="list-style-type: none"> - Hire mobile van workers <ul style="list-style-type: none"> o Monitor training requirements for staff members - Coordinate mobile van schedule with community partners - Plan and lead monthly staff meetings - Supervise mobile van staff - Create staff schedules <p>Evaluation</p> <ul style="list-style-type: none"> - Train staff on proper procedures - Monitor and update programming based on changes to HIV testing or PrEP guidelines - Monitor program fidelity - Create internal progress reports for staff and CAB meetings - Create external reports for research and partners
Mobile van staff	<ul style="list-style-type: none"> - Work two, 8-hour shifts every 3 weeks (as the program will be conducted once every three weeks at each of the three sites) - Maintain training for vaccine administration, research practices, CDC protocol, and inclusivity - Attend monthly staff meetings - Conduct HIV testing and PrEP vaccination in accordance with protocol and scripts adapted from the CDC for the PrEPARE program - Refer participants to community resources - Utilize shared spreadsheets to record participant data and track program fidelity - Schedule follow-up visits with patients
CAB Representatives	<ul style="list-style-type: none"> - Attend quarterly meetings - Give feedback on program components - Approve program modifications - Assess cultural competence of program materials - Maintain lists of culturally competent providers and community resources
Housing sites	<ul style="list-style-type: none"> - Dissemination of program materials - Provide location for mobile van (parking lot)

	<ul style="list-style-type: none"> - Work with program coordinator to coordinate mobile van schedule
Health Department	<ul style="list-style-type: none"> - Train mobile van staff on available resources in the community - Maintain up-to-date resources for mobile staff - Provide information on changes to guidelines for HIV testing and PrEP - Provide community connections to needed resources
UDC Social Worker	<ul style="list-style-type: none"> - Train mobile van staff on available resources in the community - Maintain up-to-date resources for mobile staff - Provide community connections to needed resources - Opportunity to help with research and evaluation

Table 3: Calculations for fringe benefits*

	Percent of Salary
Social Security	7.65% <i>Salary x 0.0765 x 3</i>
Retirement	10% <i>Salary x 0.10 x 3 x # of staff</i>
Life Insurance	0.055% <i>Salary x 0.00055 x 3 x # of staff</i>
Other fringe	2.5% <i>Salary x 0.025 x 3 x # of staff</i>
Staff Bonus (after each year of employment)	5% <i>Salary x 0.05 x 3 x # of staff</i>

*Based on information shared by the University of Kentucky (UK, n.d.).

Table 4: Calculations of travel expenses

	Distance to Whitman-Walker (roundtrip)	Visits per Year	Cost of Diesel Gas (estimated*)	Repairs/Maintenance Cost**	Amount Requested***

Pat Handy	10 miles	18	\$6/gallon	\$0.0955/mile	\$126
CCNV	6 miles	18	\$6/gallon	\$0.0955/mile	\$76
St. Elizabeth's	3 miles	18	\$6/gallon	\$0.0955/mile	\$38
				3-year total	\$720

* Based on 2022 data from the U.S. Energy Information Administration (eia, 2022).

** Based on AAA cost estimates for maintenance, repair, and tires per mile (AAA, 2021).

*** Based on U-Haul estimates of miles per gallon (U-Haul, n.d.).

Table 5: Overall budget for the PrEPARE mobile program

	Year 1	Year 2	Year 3
A. Personnel	\$162,000	\$152,955	\$157,548
B. Fringe	\$40,831	\$38,556	\$39,665
C. Training	\$6,392	\$0	\$0
E. Supplies	\$16,851	\$14,601	\$14,601
F. Travel	\$640	\$1,440	\$1,440
G. Incentives	\$32,000	\$32,000	\$32,000
Total	\$258,714	\$239,552	\$245,254