Alive!
MARYLAND
BUILDING CAPACITY TO IMPROVE HEALTH

NEEDS ASSESSMENT

A Report on the Healthcare Capacity Building Needs of Maryland's Primary Care and Infectious Disease Workforce

PREPARED BY
HealthHIV

LET'S BUILD A HEALTHIER MARYLAND TOGETHER

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EXECUTIVE SUMMARY

In 2021, the Maryland Department of Health engaged HealthHIV to begin *Alive! Maryland*, the first-ever comprehensive capacity building initiative for the state of Maryland's primary care and HIV, viral hepatitis, STI, and harm reduction workforce. *Alive!* stands for **A**ssess, **L**earn, **I**ntegrate, **V**isualize, **E**ngage—representing each phase of the program—and serves as a motivational call to action to build capacity to improve health in Maryland.

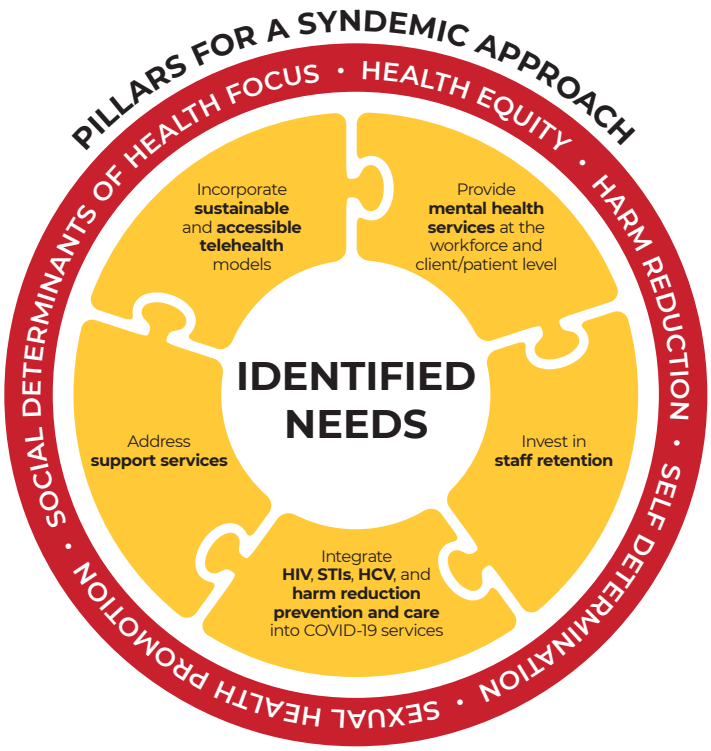
Alive! Maryland administered a mixed-methods needs assessment to gain insight into training and technical assistance needs of Maryland's primary care and infectious disease workforce. *Alive! Maryland* outlined the following pillars, which were used to address the needs assessment through a syndemic, comprehensive, and coordinated approach:

- Health Equity
- Harm Reduction
- Self Determination
- Sexual Health Promotion
- Social Determinants of Health

The assessment examined these pillars to inform the design, development, and delivery of the curricula to strengthen the technical capacity of Maryland's infectious disease and primary care workforce.

The results indicated that COVID-19 greatly impacted prevention and care activities at all levels and highlighted the need for a more responsive approach to address the intersectionality of the HIV, STI, hepatitis, and opioid epidemics through a health equity lens. Additional areas observed in both the quantitative and qualitative data collection and described in detail in this report are:

- Integrate HIV, STIs, HCV, and harm reduction prevention and health services into COVID-19 services;
- Provide mental health services at the workforce and client/patient level;
- Invest in staff retention;
- Incorporate sustainable and accessible telehealth models; and
- Address support services.



PURPOSE OF THE NEEDS ASSESSMENT

HealthHIV, in partnership with the Center for HIV/STI Integration and Capacity (CHSIC) within the Infectious Disease Prevention and Health Services Bureau at the Maryland Department of Health (MDH), conducted a rapid needs assessment to gain insight into the training and technical assistance (T/TA) needs of the state for the Alive! Maryland project. The assessment process examined workforce needs to inform the design and delivery of educational programming to bolster the capacity of Maryland's health workforce to tackle today's pressing population health challenges and to prepare for, prevent, and address tomorrow's challenges. The assessment will be conducted annually in calendar years 2021, 2022 and 2023.

HealthHIV developed the needs assessment in collaboration with the CHSIC. HealthHIV utilized validated assessment tools and sampling strategies that have been previously used in educational assessments and programming. This needs assessment included quantitative and qualitative instruments. More specifically, the needs assessment was conducted utilizing an online survey hosted on REDCap, as well as through key informant interviews (KII), focus groups, and community listening sessions. The MDH's Institutional Review Board reviewed and approved this protocol (protocol #21-35).

BACKGROUND AND RATIONALE

In 2019, Maryland ranked 8th among states and territories in adult/adolescent HIV diagnosis rates (per 100,000). Among people living with HIV in Maryland in 2019, the CDC estimated that 89% have been diagnosed, while an estimated 3,830 people remain undiagnosed.[1] [2] As the COVID-19 pandemic struck in 2020, Marylanders began to access healthcare less frequently. There was a 25% decrease in the total number of reported HIV-related tests relative to a 5-year average.[3] With this and other population health data, including the demographic profile or service utilization rates of people living with or who are vulnerable to HIV in Maryland, it is clear that there is good insight on health outcomes of patients based on key metrics.

However, many questions remain unanswered about Maryland's infectious disease and primary care workforce; presenting barriers for long-term health planning and effective public health actions. Effective public health action requires an adequately staffed, adequately skilled, and interprofessional workforce that is affirming of all Marylanders' lived experience. But in order to quantify and qualify the workforce across the state, it is essential to create and utilize health workforce data points that enable systems of care to measure the supply and distribution of professionals, and to inform the career and technical development opportunities to improve and advance specific job-related skills.[4]

In 2019, as MDH prepared a strategy for identifying the workforce development needs of healthcare personnel, more information was needed to better understand how the workforce interacts with Marylanders seeking HIV, STI, and viral hepatitis care services, including harm reduction. It is for this reason that MDH invested in Alive! Maryland; to gain more knowledge about the skills and competencies that the workforce needs to effectively do their job as well as the demographics of the workforce and their ability to liaise effectively with program participants. By integrating these data points with existing epidemiological data, MDH and its systems of care will be in an improved position to target where and how workforce development resources are deployed.

With this in mind, HealthHIV and MDH pursued conducting a needs assessment of the infectious disease and primary care workforce. In an effort to address the epidemic through a syndemic, comprehensive, and coordinated approach, MDH outlined the following fundamental pillars to guide their work:

- Health Equity
- Harm Reduction
- Self-Determination
- Sexual Health Promotion
- Social Determinants of Health Focus6

As a result, through quantitative and qualitative methods, the needs assessment examined these pillars to inform the design, development, and delivery of the necessary curricula to strengthen the technical capacity of Maryland's infectious disease and primary care workforce. The needs assessment also examined COVID's impact on infectious disease and primary care service delivery from a systems approach and its findings are discussed herein.

Methods

This needs assessment included quantitative and qualitative instruments. More specifically, the needs assessment was conducted utilizing a comprehensive online survey hosted on REDCap, as well as through key informant interviews (KII), focus groups, and community listening sessions.

Needs Assessment Quantitative Survey

HealthHIV developed an online needs assessment survey to elicit information about barriers, facilitators, and training and technical assistance needs for infectious disease and primary care workforce. The survey was hosted on REDCap, which is a secure web application for building and managing online surveys and databases. REDCap is in compliance with 21 Code of Federal Regulations (CFR) Part 11, Federal Security Modernization Act (FISMA), Health Insurance Portability and Accountability Act (HIPAA), and General Data Protection Regulation (GDPR), and it is specifically designed to support online and offline data capture for research studies and operations.

Qualitative Data Collection Events

HealthHIV administered qualitative instruments, key informant interviews (KIIs), focus groups, and a community listening session to elicit multi-level perspectives from health care providers, organizational leaders, key stakeholders, and residents of Maryland. These instruments encompassed semi-structured and structured question guides that were used to solicit feedback from participants.

HealthHIV conducted the following qualitative data collection events:

- One-on-one interviews with workforce (clinical providers and organizational leaders)
- One-on-one interviews with participants (residents of Maryland)
- Workforce focus groups
- Participant focus groups
- Community listening session with rural focused workforces

THE TOPICS COVERED IN THE SURVEY INCLUDED THE FOLLOWING:

- **Organizational background**
- **Individual background**
- **Client and patient engagement**
- **Continuity of program services and service utilization**
- **Organizational infrastructure**
- **Workforce planning**
- **State guidance and support**
- **Technical assistance needs**

Recruitment and Overall Sampling Approach

To facilitate maximum variation sampling, the program implemented a sampling strategy that ensured the broadest range of perspectives within Maryland's infectious disease and primary care workforce.

The *Alive! Maryland* needs assessment incorporated a variety of recruitment strategies as follows:

- Program-tailored emails via a customer relations management tool (CRM)
- Broad-scope emails to Maryland-based contacts via the CRM
- Influencer emails utilizing Interprofessional Advisory Board (IAB) members
- Posts on the *Alive! Maryland* website
- Advertisements in workforce publications
- Announcements at various Maryland-based meetings
- Community consultant to recruit residents of Maryland
- Local health department calls
- Marketing at national meetings (SYNC 2021)
- Phone banking Maryland workforce lists
- Incentives: SYNC 2021 access for survey respondents; Amazon gift cards for qualitative methods ($75 for interviews and $40 for focus groups and community listening sessions)

Needs Assessment Sample

HealthHIV, in collaboration with MDH, conducted outreach to the state of Maryland's infectious disease and primary care workforce using a sampling approach that ensures representation from across the state of Maryland.

Infectious Disease and Primary Care Workforce: The inclusion criteria included adult clinical and non-clinical health care providers who work in the field of infectious disease and/or primary care in the state of Maryland. Clinical and non-clinical health care providers include the following:

- Physicians (MD/DO)
- Physician Assistants (PA)
- Certified Nurse Practitioners (NP)
- Registered Nurses (RN)
- Midwives (CNM)
- Pharmacists (PharmD/RPh)
- Community Health Workers (CHWs)
- Public Health Workers
- Peer Recovery Specialists (PRCs)
- Social Workers, Therapists/Counselors
- Obstetrician/Gynecologists (OB/GYN)
- Administrative and leadership staff

Participants: Inclusion criteria included adults 18 years of age and older who reside in Maryland and access health services. Moving forward, this report will refer to residents of Maryland who engaged in the qualitative data collection activities as participants.

FINDINGS

Detailed below are notable findings from the needs assessment survey. Many respondents wrote in specific needs, which echoed stories and details shared during the qualitative data collection activities. They commented on emerging training and technical assistance needs, particularly around telehealth infrastructure and electronic messaging systems and the associated costs. Further, respondents expressed their thoughts regarding training sustainability and how to improve engagement and retention of patients during times of stress, namely the COVID-19 pandemic.

Needs Assessment Survey

The *Alive! Maryland* needs assessment survey was administered from July 20th to November 4th, 2021. 319 people in the workforce participated in the survey. To start the needs assessment, respondents were asked, "What is the State of Infectious Disease and Primary Care in Maryland in one word?" Respondents answered along a continuum from improving to lacking, signifying that providers are reporting a vast range of experiences They reported that the state was:

- Improving
- Concerning
- Limited
- Overwhelmed
- Lacking

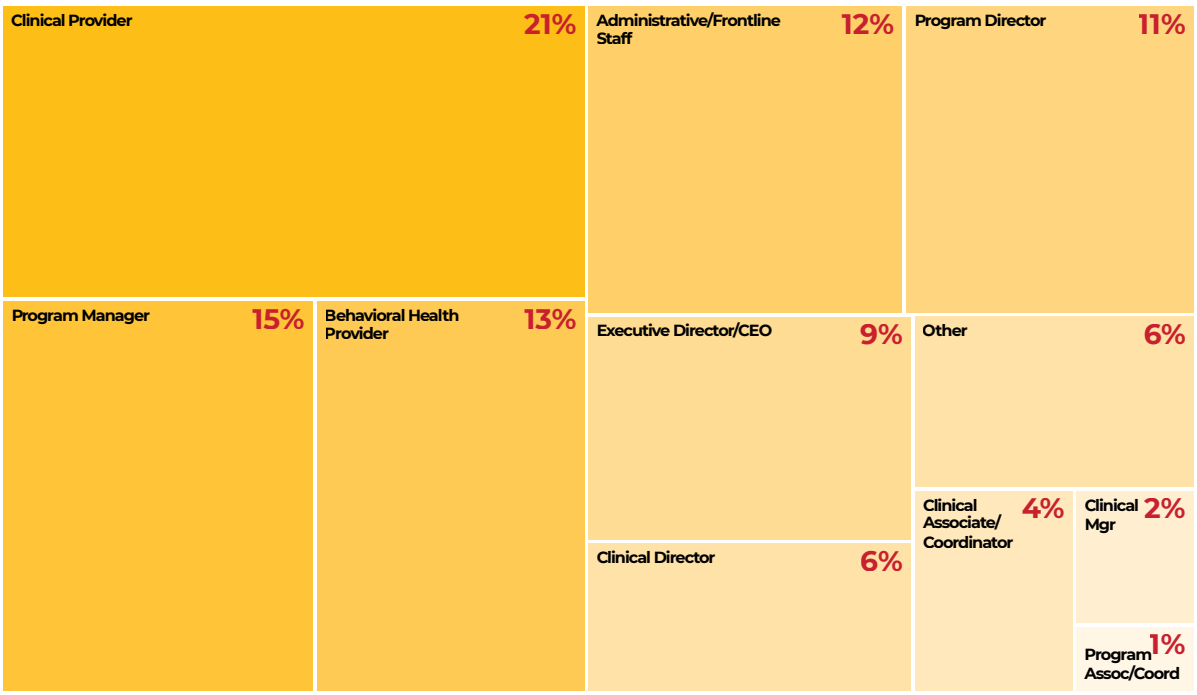
This data indicated the needs for training and technical assistance for the workforce to overcome these challenges.

Demographics

More than half of respondents were 45 to 64 years of age (58%). Of the 319 respondents, 55% identified as White, and 32% as Black/African American. In regards to gender identity, 75% identified as woman/female, 20% man/male, and 4% as gender queer/gender non-binary.

The survey included respondents from 23 out of the 24 counties/jurisdictions in Maryland, primarily from Baltimore City (22%), Prince George's (18%) and Montgomery (14%) counties. These three jurisdictions represented the majority of new HIV diagnoses.

RESPONDENTS INCLUDED A REPRESENTED DISTRIBUTION OF CLINICAL AND ADMINISTRATIVE POSITIONS



Of the clinical providers, 27% specialized in HIV and 25% in general family medicine/primary care. The majority (74%) of clinicians have been in practice for more than 21 years. Respondents included a diverse set of organization types: health departments (37%), primary care clinics/practices (13%), behavioral health organizations (11%), federally qualified health centers (FQHCs)/FQHCs look-alikes (10%), and community-based organizations (10%). Please see the Appendix for more information.

Respondents indicated that they offered a wide range of services. The top five services reported were as follows:

Training Needs

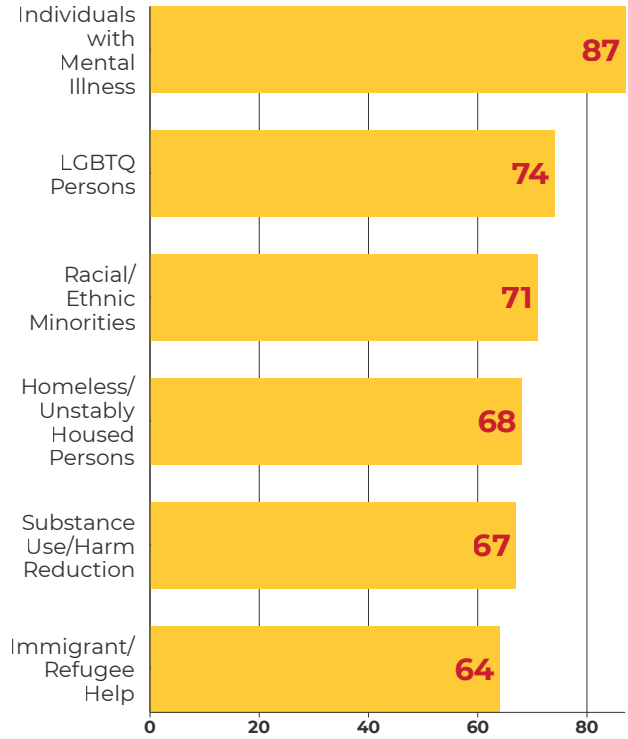
When respondents were asked about preferred training format, they overwhelmingly reported that they preferred online trainings (79%).

Respondents stated that they normally learn about training through the following channels:

1. State and local health department listservs/ emails
2. Maryland Department of Health website
3. Federal government website
4. General searches online
5. Federal government listservs/emails
6. Technical assistance provider websites

When asked about training needs by audience type, respondents indicated that they need technical assistance and trainings for individuals who are marginalized and vulnerable as outlined in the graph below.

RESPONDENT TRAINING AND TA NEEDS BY AUDIENCE (TOP 6 IDENTIFIED)



The survey included items that asked about training needs for the following specific areas to help guide MDH's work.

Clinical and behavioral areas yielded the most need for trainings and technical assistance. The top seven areas were:

- Mental health
- Harm reduction
- Intersectionality of substance use, HCV, STIs, and HIV
- Whole person health
- Telehealth
- STIs
- Motivational interviewing

The **prevention and surveillance** needs centered around engaging with the systems and providing direct services.

- Community health centers and primary care practice engagement
- Retention and re-engagement in care
- High impact prevention†
- Testing
- Behavioral surveillance
- Healthcare reform

For **organization and infrastructure development**, respondents reported a diverse set of needs from marketing to human resources.

- Social media and marketing
- Emergency preparedness
- Evidence-based policy development
- Research and data use
- Technology integration
- Human resources and workforce planning

The **fiscal training** needs identified were both at the system level and individual level including:

- Tracking grant funds
- Fiscal planning and resource development
- Budget development
- Assessing client and patient financial need
- Third party reimbursement

† In the High-Impact Prevention approach, HIV prevention efforts are guided by five major considerations:
- Effectiveness and cost
- Feasibility of full-scale implementation
- Coverage in the target populations
- Interaction and targeting
- Prioritization

For more information, please reference this link: https://www.cdc.gov/hiv/policies/hip/components.html

To ensure that the trainings reach those that would benefit from them, the survey inquired about challenges when accessing trainings. The most prominent challenge was lack of time. The workforce has been hit particularly hard as a result of the pandemic due to mental health issues, burn out, and staffing shortages. Therefore, trainings need to be relevant to the workforce's identified needs, provide incentives such as CME/CE credits, and be offered at times that work best for the workforce's demanding schedules.

Other challenges included being unaware of the training and technical assistance opportunities as well as unsure how to access trainings. These challenges require more awareness campaigns through *Alive! Maryland* to reach those that would benefit from the trainings.

Telehealth

Telehealth has become an integral, mainstream part of healthcare delivery. Once considered a novel service innovation with nominal uptake, telehealth demand skyrocketed globally with the pandemic. As outlined in the training needs section above, most respondents commented on emerging training and technical assistance needs, particularly around telehealth infrastructure and electronic messaging systems and how to pay for these systems. Further, they requested training on sustainability and how to improve engagement and retention of clients and patients during times of stress, namely the COVID-19 pandemic.

Since the beginning of the COVID-19 pandemic, 73% of respondents implemented telehealth as an alternate service delivery approach. Since implementation, the vast majority (69%) of respondents believe that telehealth effectively engages people and promotes the continuity of services. Most respondents reported that behavioral health and case management services can be conducted effectively via telehealth.

To support telehealth, respondents stated that they offered in-clinic access to telehealth and internet access, distributed mobile phones and tablets, and

lastly provided technical assistance to navigate telehealth.

However, telehealth does not work well for everyone as there are issues with access, equipment, safe, private and confidential spaces, technical literacy, and trust with a new service delivery approach. Respondents noted that persons experiencing financial difficulties, homelessness, and older patients are less likely to engage with telehealth.

Workforce Shortage, Burnout, and Retention

When asked about the factors that make staff leave their organizations, respondents said that it was primarily due to burnout (70%), staffing shortages (54%), new employment opportunities (55%), and low pay (52%). These are issues that the workforce is experiencing on a national level known as the "Great Resignation." The respondents indicated that the following is helpful in addressing burnout and staffing shortages:

- Retention incentive
- Alternate work schedules
- Workforce development programs
- Childcare assistance

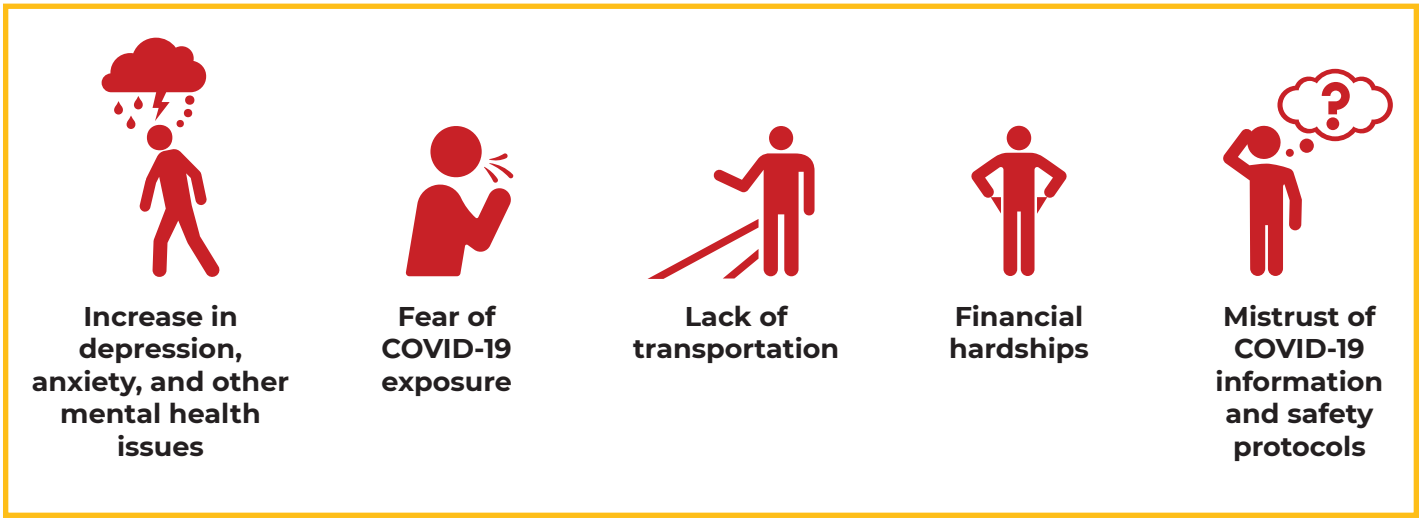
COVID-19 Eclipse and Integration

The results showed that COVID-19 has impacted health service at all levels; it has eclipsed the other epidemics including HIV, STIs, and HCV. The data indicated that the workforce in Maryland was largely unprepared to respond to the COVID-19 pandemic.

The respondents reported a number of client/patient-level barriers experienced during the height of the COVID-19 pandemic:

- Increase in depression, anxiety, and other mental health issues
- Fear of COVID-19 exposure
- Lack of transportation
- Financial hardships
- Mistrust of COVID-19 information and safety protocols

Respondents reported that they still require help adapting to the new reality of COVID-19. They requested workflow improvements, COVID-19 testing kits, office redesigns, PPE, non-contact thermometers and other medical devices, plexiglass barriers, seasonal equipment to allow for outdoor engagements, and signage.



Qualitative Data Collection

For the second phase of the needs assessment, the *Alive! Maryland* team conducted interviews, focus groups and a community listening session with the workforce and participants as outlined in Table 1.

WORKFORCE AND DATA COLLECTION TOOLS

Workforce	Participants (Residents of Maryland)
10 Interviews	10 Interviews
2 Focus Groups	2 Focus Groups
1 Community Listening Session	

Workforce

The respondents represented a diverse set of the workforce—clinical providers, behavioral health professionals, government administrative employees, disease intervention specialists, and executive directors. They were from both urban and rural areas: Baltimore City, Baltimore, Prince George's, Montgomery, Cecil, Dorchester, Worcester, Queen Anne's, and Howard counties. They represented a variety of organizations including FQHCs, behavioral health organizations, health departments, HIV/AIDS service organizations, substance use treatment facilities, faith-based organizations, and health systems.

I. Staff Mental Health

Respondents noted that the mental health of their staff has been significantly impacted by the pandemic, and that in many cases, the longer the crisis continues, the greater the impact.

In regards to mental health, the issue of grief surfaced. The results highlighted the increasing need for grief counseling not only for mourning people that have passed away, but also grieving for life before COVID-19. As a result of this new reality, the workforce respondents discussed utilizing non-traditional mental health practices including yoga, art therapy, equine therapy, breatheology, meditation, dance, and acupuncture with both clients and patients as well as staff.

II. Workforce Shortage, Burnout, and Retention

Since the start of the COVID-19 pandemic, workforce shortages in healthcare settings have become more common as outlined above. Respondents reported that work hours have increased over the last two years to compensate for staff shortages and the increase in COVID-related duties:

> *My colleagues work all the time. They work all the time. They do notes in their pajamas, they spend 6 to 12 hours every weekend on just electronic paperwork … There's extreme amounts of stress on people.*

As a result, many members of the workforce experienced fatigue and burnout, and employers struggled to find ways to adequately support their staff.

> *I think there are gaps in terms of how we support people, in terms of their emotional state and their burnout. I don't think there are great … tools to deal with that … I don't know that the institution … sending me a hoodie and saying "thanks" [is] … going to address the burnout…*

The rural providers specifically noted that more public health nurses are needed in their communities to deliver services. They further explained that the "great resignation" and burnout has significantly impacted their workforce, which impacted clients' and patients' ability to see their providers for routine visits and accessing essential medical services.

As a result of these staff shortages, several interviewees noted that it is becoming necessary to think creatively in order to support and retain staff, citing a variety of policies and workflows they have implemented in order to ease their staff's burdens. Some have encouraged their staff to work flexible/non-traditional hours that complement their personal lives or to take their birthdays off, while others have canceled all Monday meetings, prohibited emailing after 7:00 pm, and made concerted efforts to minimize meeting time across the board. One respondent explained that many

prefer these practices to more traditional methods of staff support:

> *I think the entire healthcare industry's gone in the wrong direction around supporting people. I think we've gone in the direction of resilience and pizza parties and not looking at drivers of moral injury and what we can do to really help people feel supported at work, which is, 'are our systems and processes working and our expectations reasonable?'*

Though respondents listed a variety of best practices for ensuring staff retention—including sending out gift cards, maintaining a healthy work environment, providing easy and frequent opportunities for communication, allowing remote work, and prioritizing mentorship—nearly every response ultimately pointed towards the importance of mental health and the value of comprehensive training. Interviewees reiterated that employee satisfaction and fulfillment are intertwined with mental health, particularly when so many public health professionals continue to be negatively impacted by the ongoing public health emergency. Additionally, they noted that a well-trained workforce is also likely to be a stable one:

> *Training definitely helps with retention because … you definitely don't want your staff thinking that they can't do the job because then that'll lead to them wanting to leave the job. You want to arm them with any tool you can in their tool belt to make them successful at their job.*

Finally, respondents stressed the importance of providing extra support to health workers who are disproportionately impacted by COVID-19, work shortages, and burnout—namely people of color and lower-paid employees:

> *Lower-paid healthcare workers are disproportionately people of color. The fact that it's cost-effective just means that they're underpaid for the labor that they're doing. There's just all of these inequities tied into that.*
>
> *… COVID-19 has laid bare all sorts of employment-related inequities. Even thinking about within our clinic, I had the privilege to telework. My medical assistant, who earns a lot less money than I do, had to come into the clinic every single day …*

III. Telehealth

The majority of organizations interviewed are finding that a hybrid model of care, which combines in-person and remote services, is likely to become a permanent component of their practice.

> *We were also able to telework when need be. If I wasn't needed in a clinic, I was able to telework and do my work at home, which was a great thing too. We still are doing that now.*

90% of organizations that implemented telehealth services foresee those services becoming lasting parts of their work. Interviewees explained that telehealth has had many positive impacts on their work, allowing them to reach clients and patients whose schedules or transportation options had previously prevented them from accessing services.

However, interviewees also expressed serious concern that the widespread adoption of telehealth is resulting in the widening of key health disparities, highlighting the significance of the technology/internet divide and the critical need for increased access to technology among vulnerable populations. More specifically, they noted that significant challenges to telehealth implementation include lack of broadband, WiFi, and technology, especially in underserved and rural communities, in addition to limited technological literacy among older clients and patients. Additionally, two years into the pandemic, providers, clients, and patients alike report missing human contact:

> *I think one of the things … people call and they want physicals. I think people want to be touched. They want a relationship, they want an exam, they feel better when I lay my stethoscope down on their chest. I understand all of that. I think that there's a level on which … if you have knee pain, you don't want to just talk about it on the phone.*

IV. Technical Assistance and Trainings

Respondents listed a variety of factors which influence their decisions around choosing TA, including:

- Client/patient feedback,
- Reported service gaps,
- Recurring professional or skills development for their team,
- Demonstrated need for structural organization growth (especially when navigating changes in policy, medicine, or research).

These factors were evaluated through patient surveys, standardized performance measures, and staff feedback and brainstorming sessions:

> *This decision, again, starting with consumers, but also then looking at our team and saying, "How do we develop the team, in what ways?" That may be brand new initiatives to make sure that the staff is on board, but it'd also be revisiting and rehashing or redeveloping or adding additional skills.*

Workforce respondents reported obtaining TA and training through a variety of avenues including the websites or TA centers of universities, health departments, non-profit capacity building organizations, and national health experts. Some resources listed by interviewees included Johns Hopkins University, the University of Maryland, the Maryland Department of Health, HealthHIV, the CDC and the AETC. Alternatively, some find presenters and TA opportunities through their personal and professional connections.

There were multiple recurring themes in terms of TA approach and style preferences. Interviewees expressed that the most successful trainings use real-life scenarios and case stories, include some form of evaluation, engage a diversity of approaches and cater to a range of learning styles. These training sessions were successful because they are inclusive, engaging, group-oriented, visual, and critically, not too long so as to avoid scheduling conflicts:

> *Have a diversity of approaches within the training. Some didactic, some small group, some big... some opportunity to ... assess where people are having responses, scenarios et cetera, so people can actually understand how they actually walk into the scenario.*

Less successful sessions were described as being too long, not requiring active participation, not being relevant or interesting, or too dependent on an online platform without sufficient personal engagement. Interviewees indicated that program managers struggling to develop exciting and interesting TA should consider asking staff to practice skills they need to refine and use every day such as taking sexual histories or doing calls with clients and patients, sending supplementary reference materials for staff to go back to later, creating breakout rooms, and requiring that cameras be on if the session is virtual.

Crucially, several respondents also pointed out that it is important for TA presenters to be informed and relevant to the staff and the organization's mission, saying:

> *I think ... ensuring, to the [greatest] extent possible, that the trainers are also culturally concordant with the staff ...*
>
> *... Having local presenters, definitely ... helps a lot. That way, you're communicating not only with a local provider, but somebody that you may work with later down the line...*

V. COVID-19 Eclipse and Integration

Since the start of the pandemic, other public health crises including the opioid epidemic, the HIV epidemic, and the growing STI epidemic have all been eclipsed by the COVID-19 response. However, these crises continue to impact millions of Americans, and in many cases, have converged with COVID-19 to produce perfect storms of vulnerability for those affected. Interviewees noted that this was particularly true for their clients and patients who have experienced increased depression and substance use since the start of the pandemic, all

the while having less access to care due to COVID-19 shortages and closures:

> *COVID-19 has increased folks' alcohol use, probably concordant with that anxiety so just lots of alcohol use disorder to deal with.*
>
> *We were limiting STI testing, not that we [should] ever limit STI testing for adolescents, but we did.*
>
> *Not being able to see their primary doctors face to face based on lack of broadband, based on transportation, based on the risk of contracting COVID.*

Several interviewees argued that the best response to this reality was to acknowledge these overlapping crises as constituting a syndemic and requiring integration of health care services. One provider described their organization's approach to care integration, saying:

> *We attempt to try to hit all four of the populations that we want to serve, getting to them all at the same time by offering HCV, PrEP, harm reduction, and prevention resources all at the same one-stop-shop.*

VI. Supports — Social Determinants of Health Approach

Interviewees noted that COVID-19 has amplified barriers-to-care that already existed for their most vulnerable populations. The clients and patients who continue to be the hardest to reach include those in rural locations, non-English speaking people, unhoused people, undocumented people, people who inject drugs, and sex-workers. Providers report that these communities experience heightened social isolation, fatigue and mental illness, in addition to food and housing insecurity, job loss, and intimate partner violence. **Health continues to be determined by a person's social conditions as much as it is determined by the quality of their care, and providers across the care continuum remark that the TA available to them fails to help them overcome the multitude of social barriers facing their clients and patients**:

> *I think certainly in terms of how COVID has impacted our consumers, it's been the great magnifier. What's already been there, it [has] just put the magnifying glass in some ways, heated up so we see it more. More mental health, more depression, more insecurity, more housing insecurity, more Intimate Partner Violence, more, more, more and more.*

The most frequently cited social determinants of health included transportation, income, tech-literacy, nutrition, insurance, immigration-status, housing, and stigma. Those who do not have access to personal transportation and who are too vulnerable to use public transportation during the pandemic have experienced increased social isolation and mental health challenges. For many older folks, this has converged with isolation and illness to significantly impact their health. In the rural communities, it was not uncommon for clients and patients to travel three hours for a medical appointment. COVID-19 exacerbated this challenge, which resulted in more missed appointments and limited people being able to access services.

Additionally, people who are low-income, unemployed, or unhoused often have difficulty accessing the technology necessary to attend telehealth visits, and may not have permanent addresses at which to receive lab results, home-tests, or medical supplies. As a result, many members of these communities were unable to access care during the course of the pandemic. In the rural communities, the health departments received emergent funds that provided cell phones for clients. However, they do not have access to that funding source anymore, but the need is still there.

VII. Meeting People Where They Are

In order to address the syndemics of HIV, COVID-19, HCV, STIs, substance use, and mental health, providers described developing highly flexible programs designed to meet clients and patients wherever they are. This approach included:

- Providing education via social media
- Communicating with clients and patients over messaging services
- Paying for ride shares
- Delivering food and medical care to people's homes
- Incorporating mental health first and harm reduction into clinical care

> *Getting people Lyft passes, if they can get to work because they have to go to work. Just meeting people there, getting groceries and bringing them to their house, so they couldn't go out. It was special. Just extending our funding and thinking creatively about all of that, because with our funding, we have to link back to viral suppression. How does that link back? Well, if we can make them feel safer and navigating the role with COVID and help them to get there, they're more likely to then take their meds.*

> **"I think having needs assessments more frequently will help us pinpoint, these were what we had in place before. This is going to work based according to what's going on now, but this is what just came up, we need to modify this."**

Participants (Residents of Maryland)

Participants represented Maryland's diverse geographic, socioeconomic, and demographic sectors. While their experiences living with HIV varied, they shared similar stories around engaging prevention, treatment, and care services in Maryland, particularly under the unprecedented pressures of the COVID-19 pandemic. They noted that they experienced ongoing and evolving challenges related to their financial circumstances, housing, travel, and in-person care access during the pandemic. Participants reported facing layoffs and job losses, and limited opportunities to maintain or find housing due to bureaucratic and housing market pressures. Health care transportation services were limited as well, forcing participants to rely on rideshare services and public transportation. They also noted that limited capacity in health care offices often meant they could not get an appointment when needed. They often described telehealth as a viable, convenient alternative way to health care access, even though some participants reported a steep learning curve at the start of the pandemic due to the software and technological skills required. Telehealth also offered a way to mitigate exposure to not only COVID-19, but also HIV stigma, which was exacerbated by the pressures of the pandemic.

Themes of note encompassed:

I. Access to Care During COVID-19

APPOINTMENTS: LIMITED ACCESS

Many of the interviewees discussed their engagement in care since the beginning of the pandemic two years ago. After the shock of the initial lockdowns in spring 2020, many participants said they continued to access care, describing COVID protections as somewhat normalized in their doctors' offices. As one noted,

> *It's been running pretty fine. I have no problem with it. You just have to mask up and stuff, that's all.*

Another explained,

> *I go to my doctor regularly, my support groups and stuff like that. I'm good with that.*

Others described health care offices that had created well-coordinated care systems during the pandemic that facilitated regular in-person visits. They explained how many health care offices supported patient safety by establishing strict COVID-19 protocols, such as patient temperature check-ins at arrival; provision of masks, sanitizer, socially distanced waiting areas; and regularly scheduled telephone/video-based telehealth visits. As one patient noted:

> *Well, my doctor spreads appointment times out. That way, I don't have to sit in a waiting room and wait half an hour, or hour to get seen. When you go into the room, everything is wiped down and clean. They got on gloves. You got your hand sanitizer, everything in your room when you go in … They're very strict on that—even the type of mask you wear. If they see you with a cloth mask, they'll actually give you a different one. Even when we're sitting in the waiting area, they even have the chairs marked where you should sit. They've done all that they could do.*

Other participants, however, described providers who were still struggling with staff shortages and closures, which created barriers to care: longer wait times for care appointments, including those for HIV, primary care, behavioral health, and dental care. One patient said:

> *My ability for the access services because of the pandemic. It's been a little hard … especially for people with low income like me. I'm usually off on Tuesdays, but I couldn't schedule an appointment for that day because my doctor's always booked. [Getting care is hard] especially with work impacting me and my job and people are quitting, it's just like, it's unbalanced for me right now.*

LIMITED APPOINTMENTS: IMPACT ON HEALTH AND SAFETY

Other interviewees described how the barriers to appointment undermined their health:

> *Trying to get an appointment quick [was impossible]. I would have to wait like months. Before COVID, I would check in with my doctor every two months. When it was time for me to do that during COVID, it was hard for me to get an appointment. Then I had skin problems too. I was having outbreaks and just a lot of stuff when I couldn't get an appointment.*

Participants also described how workforce shortages often meant delays in seeing a provider, as well as long and sometimes unsafe wait times in the waiting room:

> *It was very bad. Like it was backed up with my doctor. When I would make an appointment, I would wait two or three months. The next time I would go in, it would be so packed with other patients.*
>
> *Sometimes, I didn't get my lab work done during the pandemic, because it was really backed up. It would be like two people doing blood work. It'd be like, 30 people waiting out in the lobby. I was just like, no. Sometimes they ain't get it done, or I would be sitting there for too long, and I feel like it was just taking up most of my time, so I'll end up leaving.*

TRANSPORTATION

Limited appointments often meant participants found themselves forced to see providers in different cities, requiring extended travel times on public transportation. As one patient explained:

> *I was trying to get a dental [appointment] [and] get my eyes checked. Every time I looked on the patient website, I would see that the available appointments were so far away from me—an hour to like an hour and a half away. I'm just like, wow, I don't even drive. I had to take a lot of buses. It was very difficult.*

Interviewees who depended on city-provided transportation to go to appointments said they often faced long wait times or last-minute cancellations due to driver shortages during the pandemic:

> *The services are not reliable because you don't have as many drivers as before. A lot of people aren't comfortable working. A lot of people aren't comfortable driving people around.*
>
> *I had a dental appointment on Monday. The driving service waited until my appointment time to tell me they couldn't pick me up.*

As a result, many participants and providers have turned to more expensive rideshare services to more safely and conveniently access care. Without these alternatives, participants talked about ultimately dealing with health care issues on their own rather than facing long travel times to access appointments:

> *There are not a lot of options nearby. I still have to go very far to see my provider. Nobody got time for that, especially if you're working. I haven't even seen this [doctor] or my foot specialist since I twisted my ankle.*

CUSTOMER SERVICE AND PATIENT RETENTION

Interviewees explained that they deferred care due to a multitude of challenges at the individual and structural levels. One described how her provider's office required patients to wait in their vehicles before seeing the doctor. She said she often had to "sit for long periods of time in the cold or heat," sometimes missing her appointment when staff forgot to bring her in. The situation created significant barriers to care, with one participant saying:

> *I just don't want to do all of that. They overbook people, and it is too much.*

Another said she just didn't have time to wait to see a provider, especially if it meant being around others who might have COVID-19:

> *If you give me an eleven o'clock, and if I'm there at eleven o'clock, I want to be seen at eleven o'clock because that's the time you put down … I don't want to be sitting there till 1:00 or two o'clock because then I'm going to get mad and I'm going to leave.*

II. Telehealth

STREAMLINED CLINICAL AND BEHAVIORAL HEALTH CARE

Nearly all participants interviewed accessed care both in-person and online. Most reported reserving in-person appointments for lab work at their doctor's office or laboratory service provider, except in cases of injury or severe illness. They often described the new focus on telehealth as surprisingly beneficial since they no longer had to take off work to receive lab results, but could access them through an online portal or telephone call from their doctor's office. As one patient noted, telehealth meant she could:

> *Get messages from my doctors through many emails and the medical portal. My doctors use something called MyChart, where we can communicate back and forth.*
>
> *When it's time for my blood work to get done, they do my blood work. When the results come back, my doctor calls me on the phone and lets me know about what they tested me for and all that. Let me know if it is normal or if something is wrong. That's why I like them because they don't wait until you come back on your next appointment to tell you what your lab result was.*

Participants noted that secure telehealth portals allowed them to maintain relationships with their counselors and support groups, providing them pivotal social support. A patient explained that:

> *I like telehealth. I also have one-on-one therapy, and then my other therapy group. It helps me a lot because I don't have to go a long way. My therapist can call me or Zoom meet me. We actually became a little closer. I actually trust her in a lot of different things. I always have a lot of questions for her. It just makes it easy for me.*

Another patient shared that telehealth helped her have a closer relationship with her support group, ensuring that she never misses an appointment:

> *I love my support group. We have a very close relationship with everyone there and with the leader. I love it. I love it. I wish we could meet more in person, but because of my hours at work, I'm glad that we can do it over the phone or through video because I'm at work usually now during the time that we have our meeting, so, I like it.*

TELEHEALTH CHALLENGES

While interviewees who participated in this study met with researchers using online meeting software, many described their challenges accessing telehealth:

> *I don't have any Internet access or WiFi. I'm calling telehealth through my data [plan]. I need to get the right phone plan. There is not a lot of assistance or equipment [though my doctor's office].*

Participants expressed concern about family members and peers who faced even more significant challenges to telehealth:

> *I'm also using online services with Medicaid. It's tricky to navigate for somebody that doesn't [have experience] going online to see a provider.*

> *When you try to get a provider on the phone, it's like they won't be able to give you the information at all, which would be [hard] for somebody that struggles with English, and they don't know how to do certain things on the computer, like an older person, older than me, and they don't know how to navigate a computer, or they're living by themselves.*

PERCEIVED IMPACT ON HEALTH CARE QUALITY

Others participants described feeling that telehealth care was sub-par to that provided during in-person engagements. One described their concerns about telehealth, noting:

> *I prefer to see [my doctor] face-to-face. I'm really not a phone person. I don't really know too much about the computer and all that stuff. I like doing stuff face to face.*
>
> *I've done [telehealth] and I don't like it. If something's wrong with me, how can I show you on a phone? How are you going to take my blood pressure? How are you going to check my weight? How are you going to check my breathing over the phone? My blood pressure? How would you know if my blood pressure was up if we're doing a phone appointment?*

Other participants said that telehealth made tracking appointments more challenging than in-person engagements. As one patient described:

> *I miss getting a card saying when the next appointment is. I was used to getting a card saying what was my next appointment and stuff like that. It used to be a hardback plastic card, and they'll give little lines of what's your next appointment. Everything has been electronic now, and it's hard for me to track electronic notices [since] my email is always blowing up with spam, all that stuff.*

SAFETY, PRIVACY, AND CONFIDENTIALITY

During the pandemic, providers and participants have been concerned with patient safety, privacy, and confidentiality. Participants described being unable to find a private place to meet with their providers, forcing them to risk unwanted disclosure of health information to family, significant others, and so on. For persons with HIV, disruptions in confidentiality could put them at risk of being forced out of their home, intimate partner violence, etc. One woman described her experience with such challenges:

> *I lived with my mom for a little bit. It would just be too much noise, and I was trying to get somewhere where it was quiet and just couldn't seem to find a quiet spot for me to be on the phone. Sometimes I just didn't want to talk about stuff in front of people, like certain stuff that I experienced. I didn't want to let everybody in on it or things like that. Just finding that safe, confidential space where you can share what's going on is really important. You definitely have that when you go into a doctor's exam room. It's just a different reality now [because of COVID].*

Another patient worried about his private data being misused by doctors he met through telehealth, and not in person:

> *Not everything will be confidential. I [believe] Telehealth can't be trusted. There has been a lot of shady doctors out there that will actually sell your information. Those are just crooked doctors. It's nerve-wracking sometimes to me.*

III. Provider Communication, Support, and Trust

The interviews and focus groups highlighted the need for providers to support patient engagement. Nearly all participants interviewed noted the significant role of providers in supporting participants' ability and desire to engage in care.

As one patient noted, their provider and peer navigator:

> *...could relate to and understand my life and my work balance and everything like that. I think that was something that was really good.*

Interviewees noted that the pandemic intensified their need to feel safe with their providers, especially with the disconnect created by telehealth. Participants said they found comfort in email communications received from their doctor at the start of the pandemic. One patient said that, in addition to details about how to attend appointments online, their provider:

> *...sent out information about how to basically to wear your mask, how to wash your hands, when to wash your hands, how to sanitize your house, like that kind of stuff.*

Participants saw such efforts as signs of caring for them beyond merely as patients. As one shared:

> *I trust my doctor. I like to see my doctor. I don't have a problem with him. I just feel comfortable when I go over there and see him.*

Another noted that her doctor treated her like a caring family member:

> *Very personable [and] very concerned about my health, and if there was anything that came up that he needed to explore, he would talk to me. He would really get on me about how I was eating and my weight and stuff like that.*

These positive engagements were threaded throughout the provider-patient encounter:

> *When I go see my primary doctor, before you leave, they automatic-schedule your appointment. They put it in your hand for your next appointment. Yes. I don't have to call and schedule, none of that. Right after my visit, I go to the front desk; he sends the paperwork up and schedules me another appointment day.*

Another participant fondly shared how his provider refused to let him skip an appointment. If he ever misses an appointment, he says:

> *My doctor wakes me up, blowing up my phone. I'm just like, "She does care." She goes, "Yes, you didn't come into the Zoom meeting at all, so I decided to call you."*

Interviewees indicated that the support proved essential to trusting a provider and following their advice. Several participants noted that they had lost their provider during the pandemic. They talked at length about how the sudden change in care created anxiety around the desire and ability to engage in care, whether in person or via telehealth. One explained the sense of discombobulation after losing their long-term HIV provider:

> *I don't like it. You know how you get used to one [provider] now you got to get used to someone else. It was like a shock to me that he left because he didn't tell me that he was leaving. I found out from one of the nurses that he had left. Now I have to get readjusted to another doctor, and I don't like it.*

IV. Exacerbation of Stigma During COVID

Participants interviewed commented on the negative impact of HIV stigma accessing care, particularly during the pandemic. Indeed, even limited privacy during the pandemic meant participants curtailed telehealth or avoided discussing health issues due to fear of stigma. Interviewees said the pandemic exacerbated stigma among persons from populations disparately impacted by barriers to care, such as low socioeconomic status, limited digital access, and co-morbid conditions. Several participants were especially concerned about the disparate impact on older persons, LGBTQIA+ youth, and others:

> *Well, if you think about it, yes, there are people like me. We have our jobs, we have phones, we have working phones, and we know about telehealth. People, like homeless people, or people who just got kicked out of their homes for their sexual orientation as younger kids or young adults, or those using drugs, may not be able to access care.*
>
> *We still have those ignorant parents out in this world, and they're not very educated with the LGBTQIA+ history or anything. These patients may encounter folks who treat them poorly, "Yes, you use substances, but you're also wasting your money, you're robbing, you're lying, you're doing stuff like that." It will be hard for these patients to access care. They will be in the streets. They don't know about telehealth, or they will have to go into a hospital and admit themselves and stuff like that. They might not have a working phone.*

Other participants were concerned that the pandemic had increased stigma-driven avoidance of care, creating barriers to HIV testing, treatment, and uptake of biomedical approaches to HIV prevention, notably pre-exposure prophylaxis (PrEP). Others interviewed said they were concerned that limiting training and workforce shortages among staff had created tension that could create additional barriers to care for marginalized populations. As one patient noted, he noticed that frontline staff at his doctor's office treated him with respect because he was well-educated, had a high-paying job, and had few questions when he came in for care. He noticed, however, that the same staff members often berated his less-educated counterparts who needed additional assistance—a situation he said could be remedied with additional staffing and more training in cultural competency and customer service.

DISCUSSION: A CALL TO ACTION

Behind every provider, patient, and client surveyed here, there is a human navigating the reality of living through a pandemic. COVID-19 has disrupted nearly every aspect of how healthcare is delivered in Maryland, resulting in a depleted and overextended workforce, lack of access to care, and heightened inequities. The negative effects of this fracturing described here will continue to affect our health care delivery system. Yet in this disruption lies the opportunity to re-imagine a new model for the future of healthcare. One that supports the overall well-being—physical, mental, emotional, spiritual—of both the care-giver and the care-receiver, and provides people with the tools and resources they need to achieve and promote health. It is also a call to action to listen to what those people most affected by the pandemic—both providers and patients—say they need and to start to rebuild a system that is eminently accessible and equitable as defined by these stakeholders.

COVID-19 ECLIPSE AND INTEGRATION

The results of the *Alive! Maryland* needs assessment demonstrates that COVID-19 has far reaching effects on the provision and reception of health services for both providers and providers, clients, and patients. The social and medical crises elicited by COVID-19 have intersected with pre-existing social determinants for those living, working, and playing in Maryland, especially under-served populations. COVID-19 has amplified the pandemic's impact resulting in food and housing insecurity, transportation issues, mental health complications and an increased need for services, oral health needs, insurance issues, unemployment, disrupted access to healthcare, mental health challenges, and isolation.

However, the COVID-19 response has opened a new door in the medical system for patients seeking access to services. Maryland's workforce should leverage this new door and take advantage of the innovations in care delivery brought about by the pandemic in order to incorporate and consolidate HIV, STI, HCV, and harm reduction services in conjunction with COVID-19 care; thus decreasing fragmentation in the healthcare system and promoting a 'one-door' approach.

IMPLEMENTATION OF MENTAL HEALTH SERVICES

One of the most pronounced needs that surfaced through this assessment is the need for more mental health services for both the workforce, clients, and patients. In order to address these issues, organizations and health systems need to integrate mental health into all healthcare and provide access to mental health providers and services for both internal staff, clients, and patients.

INVESTING IN STAFF RETENTION

Health care provider burnout and loss of retention of engaged staff are potentially the "most disruptive forces facing hospitals and health systems in the next three years."[5] The weight and constant stress of the pandemic has contributed greatly to staff burnout, resulting in staff shortages. The workforce reported significant reductions as a result of burnout, other opportunities, and low pay. Organizations witnessed further reductions in full-time staff, with implications for all levels of programming. Staff shortages are further exacerbated by clients' and patients' increasing needs, thus creating an inverse relationship between staffing and services provided.

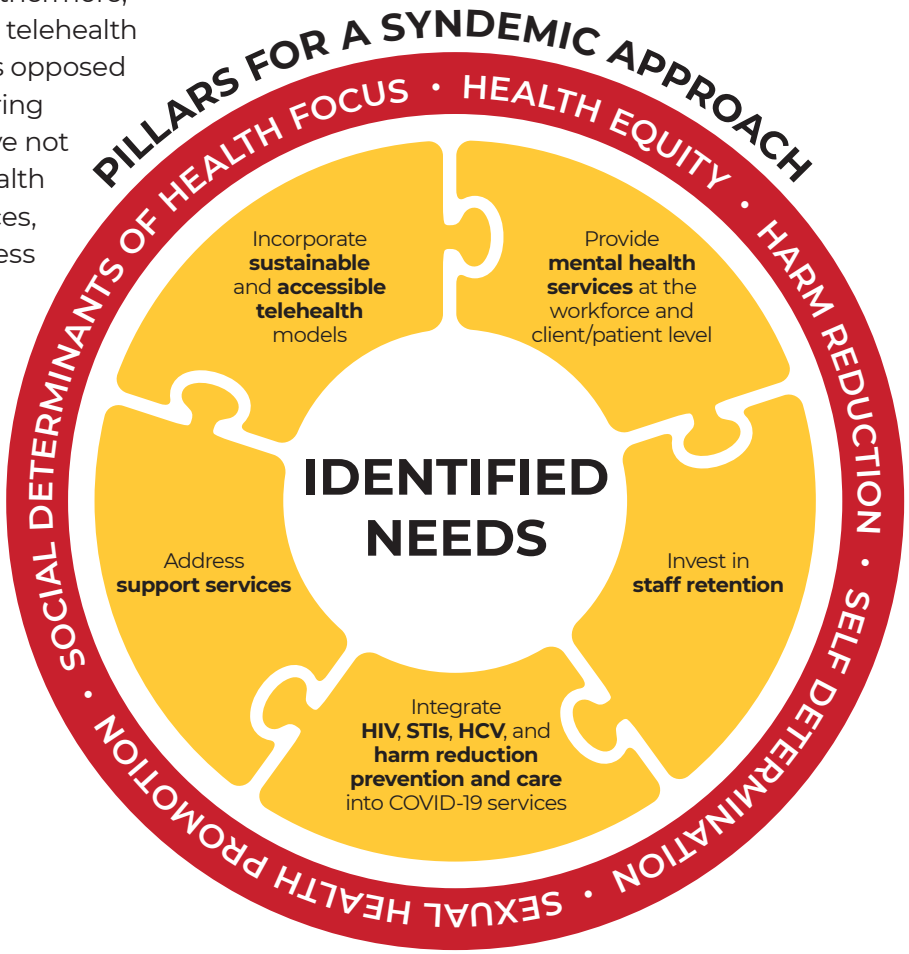
The infectious disease and primary care workforce needs a diverse portfolio of support to address staff retention including toolkits, trainings, and capacity building support.

INCORPORATION OF SUSTAINABLE TELEHEALTH MODELS

For many, COVID-19 has brought about a new reality. Most notably was the transition to telehealth, which has become a realistic and accessible option for providing and receiving services and care. Telehealth gives the workforce, clients, and patients a new flexible modality of care, allowing clients and patients to access services where they are and dismantling certain barriers to accessing care. For example, many rural communities welcomed the telehealth model, as it helped to reach those who face multiple structural barriers that result from living in a care desert where transportation is inaccessible. Furthermore, most reported positive experiences with telehealth and some actually prefer that method as opposed to in-person care. However, those preferring telehealth all acknowledge that they have not experienced barriers in accessing telehealth such as access to WiFi, broadband, devices, and a safe and confidential space to access care. The respondents recognized that telehealth is not equally available to everyone, thus creating a disparity between those with and those without access to technological resources. Agencies, policy makers, and funders will need to address this disparity and identify strategies to create more equity when building telehealth systems and processes.

ADDRESSING SUPPORT SERVICES

The respondents acknowledged the need for more comprehensive support services in order to promote more equitable care and to address the social determinants of health. They identified that transportation, income, tech-literacy, insurance navigation, nutrition, immigration-status, housing, and stigma were issues that need to be addressed comprehensively and sustainably. Case managers and other supportive staff need to be supported to provide and promote these services to those in need.



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APPENDIX

The data compiled in these tables is from the Alive! Maryland Needs Assessment Survey.

I. Demographics

AGE	
25-34	11%
35-44	19%
45-54	25%
55-64	33%
65+	13%

GENDER IDENTITY	
Woman/Female	75%
Man/Male	20%
Gender Queer/Gender Non-Binary	4%
Other	1%

RACE	
Black/African American	32%
Native American/Alaskan Native	1%
Asian/Southeast Asian	3%
White	55%
Multi-Racial	6%
Other	4%

WHAT COUNTY DO YOU LIVE IN?	
Allegany County	1%
Anne Arundel County	1%
Baltimore County	6%
Baltimore City	25%
Calvert County	1%
Caroline County	2%
Carroll County	2%
Cecil County	3%
Charles County	2%
Dorchester County	3%
Frederick County	3%
Garrett County	1%
Harford County	1%
Howard County	3%
Kent County	2%
Montgomery County	15%
Prince George's County	19%
Saint Mary's County	1%
Somerset County	1%
Talbot County	1%
Washington County	2%
Wicomico County	3%
Worcester County	2%

WHAT COUNTY DO YOU WORK IN/SERVE?	
Allegany County	13%
Anne Arundel County	29%
Baltimore County	36%
Baltimore City	35%
Calvert County	17%
Caroline County	17%
Carroll County	18%
Cecil County	16%
Charles County	20%
Dorchester County	17%
Frederick County	22%
Garrett County	12%
Harford County	21%
Howard County	25%
Kent County	16%
Montgomery County	38%
Prince George's County	41%
Queen Anne's County	16%
Saint Mary's County	13%
Somerset County	17%
Talbot County	16%
Washington County	13%
Wicomico County	18%
Worcester County	16%
Washington, DC	20%
Delaware	7%
Virginia	13%
Other	5%

WHAT IS YOUR PROFESSION/ROLE?	
Administrative/Frontline Staff	12%
Behavioral Health Provider	13%
Clinical Associate/Coordinator	4%
Clinical Director	5%
Clinical Manager	20%
Clinical Provider	21%
Executive Director/CEO	9%
Program Associate/Coordinator	1%
Program Director	11%
Program Manager	15%
Other	6%

WHAT TYPE OF CLINICAL PROVIDER ARE YOU?	
Physician (MD/DO)	26%
Physician Assistant	6%
Certified Nurse Practitioner	19%
Advanced Practice Nurse Registered Nurse	3%
Registered Nurse	40%
Clinical Nurse Specialist	3%
Midwife	2%
Pharmacist	6%
Community Health Worker	19%
Public Health Worker	14%
Social Worker/Counselor/Therapist	37%
Obstetrician/Gynecologist	2%
Behavioral Health Provider (other)	16%
Healthcare Provider Administrative Staff	15%
ASO/CBO Administrative Staff	7%
Other	8%

WHAT TYPE OF ORGANIZATION DO YOU WORK FOR?	
AIDS service organization (ASO)	3%
Behavioral health organization	10%
Community-based organization (CBO)	9%
Faith-based organization (FBO)	1%
Food banks/nutrition	1%
Health department	35%
Health center / FQHC / FQHC-look alike	10%
Health organization HIV planning body	1%
Housing	1%
Municipality/Government pharmacy	1%
Primary health care setting	13%
Substance use treatment facility	3%
Other	12%

WHAT TYPES OF CLINICAL CARE DO YOU PROVIDE?	
Primary Care	36%
PrEP Prescriptions/Management	44%
Sexually Transmitted Infection (STI) Testing	59%
STI Treatment	57%
Hepatitis C (HCV) Screening HCV Treatment	45%
HIV Testing	68%
HIV Treatment	39%
Infectious Disease Care	40%
Hospice Care	4%
Urgent Care	11%
Substance Use Treatment Emergency Care	17%
Prescription Fulllment Vaccinations	24%
Viral Resistance Testing	17%
Sexual Health Assessments	40%
Behavioral Health Assessments	47%
CD4 Count Monitoring	22%
Mental Health Counseling	45%
Dental Care	19%

WHAT POPULATIONS DO YOU SERVE?	
Black/African-American	93%
Asian/Southeast Asian	70%
Native American/Alaskan Native/Native Hawaiian/Pacific Islander/Multi-racial	61%
Persons over 50	80%
Women	86%
Children	55%
Persons with HIV	81%
Persons with COVID-19	54%
LGBTQ+ Persons	81%
Transgender Persons	77%
Homeless/Unstably Housed Persons	71%
Migrant and Seasonal Farmworkers and their Families	44%
Incarcerated/Formerly Incarcerated Persons	60%
Individuals/Persons Experiencing Homelessness	66%
Economically Disadvantaged Persons	74%
Military Personnel (Active/Inactive)	47%
Persons with limited English Proficiency	66%
Out-of-workforce Individuals	65%
Rural Populations	55%
Urban Populations	57%
Undocumented Persons	47%
Other	14%

DOES YOUR ORGANIZATION RECEIVE FUNDING FROM THE MARYLAND DEPARTMENT OF HEALTH?	
Yes	61%
No	39%

II. Training

WHAT TRAINING MODALITIES WORK BEST FOR YOUR ORGANIZATION?	
In person/classroom trainings	40%
Hands on/practical trainings and exercises	37%
Online training sessions	79%
Asynchronous trainings (Combined online and in person training sessions)	32%
Personal coaching sessions	12%
Special sessions during larger conferences	17%
Pre-conference meetings	8%
Other	1%

WHICH OF THE FOLLOWING TRAINING/TECHNICAL ASSISTANCE SESSIONS TO BUILD SKILLS IN ENGAGING SPECIAL POPULATIONS WOULD HELP BENEFIT YOUR ORGANIZATION?	
Rural Health	35%
Urban Populations	38%
Immigrant/Refugee Care	43%
Racial and Ethnic Minorities	47%
Delivering Substance Use (Harm Reduction) Care	45%
Incarcerated and Formerly Incarcerated Persons	34%
Homeless/Unstably Housed Persons	45%
Youth	36%
LGBTQ Persons	49%
Individuals with Mental Illness	58%
Individuals with Disabilities	33%
Cultural and Linguistic Minorities	32%
Interpretation Service Utilization	27%
Hearing Impaired Populations	25%

WHICH OF THE FOLLOWING TRAINING/TECHNICAL ASSISTANCE SESSIONS ON PREVENTION AND SURVEILLANCE WOULD BENEFIT YOUR ORGANIZATION?	
Community Health Center/Primary Care Provider Engagement	43%
Program Collaboration/Service Integration	33%
Behavioral Surveillance	31%
Integrated Community Planning	26%
Healthcare Reform Implementation	26%
Data to Care Surveillance/Care Provision	21%
Testing (Routine, Streamline, Rapid, Clinical/Non-Clinical Settings)	32%
Partner Services	27%
Developing and Evaluation Effective Interventions and Public Health Strategies	23%
High Impact HIV Prevention	34%
Cost Benefit Linkage	19%
Retention and Re-engagement in Care	39%
Program Planning/Monitoring	26%
Protocol Development	23%
Health Care Reform	21%
Evidence Informed Policy Development	24%
Public/Private Partnerships	23%
Regional/Local EHE Planning, Implementation	15%
Integration of Surveillance and Prevention Programs	16%
EHE Evaluation Planning	14%
HIV HealthForce Jurisdictional Coordination/Training	20%
Ethical Alignment of Services/Strategies with EHE Efforts	19%

WHICH OF THE FOLLOWING TRAINING/TECHNICAL ASSISTANCE SESSIONS ON CLINICAL AND BEHAVIORAL CARE AND TREATMENT WOULD BENEFIT YOUR ORGANIZATION?	
Mental Health	58%
COVID-19 Vaccine: Building Staff and Community Literacy and Confidence	34%
Harm Reduction	44%
Proper Opioid Prescribing and Overdose Prevention	23%
Sexually-Transmitted Infections	35%
Substance Use and HCV, STIs, and HIV	43%
Biomedical HIV Prevention/Adherence (PrEP/PEP/ART)	29%
Medication-Assisted Treatment (MAT)	22%
Performance Coaching	17%
Whole Person Health	37%
Motivational Interviewing	35%
Integrated Care Team Development/Clinical and Non-Clinical Programming	16%
Building FBO/CBO Relationships	11%
HIV and Co-Morbidities	29%
Medical Case Management/Linkage to Care	28%
Developing/Expanding Infectious Disease Care in Primary Care	17%
Infectious Diseases and Pregnancy Integrated Care Team Development	15%
Clinical and Non-Clinical Programming	18%
Electronic Medical/Health Records	18%
Telehealth	36%
Treatment Adherence HIV Epidemiology	22%
Regional Considerations for Service Provision	11%
Patient-Centered Medical Homes	15%
HIV Testing/Linkage to Care	24%
HIV and Aging	29%
Substance Use and Aging	28%
COVID-19 Care Provision	21%
Confidentiality/HIPAA/Public Health Ethics	26%
Intimate Partner Violence	32%

WHICH OF THE FOLLOWING TRAINING/TECHNICAL ASSISTANCE SESSIONS ON ORGANIZATIONAL AND INFRASTRUCTURE DEVELOPMENT WOULD BENEFIT YOUR ORGANIZATION?	
Research and Data/Data Use	32%
Creating Accessible Data Visualizations	25%
Communications and Marketing Infrastructure and Planning	29%
Social Media and Social Marketing (Community Outreach)	44%
Human Resources/Workforce Planning	29%
Organizational Protocol Development	22%
Surveillance Systems	14%
Emergency Preparedness	35%
Event Planning	21%
Strategic Business Planning	15%
FQHC Look-Alike Applications and Regulations	15%
Health Care Reform	22%
Evidence-Based Policy Development	32%
Public/Private Partnerships	24%
Technology Integration	29%

WHICH OF THE FOLLOWING TRAINING/TECHNICAL ASSISTANCE SESSIONS ON FINANCIAL AND GRANTS/MANAGEMENT/ COMPLIANCE WOULD BENEFIT YOUR ORGANIZATION?	
Fiscal Planning/Resource Development	33%
Health Care Finance/Policy	26%
Establishing an Indirect Rate	13%
Budget Development	32%
Tracking Grant Funds	39%
Revenue	25%
Resource Development/Diversification	22%
Complying with Federal and State Monitoring Standards	23%
Maximizing Medical Documentation for Billing	24%
Leveraging 340B to expand services	22%
Nonprofit Accounting	12%
Assessing Client Financial Need	32%
Preparing for/Responding to Audits	21%
Third-Party Reimbursement	26%

WHAT BARRIERS TO ENGAGING IN TRAINING AND TECHNICAL ASSISTANCE HAS YOUR ORGANIZATION EXPERIENCED?	
Unaware of training/technical assistance opportunities	30%
Unsure how to request training and technical assistance	18%
Lack of time available to participate/scheduling conflicts	48%
Lack of interest among staff	14%
Financial constraints	22%
Limitations set by funders	11%
COVID-19	29%
Other	6%

III. Telehealth

DO YOU FEEL TELEHEALTH EFFECTIVELY ENGAGES PATIENTS IN TREATMENT AND CARE?	
Yes	68%
No	12%
Don't know	17%
N/A	3%

WHAT TYPES OF SUPPORT HAVE YOU BEEN ABLE TO PROVIDE CLIENTS TO FACILITATE ACCESS TO TELEHEALTH SERVICES? (CHECK ALL THAT APPLY.)	
In-clinic access to telehealth	34%
Internet access	20%
Mobile/Cellular phone access	25%
Phones, tablets or other devices	22%
Technical assistance to facilitate communication	39%
Other	1%
None of the above	29%

THINKING ABOUT YOUR ORGANIZATION'S EXPERIENCE WITH TELEHEALTH, HOW MUCH DO YOU AGREE WITH THE FOLLOWING STATEMENTS:	
YOUNGER PATIENTS (UNDER AGE 50) FARED BETTER WITH TELEHEALTH THAN OLDER PATIENTS.	
Strongly Agree	24%
Agree	37%
Neutral	19%
Disagree	8%
Strongly Disagree	2%
N/A	10%

ESTABLISHED PATIENTS HAD AN EASIER TIME ENGAGING IN CARE THROUGH TELEHEALTH THAN NEW PATIENTS.	
Strongly Agree	11%
Agree	34%
Neutral	28%
Disagree	14%
Strongly Disagree	4%
N/A	9%

TELEHEALTH HELPED PATIENTS LOST-TO-CARE BECOME RE-ENGAGED IN CARE.	
Strongly Agree	13%
Agree	33%
Neutral	26%
Disagree	14%
Strongly Disagree	3%
N/A	10%

WE WERE ABLE TO ATTRACT NEW (NOT PREVIOUSLY LOST-TO-CARE) PATIENTS BY PROVIDING ACCESS TO TELEHEALTH.	
Strongly Agree	13%
Agree	31%
Neutral	29%
Disagree	13%
Strongly Disagree	4%
N/A	10%

WE WERE ABLE TO FACILITATE BEHAVIORAL HEALTH COUNSELING THROUGH TELEHEALTH (ONE-ON-ONE APPOINTMENTS, GROUP THERAPY).	
Strongly Agree	21%
Agree	30%
Neutral	19%
Disagree	4%
Strongly Disagree	2%
N/A	24%

WE WERE ABLE TO FACILITATE CASE MANAGEMENT (SOCIAL SUPPORT) AND PEER SUPPORT SERVICES VIA TELEHEALTH.	
Strongly Agree	21%
Agree	36%
Neutral	18%
Disagree	2%
Strongly Disagree	4%
N/A	19%

MEDICALLY COMPLEX (COMORBIDITIES) PATIENTS HAD A HARD TIME ACCESSING TELEHEALTH SERVICES.	
Strongly Agree	7%
Agree	27%
Neutral	33%
Disagree	12%
Strongly Disagree	2%
N/A	19%

UNSTABLY-HOUSED (COUCH-SURFING) AND HOMELESS PATIENTS FOUND IT DIFFICULT TO ACCESS TELEHEALTH SERVICES.	
Strongly Agree	25%
Agree	28%
Neutral	23%
Disagree	4%
Strongly Disagree	2%
N/A	17%

PATIENTS EXPERIENCING FINANCIAL HARDSHIP EXPERIENCED CHALLENGES USING TELEHEALTH.	
Strongly Agree	19%
Agree	31%
Neutral	23%
Disagree	13%
Strongly Disagree	3%
N/A	11%

MANY CLIENTS PREFER TELEHEALTH APPOINTMENTS.	
Strongly Agree	9%
Agree	33%
Neutral	36%
Disagree	11%
Strongly Disagree	3%
N/A	8%

PATIENTS HAD TROUBLE FINDING PRIVATE SPACES TO ENGAGE IN TELEHEALTH APPOINTMENTS.	
Strongly Agree	7%
Agree	27%
Neutral	39%
Disagree	13%
Strongly Disagree	4%
N/A	11%

APPROXIMATELY WHAT PERCENTAGE OF YOUR STAFF IS ELIGIBLE TO RETIRE?	
0-5%	40%
6-10%	27%
11-15%	18%
More than 15%	16%

IV. Retention

WHAT FACTORS DO YOU BELIEVE HELP ENSURE EMPLOYEE ONBOARDING AND/OR RETENTION?	
Clear onboarding training procedures	68%
Cultural Competancy	55%
Recruitment Incentive	28%
Relocation Incentive	9%
Retention Incentive	26%
Highest Previous Rate (HPR)	8%
Subsidized Transportation	8%
Physicians Comparability Allowance (PCA)	3%
Alternative Work Schedules	46%
Job Sharing	13%
Part-Time Work	29%
Telework	65%
Accelerated Annual Leave	13%
Accrual Rate	12%
Workforce development programs (paid tuition, etc.)	42%
Student loan repayment options	31%
Childcare Assistance	23%
Other	8%

WHAT FACTORS MAKE CLINICAL AND BEHAVIORAL HEALTH AND OTHER STAFF DECIDE TO MOVE ON?	
Unclear expectations/ lack of performance management	41%
Staffing shortages	54%
Supply shortages	13%
Lack of consistent funding	24%
Burnout	70%
Stressful work environment	61%
Lack of good management or leadership	43%
Low pay	52%
Limited benefits	21%
Inflexible work hours/situation	33%
Retirement	16%
Student loan debt	9%
New employment opportunities with better pay/ benefits	55%
Commute	17%
Other	8%

WHAT IS THE OVERALL AVERAGE TENURE OF STAFF AT YOUR AGENCY (CLINICAL PROVIDERS, BEHAVIORAL HEALTH PROVIDERS, AND ORGANIZATIONAL STAFF)?	
Less than a year	3%
1-2 years	10%
3-5 years	34%
6+ years	53%

WHICH OF THE FOLLOWING TRAINING/TECHNICAL ASSISTANCE DO YOU BELIEVE WOULD HELP CREATE A RESPECTFUL WORKPLACE THAT IS BENEFICIAL FOR STAFF AND CLIENTS? (CHECK ALL THAT APPLY.)	
Cultural Competency/Awareness	59%
Stigma and Cultural Humility/Cultural Flexibility	59%
Structural Racism	41%
Non-Violent Crisis Intervention	39%
Mental Health First Aid	53%
Motivational Interviewing/Patient Centered Interviewing	43%
Anti-Racism	36%
Diversity and Inclusion	42%
Advocacy	42%
Coalition Building	25%
Interpreter Utilization	26%
Implicit Bias	31%
LGBTQ+ Health Provision	43%
Being an LGBTQ+ Ally	36%
Health Quality Improvement	37%
Access and Disparities	36%
Leadership Development	42%
Social Justice Advocacy	36%
Health Literacy	40%
Status Neutral Approaches to Service Provision	27%
Community Trust Building/Community Engagement	40%
Social Determinants of Health Resiliency	35%
Other	4%

V. COVID-19

WHAT ARE THE TOP FIVE (5) BARRIERS TO CLIENT ACCESS TO CARE DURING THE COVID-19 PANDEMIC AND BEYOND?	
Limited health literacy	25%
Loss of health insurance	22%
Increase in depression, anxiety and other mental health issues	55%
Concerns about racism, homophobia, and other (non COVID) disease stigma	11%
Fear of COVID-19 exposure	52%
Fear of COVID-19 testing	6%
Fear of COVID-19 contact tracing	5%
Fear of COVID-19 stigma	9%
Mistrust of COVID-19 information and safety protocols	31%
Mistrust of COVID-19 vaccines	36%
Challenges navigating Medicaid/Medicare or other public health care options	15%
Lack of transportation	42%
Lack of child care services	11%
Housing instability and homelessness	27%
Lack of access to technology/tech literacy for telehealth (mobile/computer equipment, Internet access)	29%
Financial hardship (living at/below the Federal poverty level)	33%
Under/unemployment	16%
Lack of access to substance use disorder (SUD) treatment	7%
Limited access to medication assistance treatment/ harm reduction services	4%
Limited access to mental health/counseling and treatment	16%
Limited access to medication assistance services	5%
Other	9%

HOW ARE YOU INCREASING THE CONFIDENCE OF CLIENTS IN ACCESSING IN-PERSON/ONSITE SERVICES DURING THE GLOBAL COVID-19 PANDEMIC? (CHECK ALL THAT APPLY.)	
Posting signage/flyers in clinic/elsewhere	36%
Mailing communications	20%
Posting online communications (website, social media, app)	46%
Sharing information about COVID-19 and its possible impact on people with HIV	45%
Sharing resources about HIV and/or STI self testing	33%
Providing access to personal protective equipment (PPE)	48%
Establishing safe onsite check in spaces/waiting areas	51%
Providing care packages, including PPE, personal sanitizers, and other hygiene supplies	36%
Creating personalized health plans in case of hospitalization with COVID 19 -- bringing antiretrovirals (ARVs), both for prevention and treatment, to the hospital, contact plans for family/ HIV primary care providers, etc.	11%
Other	6%
N/A	9%

WHAT TYPES OF ALTERNATIVE SERVICE DELIVERY APPROACHES HAVE YOU IMPLEMENTED DURING COVID-19? (CHECK ALL THAT APPLY.)	
Telehealth (synchronous video/voice)	73%
Phone encounters (voice only)	75%
Virtual groups (e.g. support groups, health education)	41%
Text messaging/SMS	54%
Receipt of services from an alternate provider that coordinates with your provider	10%
Alternate location for laboratory tests	18%
Referral/Linkage to HIV home testing	15%
Referral/Linkage to STI home testing	15%
Mobile van visits	16%
Longer (multi-month) prescription periods for ARVs	12%
Longer (multi-month) prescription periods for other medications	17%
Early/automatic prescription refill authorization Use of alternate pharmacy that offers delivery	11%
Updated check in procedures to assess possible SARS CoV-2 (COVID-19) exposure	32%
Alternate waiting and treatment areas (cars, outside areas, outdoor treatment rooms, etc.)	34%
Other	4%

WHICH OF THE FOLLOWING OF ALTERNATIVE SERVICE DELIVERY APPROACHES DO YOU BELIEVE CLIENTS WILL WANT TO CONTINUE AFTER THE PANDEMIC IS OVER? (CHECK ALL THAT APPLY.)	
Telehealth (synchronous video/voice)	76%
Phone encounters (voice only)	72%
Virtual groups (e.g. support groups, health education)	37%
Text messaging/SMS	54%
Receipt of services from an alternate provider that coordinates with your provider	10%
Alternate location for laboratory tests	11%
Referral/Linkage to HIV home testing	16%
Referral/Linkage to STI home testing	16%
Mobile van visits	23%
Longer (multi-month) prescription periods for ARVs	16%
Longer (multi-month) prescription periods for other medications	18%
Early/automatic prescription refill authorization Use of alternate pharmacy that offers delivery	17%
Updated check in procedures to assess possible SARS CoV-2 (COVID-19) exposure	22%
Alternate waiting and treatment areas (cars, outside areas, outdoor treatment rooms, etc.)	25%
Other	3%

WHAT ACTIONS HAVE YOU IMPLEMENTED TO ENSURE CONTINUITY OF CARE SERVICES DURING THE COVID-19 PANDEMIC? (CHECK ALL THAT APPLY.)	
Maintain regular patient check-ins to contact, encourage treatment adherence, etc	78%
Provide telehealth services	67%
Leverage/create partnerships with other providers to provide alternate treatment and care access	32%
Leverage mobile van facilities	17%
Create longer prescription time periods	19%
Authorize early/automatic prescription refills	16%
Expand pharmacies/delivery services	12%
Establish alternate locations for laboratory tests	15%
Other	4%
None of the above	8%

HAVE YOU REDUCED YOUR WORKFORCE (LAYOFFS, FURLOUGHS, ETC.) AT ANY TIME DURING THE PANDEMIC?	
Yes	12%
No	72%
Don't know	16%

WHAT PERCENTAGE OF YOUR ENTIRE STAFF WAS IMPACTED BY THESE REDUCTIONS?	
< 10%	36%
10-24%	23%
25-49%	23%
50-75%	9%
>75%	0%
N/A	9%

WHAT STAFF POSITIONS WERE FURLOUGHED OR LAID OFF? (CHECK ALL THAT APPLY.)	
Medical providers (MD/DO/NP/PA)	14%
Nurses	5%
Pharmacists	0%
Behavioral health providers	18%
Administrative personnel	36%
Health/peer navigators	14%
Case managers/social workers	9%
Outreach workers	14%
Development/communications	5%
Other	27%

HAVE YOU CLOSED ONE OR MORE LOCATIONS AT ANY POINT DURING THE PANDEMIC?	
Yes	29%
No	57%
Don't know	9%
N/A	5%

HOW LONG WERE YOU CLOSED?	
> 1 month	8%
1-2 months	10%
3-4 months	14%
5 or more months	42%
Still shut down	27%

HOW HAS YOUR ORGANIZATION'S FISCAL HEALTH BEEN IMPACTED BY COVID-19?	
Increased	13%
Decreased	32%
Remained the same	14%
Don't know	36%
N/A	4%

VI. Resources

WHAT RESOURCES DO YOU STILL NEED TO SAFELY DELIVER SERVICES? (CHECK ALL THAT APPLY.)	
Office redesigns	30%
Workflow improvements	42%
COVID-19 testing kits	33%
PPE (gloves, gowns, masks, face shields, etc.)	33%
Non-contact thermometers and other medical devices	24%
Disinfectant	28%
Plexiglass barriers/installation	24%
Seasonal equipment for outdoor/curbside service delivery (tents, tables, etc.)	23%
Signage	20%
Other	6%
N/A	27%

WHAT TYPES OF SUPPORT HAVE YOU RECEIVED/ACCESSED FROM CITY/STATE HEALTH DEPARTMENTS DURING THE PANDEMIC? (CHECK ALL THAT APPLY.)	
Information about local impact of COVID-19	77%
Guidance on creating safe clinical spaces	43%
COVID-19 safety for providers and clients	56%
PPE supplies and other safety equipment	46%
Training and support to implement alternative service delivery	29%
COVID-19 testing kits and supplies	30%
Guidance about upcoming availability of COVID-19 vaccines	51%
COVID-19 vaccines	51%
Other	4%

Maryland
DEPARTMENT OF HEALTH

The Maryland Department of Health has engaged with HealthHIV, a national capacity building organization, to launch Alive! Maryland to build the capacity of Maryland's HIV, viral hepatitis, STIs, and harm reduction workforce to improve health for all Marylanders.

Learn more at AliveMaryland.org.

HealthHIV

HealthHIV is a national non-profit working with organizations, communities, and health care providers to advance effective prevention, care, and support for people living with, or at risk for, HIV and HCV through education and training, technical assistance and capacity building, advocacy, and health services research and evaluation.

Learn more at HealthHIV.org.

Alive! MARYLAND
BUILDING CAPACITY TO IMPROVE HEALTH

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