PENNSYLVANIA DEPARTMENT OF HEALTH

HIV PLANNING GROUP MINUTES

Park Inn Harrisburg West, 5401 Carlisle Pike, Mechanicsburg, PA
March 18th, 2015

Members: Wesley Anderson, Jr., Alicia Beatty, Adam Bocek, Jeanne Caldwell, Dan Campion, Principe Castro, Melissa Davis, Doyin Desalu, Wayne Fenton, Sharita Flaherty, Christopher Garnett, Daniel Harris, Jeffery Haskins, Lou Ann Masden, Shannon McElroy, Briana Morgan, Daiquiri Robinson, Tamara Robinson, Susan Rubinstein, Pamela Smith, Richard Smith, Rob Smith, Nathan Townsend, Tony Strobel, Grace Shu, Ann Stuart Thacker, Wayne Williams, Derick Wilson, Paul Yabor

Not Present: Linda Frank, Shubra Shetty

Dept. of Health: John Haines, Kyle Fait, Jill Garland, Sara Luby, Ken McGarvey, Benjamin Muthambi, Lisa Petrascu, Robin Rothermel, Jon Steiner , Brad VanNostrand, Christine Quimby

University of Pittsburgh: David Givens, Daniel Hinkson, Sarah Krier, Tony Silvestre

Guests: Michael Hellman, Leah Magagnotti, Sarah Gallups, Shirley Murphy

Welcome & Introductions

Chairwoman Flaherty: Welcome and introductions.

Ken McGarvey: Welcome new members, since I was unable to attend in January. I would like to welcome Chris, Adam, Lou Ann, and Jeanne. Welcome back to everyone else, as well. We will need to have a few changes to the agenda, so we'll discuss that now. We have our technology reminder – no cell phones or laptops at the main table. We do consider membership on a rolling basis, so please continue recruiting qualified applicants. We do expect a visit from our HRSA and CDC officers sometime this year, even though we no longer employ HRSA consultants, they were very valuable last year. Please pick up the travel documents during the meeting as usual. We'll now have announcements from our staff.

Jill Garland: For Prevention, we received our notice of award, and will discuss that in-meeting later today or tomorrow. We are finishing our annual report for the CDC, and we

submitted the data portion of that report Monday. We distributed, for example, 1.6 million condoms, so that's pretty awesome.

We have received notification of a new project officer –Rod Joiner. We spoke with him last week, and he seemed excited to be working with us and is hoping to attend a meeting and have a site visit sometime this year.

We are drafting a high impact prevention guidance, and it will determine what we will be funding with State and CDC Federal funds. It is a draft at this point, but will affect county health department and Ryan White Part B providers. We got quite a bit of feedback from the field, so we will be compiling and responding to the questions.

Ann Stuart Thacker: When should we expect those responses?

Jill Garland: We are fast tracking the responses, and though we don't' exactly have a date, we will be meeting next week to get some of that in the works.

Paul Yabor: I saw some recommendations last week advancing peer advocacy, do you have any stance on that?

Ken McGarvey: Our concern is having a standardized, proven set of interventions; it is more targeted in order to better utilize our dollars, we think this consistency will lead to better saturation and standard of care throughout prevention programs. We are also trying to be clearer to our grantees that they must ensure implementation of linkage and retention components, and so while we don't directly address peer advocacy components of that, we know that the CDC supports ARTAS and that is what we are requiring for now since the research supports it. If research and evaluation indicates other interventions and programs in the future then we will reevaluate them. But the framework we are laying supports consistency in programming and linkage and retention.

Alicia Beatty: Is that in cities or statewide?

Jill Garland: We have some data in areas that are using that it [ARTAS] is effective, but we are primarily basing our assessment on professional and scientific data that shows this to be effective. We will keep assessing our strategies on a yearly basis since the definition of high impact and assessment of what works is ongoing.

Ken McGarvey: We are optimistic that with the new administration we will have new opportunities to implement new interventions/activities around the state.

John Haines: For SPBP, we are looking for a new customer service staff position and have a new fiscal specialist hired. We will not be moving forward with new rebate agreements due to concerns that too many drugs would have been cut from the formulary; so, all the current formulary medications will continue unchanged. The governor announced a

change from Healthy PA to full Medicaid expansion, so our office is sending fliers to all members with the new Medicaid guidelines, and if people are eligible they will be transitioned to full Medicaid coverage for their entire healthcare, not just pharmacy benefits. But the screening for that will likely be implemented over the coming month and will have a transition period of three months so that coverage is not interrupted. There are a few requirements, but anyone under 138 percent of the federal poverty level would likely be covered.

Daniel Harris: If you have to be a resident of PA, how would students get access?

John Haines: They can use the same application – there are screening questions that we can look at.

Tamara Robinson: If something goes wrong with the screening process, what will happen at the end of that three month period?

John Haines: We will handle temporary coverage on a case by case basis – there may be ways we can extend coverage for an additional period.

Paul Yabor: Is it possible to get a preview of the application?

John Haines: There will be a few changes we are considering to simplify the application, but it won't affect the content of the application. It will also provide, for example, additional information about the temporary coverage.

Christine Quimby: We have a new project officer starting within the Care Section. We are working getting the RW regional grantee contract renewals out.

Ken McGarvey: One additional announcement I have is that the governor's budget proposes level funding for the HIV/AIDS program, which is a good thing. We also have a combined appropriation for HIV/AIDS programs and SBPS. The combined appropriation proposed total is over 17 million.

Member announcements

Paul Yabor: "Hep on the Hill" is an event in Washington D.C. to address our federal representatives about the President's recommendations for increased Hepatitis C funding, and lifting the ban on syringe exchanges. You can see the flier on the front table. I'd like to pass around a sign up for a call-in for the governor's staff to meet with us around specifics of his proposal to end AIDS in PA.

Sarah Gallups: AETC has a Wednesday webinar on "Intimate Partner Violence". Any clinicians or staff can join this, and there is a flier in the back. We are also putting on a conference for screening and treatment, with a flier as well. We are also planning a June

conference on HIV/AIDS and will be covering general updates and case management. The event will be in Gettysburg.

Chairwoman Flaherty: Are there any changes to the minutes?

Comment: Change to the January minutes - Tamara Robinson and Daiquiri Robinson names were mistakenly swapped on page 4. [Minutes pass as amended.]

Sarah Krier: For Pitt announcements, the Carnegie Library will be hosting our Acceptance Journeys project in Pittsburgh, both the images and discussion groups. We have copies of the images and narratives around stigma reduction in western PA.

Ken McGarvey: Rob McKenna and Benjamin Muthambi cannot be with us today – they are both ill and so while we hope they get better soon we will rearrange our agenda. So we'll do the membership survey next, and the rest of the agenda is unchanged.

[Break: Reconvene 10:30]

Ken McGarvey: We will now have an update from the University of Pittsburgh staff, and then move right in to our plan update.

David Givens: As part of the ongoing plan to streamline HPG orientation, it was decided last year that video explaining all support staff functions would be created to help new members understand who all the people behind the scenes are for both the state and our office at Pitt. Well, our video is finished and we presented it to new members last meeting, and the state asked that we show it again, actually, to the full HPG at this meeting. So I apologize in advance to our four new members who have seen this already, and I hope you all enjoy learning a little more about all the ways we support the HPG and the state.

Plan update

David Givens: Now we'll talk briefly about how we are working with the state to parse federal guidance and HPG input to develop a comprehensive integrated plan to PA.

[Comprehensive Plan Presentation]

Lisa Petrascu: I am responsible for the HPG meeting place/hotel contract and bidding – the IFB (Invitation for Bid), as well as overseeing travel. It is time to get the new IFB in place, and so we are developing those bid specification documents now. So here's an outline with the current estimate costs. Let's keep an eye out for ways we might reduce costs as we go through this.

Questions and comments:

Paul Yabor: I have concerns about messing with what works. I find that the meeting setting we've been doing works well, in fact I feel like sometimes we don't have enough time! I get the fiscal concerns, but I do think that this has been working very well.

Doyin Desalu: Where are the line items for lodging, then?

Lisa Petrascu: In travel, not the hotel costs.

Derick Wilson: I advocate for a few one day meetings. I think we could do great subcommittee work with conference calls or web conferences, and have a very tight meeting.

Robert Smith: I would offer a counterpoint to that – many people travel from far away, and just one day might be overly complicated for those members.

Chairwoman Flaherty: My concern with reducing to one day is the accountability associated with conference calls. While not everyone can always be at both days, we know that in general it is more likely that people will not attend and thus make it harder for the other members.

Alicia Beatty: Do you have any hard estimates on the numbers we would save switching to one day?

Jill Garland: We are not sure. It's likely that we'd cut the lodging in half if we went to one day across the board, but I don't think that large a reduction is likely.

Paul Yabor: I am not convinced that a webinar or call would be as effective because people do multiple things in those settings.

Daiquiri Robinson: We are on the cutting edge here – we just talked about that, and we saw that in Pitt's presentation. If we pare that down, I'm concerned we'll miss something. This is important work.

Robert Smith: Could we do fewer overall meetings?

Ann Stuart Thacker: Maybe the meeting budgets or travel costs could devolve to the regions?

Pamela Smith: Maybe we could do quarterly meetings that last three days?

Chairwoman Flaherty: Thank you for the suggestions so far – please don't feel like you need to qualify your comments. We want to hear all thoughts!

Ken McGarvey: The SPBP also has an advisory council, and they don't meet face to face all the time.

Tamara Robinson: What about tweaking the menus? It seems like we could get a lighter menu for lunches.

Derick Wilson: I do like the quarterly idea, but I think three days would be too much to ask for some members and would not really save money. When we go to federal meetings, or city of Philadelphia meetings, we don't get lunch at all.

Briana Morgan: I'd advocate for staying with the two days as well. I think that fosters the collaborative nature of the process – we don't want to end up where a few people are doing too much of the work.

Anthony Silvestre: The format of some one day and some two day meetings was part of our history. There were two day meetings scheduled around the planning documents that were going to be needed at specific times.

Ann Stuart Thacker: What about reducing administrative costs?

Wayne Fenton: When we accepted the roles of members, we knew that the requirement was two days. We have a few people who consistently do not attend both days, and that is a savings, as well.

Ken McGarvey: What do you mean with admin costs? We had decided that each section and a member of HPCP needed to be in each committee. You need to be careful with University of Pittsburgh, too, because that looks like a lot, but those figures were basically their entire operational budget and covers almost all aspects of their work, and the specialization of that work - all over the state. It's not simply their cost to attend these meetings.

Part of this, too, comes from serving two masters. The CDC is hoping we can do more stakeholder engagement outside of this room. HRSA expects us to do robust planning with more people at the table, while CDC expects us to reduce planning costs. These growing pains are to be expected, and hopefully HRSA and CDC will soon provide an integrated planning guidance. Should members that are part of agencies we are already funding pay for their own travel? That's something to talk about within your agency. Last year we clearly needed every hour of every day, but since this year is different and has been restructured, it's a little more unknown. Let's talk about this more in the subcommittees, and those chairs can report to the steering committee.

Paul Yabor: This is all good to be lean, but I think there are so many things this body can do, and it'd be great to see more dialogue around the issues and upcoming opportunities for and around the state.

Lunch

Five Year Stakeholder Engagement Plan

Chairwoman Flaherty: We wanted to see what the group would like to do next; we could have subcommittees meet now or do the 5 year plan now? …We'll have Dr. Anthony Silvestre present an update on the five year plan the HPG developed first.

Anthony Silvestre: So this plan was many, months in development here at the HPG, and you have all had updates on this before. What you have in front of you now is Pitt's detailed outline of the first year of this process. So even though it is a work in progress, obviously, you can see all the moving parts coalescing for 2105.

[Five Year Stakeholder Engagement Plan Presentation]

Anthony Silvestre: Are there any questions? I'd like to invite our returning guest, Michael, to offer any words or additions at this time, too.

Michael Hellman: As a former co-chair of the committee, we went after low hanging fruit first. We know who's out there today, and we know how to contact them. But as you look from year one on to year 3 and beyond, they get more difficult to reach. That's why agencies will be important throughout this process, and keep building from year to year.

Chairwoman Flaherty: While we are talking about the budget and the monies involved there, this is a great example of the many, many, things University of Pittsburgh does behind the scenes and year round to facilitate our processes.

Ken McGarvey: Thank you Tony. Before we break out into groups, let's have each group give a brief summary.

Briana Morgan: Access is looking at linkage to care, access to care and prevention services, and possibly others.

Melissa Davis: Disparities will today elect chair and co-chair, we discussed the recommendations and operating procedures for identifying what goals the committee will tackle in the current year.

Wesley Anderson: Incidence is the smallest committee right now, and we are looking at newly diagnosed across the state: we will be looking at 15, 16, and 19 in the recommendations.

Ken McGarvey: Thank you all. We expect that everyone will join or decide upon a group today. We will reconvene here at 4pm.

[Subcommittees meet]

Subcommittee Reports

Daiquiri Robinson: For Disparities, our group elected a chair and co-chair, me and Richard Smith. We will be looking and disparities with transgender persons this year.

Wesley Anderson: For Incidence, given how difficult it is to start a discussion like this from scratch, we did a great job today. The questions we will be raising are: What are the personal an institutional barriers affecting HIV testing. Why is routine opt-out testing not happening in Emergency Rooms, and by individual doctors?

Dan Campion: We also talked briefly about the meeting, and saving money by bringing our own sandwiches.

Briana Morgan: Access looked at linkage definition and the challenges to establishing that definition. We recognized that we will be working with incomplete data. We looked at the peer navigation aspects. And then we talked about budget, and we talked about how valuable in person communication is. It was a great way to show the importance of all the perspectives.

Wayne Fenton: I would like to add that with the thorough reports we have gotten from University of Pittsburgh, we definitely don't want to cut their budget.

Ken McGarvey: One challenge we have in Pennsylvania is the incomplete reporting of CD4 and viral loads. We are optimistic that this may be changed in the new administration; the new acting secretary of health has made that a priority.

Derick Wilson: We should have a short term work plan of what we will be doing and accomplishing at each meeting, and have that on the calendar. I think each subcommittee should have one for the year.

Ken McGarvey: That has worked very well for us in the past, though on the other hand the subcommittees don't know exactly what we'll be doing this year. Now that this is settling in, we can ask each group to start working on that tomorrow.

Chairwoman Flaherty: Great point, Derick. That was simply delayed since the transition with the groups didn't happen until January. Thank you all, and we'll see you tomorrow.

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Welcome and Announcements

[9:01]

Chairwoman Flaherty: Welcome!

Ken McGarvey: Are there any new announcements before we begin this morning?

Briana Morgan: At the Office of HIV Planning in Philadelphia, we are getting ready to start their priority setting process. This is mostly done in committees, and the first committee will be meeting next Tuesday, once per month. You can see all of the meetings at hivphilly.org. It used to be every year, but is now every three years or after a major event – like the expansion of Medicaid.

Paul Yabor: AIDS Watch is next month, and I hope to see you all there in Washington DC on April 12th.

Ken McGarvey: Let's review the agenda.

Review of CDC HIV Prevention Grant Award

[Jill Garland, Julia Montgomery presentation]

Ken McGarvey: You said you had a $300,000 shortfall, where did that money get cut from?

Jill Garland: A little from travel, we adjusted some numbers from testing to make them more accurate, but they were minimal. We took a look at all the components we were funding, and so we maintained those core components, and instead looked at the recommended CDC categories, like social media and capacity building. Those cuts are what we contract through the University of Pittsburgh. So they absorbed a significant portion of that cut.

Question: Why does DOH contract to hire out some of their staff?

Jill Garland: We have a civil service system here in the state, and several previous administrations have locked down our ability to increase staff hires, so as needs for specialized skills emerge, contracting these needs has become our only recourse. When we have a civil service job description, we can change their descriptions to suit our needs, but contracting is much faster, feasible, and effective once our staff compliment as defined by the state is full.

Anthony Silvestre: Is there a plan of future training for case management?

Julia Montgomery: I do know that that is a need, and we are talking with Part C and D providers and the AETC.

Susan Rubenstein: AETC is doing training for medical case managers in June.

Anthony Strobel: The problem is that we don't hear about these events.

Shirley Murphy: The conference is in Gettysburg on June 3rd and 4th, at the Gettysburg hotel.

Jill Garland: We are also working with the University of Pittsburgh to offer cultural competency and other non-medical training that any agency or provider can take advantage of.

[SPBP section presentation: John Haines]

[Break 10:05-10:20]

Ken McGarvey: Welcome back. We will now have the second part of Benjamin's epi presentation from January.

Epi Presentation

[Benjamin Muthambi]

Paul Yabor: How far are we from where we are at make the cascade model effective? Is this relevant to the progression of the cascade?

Benjamin Muthambi: there are two answers. Every year we work on the levels, and you will see the cascade in the presentation later. Second, we have to respond to that data, which I think your question is about, and how that will address public health action. That is a long question but important question. I will need to defer to the co-chairs for talking about it now, or we can put it in the parking lot for discussion later. We'll do that? Ok.

Paul Yabor: Recent national behavioral data survey and drug use suggests in Philadelphia Prevention point went over the data and we found that the amount of Hispanic people represented – we knew that there were particulars about the data – so that is one example of how data can be influenced by sampling irregularities.

Lunch 12:05

[Epi presentation resumes at 1:01 pm]

Wesley Anderson: Thank you for your presentation. When talking about reservoirs… and we've seen an epi study from Croix in Seattle that followed MSM couples and found Truvada to be highly effective. Do you think that we will ever start to follow that kind of tracking system?

Benjamin Muthambi: There is no question that the guidelines that have come out for this – high risk individuals – but at the end of the day it comes down to resources and policy and it is also possible for us to identify… though it looks insurmountable – we cannot pour all of our resources in to PrEP. Even within this, there are subgroups at extremely high risk who I think we could be reaching and it would cost the state very little or nothing. How can that be done? Perhaps we shouldn't be waiting for an ultimate solution – reaching everyone in the guidelines – when we can reach those most at risk now. When we actually know people who have extremely high viral loads when they are diagnosed, and people recognize that they are in trouble, perhaps we can reach them. Those high risk parties some people go to, who live their lives that way, it may be we can without judgments intervene to help prevent infection. You can go on the web any given night and find these sex parties. How can we do this with no cost to the state? We can talk to part C medical providers and get them to assist. Insurance doesn't know what is for PrEP or not PrEP. The claims do not say, and so the providers can assist us with providing this, because we are hearing from them that these claims are not being denied by insurance companies. That includes Medicaid. There are also programs run by the pharmaceutical companies who dispense these medications

for people with no insurance. I am not suggesting that we do away with the CDC guidelines; I am saying that there are even higher risk groups whose risks are immediate. We see from viral loads how long this has been going on. We hope we can begin doing this soon. It is a job of coordinating this with providers. So please make this suggestion to your clinicians that they talk with their clients. That is my dream.

Doyin Desalu: Can you please go over your inference over the disparities you've identified?

Benjamin Muthambi: One is modes of transmission. Those modes all have different levels of risk. MTC (mother to child) infection is not included – it is a different thing. So IDU (injection drug use) is very risky, but with lower participation numbers, and so on with the other risk groups. Then there are many other layers underneath that, but the general hierarchy is IDU, MSM (men who have sex with men), then Heterosexual transmission. So then we take those levels, and look at the individuals who could transmit the disease. We do this because prevention is also care. So who are these people? We need to know because the different activities each group engages in let us know how to prioritize people to know who to go after first. Because we do not have unlimited time and money, these are the decisions that have to be made, and this data analysis helps us make those choices. It would be nice to say we didn't need this and we can catch everyone, but since that is not the case this is the rationale we must use.

Paul Yabor: I have some concerns about this data in light of local statistics. In Philadelphia, IDU infection is about 5% now, but for black MSM it's much higher. Why don't we take these environmental factors into account?

Benjamin Muthambi: We do have to stratify what the needs are from a statewide level this is what we see. What you are talking about is more localized data that take incidence into account; we do not have this data statewide. The last time we did the prioritization model, CDC says, give us your list of priority populations, and so we say sure, but for implementation, we are going to take that list and apply it differently to various localities. We have sub-epidemics that have disproportionate impacts on various groups, and for that implementation you do need to look at that local data. So we have been creating local data collections for each county health location, so as to apply things more accurately. To do the analysis right, it takes time and effort. And since our epidemic is so diverse, it is very labor intensive. And that is why it takes time to apply these things. And then that is how we know what approach to take.

Ann Stuart Thacker: Now that we are a statewide planning committee, how do we get down to the individual populations?

Benjamin Muthambi: I don't know. There are portions in the epidemic, and we cannot afford to bury them in analysis. We must come up with a plan for getting them. For

example, the CDC came up with a plan for helping the most affected cities. It was called the "12 city" plan. In practice the plan is to come up the sub analysis per each sub-epidemic. So then when we make blanket decisions we can apply them to hot spots in ways that speak to the nuances there. Different approaches are needed for different needs.

Paul Yabor: So when we see needle exchanges work, and similar patterns in other areas that do not have these programs, what can we do other than recommend this program?

Benjamin Muthambi: My sense is that this will be a combination of community involvement and Department of Health effort. One approach that I have seen work is what NY State did. The governor and Department of Health declared health emergencies in jurisdictions and then worked with them to implement exchanges. But then who do they answer to? Voters. So I cannot tell you what to do there. But it can be done. And it can be done under a research protocol for holistic drug treatment protocols. So it's not like the DEBIs where everyone could do their own thing. I don't know if this would work in Pennsylvania… especially with the large majority in the legislature now. It hasn't been tried here, but what could be the harm in trying?

Ann Stuart Thacker: I know you're allowed to get needles prescribed, now.

Paul Yabor: Though you can't knowingly sell things for illegal uses.

Benjamin Muthambi: Ken says we must move on now. But I will be around all year, so we can talk more at any time.

Ken McGarvey: Now on the agenda, we see that subcommittees still need to meet. So if you can stick around, we will meet from 2-3pm. Then we will reconvene for roundup discussions.

Subcommittees meet

Reports from subcommittee chairs:

Daiquiri Robinson: For Disparities, we finalized our target population selection, and looked at the action steps for our work plan. We will look forward to hearing from the steering committee with what we can get when, as far as data on transgender populations, and we are all energized and excited to go.

Wesley Anderson: Incidence asked University of Pittsburgh to look into barriers in HIV testing in health care settings.

Briana Morgan: Access looked at what they want in peer navigator programs, possibly peer specialists. We will look at funding possibilities for these programs, and look at new models for possible adaptation for PA. We will compare modes in May, and assess what

might work for various regions – rural vs urban, etc. – and then move forward with that in July.

Chairwoman Flaherty: Questions for the reports?

Ann Stuart Thacker: I've bene around for a long time, and been in a lot of committees, and it's been such a pleasure being on this committee and it's so professionally run and such a great thing to be a part of.

Chairwoman Flaherty: On that nice note, I'll motion to adjourn. Afterwards, Steering Committee, please move together to the center of the room for our steering meeting.

[Seconded. Meeting adjourned.]