PENNSYLVANIA DEPARTMENT OF HEALTH

HIV PLANNING GROUP MINUTES

Park Inn Harrisburg West, 5401 Carlisle Pike, Mechanicsburg, PA
May 13th, 2015

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

Not Present: Jeffery Haskins, Derick Wilson

DOH, Division of HIV/AIDS: John Haines, Kyle Fait, Jill Garland, Sara Luby, Ken McGarvey, Benjamin Muthambi, Lisa Petrascu, Jon Steiner, Brad Van Nostrand, Nicole Risner, Christine Quimby, Cheryl Henne, Julia Montgomery

Department of Health staff: Nicole Grazi

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

HRSA: Rob McKenna

Guests: Leah Magagnotti, Jeff Funston,

Welcome

[1:04 pm]

Chairwoman Flaherty: Welcome to our afternoon meeting! We're going to hold our introductions for just a moment.

HPG Membership Presentation [Chairwoman Flaherty]

Introductions

[Members give detailed introductions about their representation]

Announcements

Chairwoman Flaherty: We are implementing several changes in procedures we'd discussed earlier. We are starting with our first day as a half day for now, and I need to

remind guests who are not invited speakers that we cannot offer them lunch any longer. These are part of our new cost saving measures suggested by the members here and passed by the Steering Committee.

Director Ken McGarvey: I'd also like to welcome Nicole Risner from the Pennsylvania Department of Human Services (formerly Department of Public Welfare); we have also been in contact with the Health Department's Hepatitis C Coordinator, Dr. Charles Howsare, and he will be attending HPG meetings.

For our integration update – Just a note that annually, the National Alliance of State and Territorial AIDS Directors (NASTAD) hosts an AIDS Drug Assistance Program technical assistance meeting. This year the meeting will also include prevention and care staff. This is an effort to enhance the integration of HIV services at the federal level.

Lisa Petrascu: We have a travel notice; there is some pushback from our travel auditors, in that renting a car will nearly always be deemed the cheapest option. So if you drive your own car for convenience, you may be reimbursed at the lower rate. This is not our decision, and we have no control over that determination. As far as meeting days go, having a day and a half versus two days will be based on need; we won't force everything to fit into a reduced time.

Jill Garland: We have prevention section updates. Our clerk typist position is now vacant, as Greta had an opportunity to not return. You may recall from our budget presentations that we have filled staff vacancies, and we have requested those funds to be used for one-time expenses to fill gaps and enhance some things we are already doing – buying IT services, condoms, rapid tests, and so on. We talked last time about the new Prevention Guidance, and some providers have requested exceptions to fund activities/interventions not specifically identified in the Guidance. Those requests will be reviewed in the next week or two. We are conducting site visits at county/municipal health departments, and at our fee-for-service testing providers; developing new contracts for 2016-17, and new invitation for bid for the hotel for 16-17. Our new CDC project officer is Rodrick Joiner and he will be here in PA on August 11-12.

We are looking to purchase more rapid tests, and we are looking to pilot new rapid test products as well, the Alere Determine and possibly the Chembio DPP test. This one may be a dual system HIV and Syphilis test.

Alicia Beatty: Where will this be piloted?

Jon Steiner: We are looking to target MSM with these new tests. One site is a rural camp setting in northeastern PA, where the testing provider is also piloting a rapid Hepatitis C

test. The other site is Project SILK in Pittsburgh. We are working with a small number of sites at first to see what results we get.

Jill Garland: This is simply something we are asking current rapid testers to do to see how the products work in real life. These sites are also testing in conjunction with our STD programs, since they will also be piloting a a rapid Syphilis test.

Shubra Shetty: Please keep in mind letting us know how soon these might be available for providers – we would love to have this kind of testing available as soon as possible.

Jill Garland: We agree – we'll certainly be looking to that in the near future.

Julia Montgomery: We have several Ryan White reports due in June and July. April first started the 2015 year. We have the women, infants and children report being compiled now, and we appreciate everyone turning in those reports so we can get it compiled in time. All 7 of the regional care grants are being renewed at level funding, and these agreements will run through June 2016.

Cheryl Henne: We have a new fiscal coordinator, and we are very glad to have her and she is a tremendous asset. We have another customer service line representative that will be starting May 19th. We are also involved with the grant close-out.

David Givens: At the University of Pittsburgh, our efforts supporting the HPG and the DOH, as well as the projects we're developing, continue to progress smoothly. Our website, though in transition to a new platform, does host all HPG planning information now, including minutes and applications; we are reviewing our Capacity Building trainings with the state to streamline and coordinate needs with what can be offered; Acceptance Journeys, our anti-stigma campaign to reduce health disparities and barriers, will be the featured gallery event at the Carnegie library beginning July 2nd; and the transition of Project SILK to operate long-term under a community-based organization is well underway.

Briana Morgan: I have a new report on young MSM in Philadelphia that we have shared with you. Please check it out, and we are hosting a major combined AIDS summit June 8th at the Philadelphia Convention Center. Sharita has postcards.

Linda Frank: The AETC is having a conference in Gettysburg on June 3rd and 4th. We can work out funding for the registration fee. We will be having very important knowledgeable speakers on a number of issues. These people have a lot of great ideas and experiences, and we'd love to have you attend.

Daniel Harris: I am extremely happy to announce that I have founded the Forward Front Foundation, which was officially granted 501c3 status. It works to help young black men

and MSM of color to envision and shape their future positively. So I'll be talking to many of you about next steps for this organization, and excited for the future of the group and its impact. [Applause]

Christine Quimby: The Pennsylvania Department of Transportation (PENNDOT) is taking comments until the end of the month about transportation and access issues in Pennsylvania, so you can go online and make suggestions about medical transportation and other issues in Pennsylvania.

Chairwoman Flaherty: Do I hear any corrections or additions to the minutes?

[Minutes approved as presented.]

Please update your emergency contact sheet as it comes around, and please wait for the microphone if you have a question or comment.

Sarah Krier: Since Dan [Hinkson] is unavailable, I'll be walking you through our survey. As Sharita said in her earlier presentation, the HPG needs members to represent certain populations, and those categories may not be clear now. So we are asking you again! Please remember that we are required to collect this information for reporting to HRSA, and that no HIV statuses are disclosed on this form. There should only be three things you put on the form two check marks, and your name. Please check a category for your primary representation, and one for your secondary. Please note the paper is two-sided.

Director Ken McGarvey: This is an important survey because it helps us with our recruiting as well.

HRSA Presentation on HRSA operations in Region III [Rob McKenna]

Alicia Beatty: What is HRSA's take on the future of CBOs?

Rob McKenna: I have not heard any particular talking points on this, and I have heard of agencies doing FQHC [Federally Qualified Health Centers] and an emphasis on service integration, and all services are being asked to do more varied types of services, which lends to becoming an FQHC…

Christine Quimby: It seems from your presentation that PA has 45% of the clients in region III and only 35% of the funding. What is your take on that? Is that fair?

Rob McKenna: First, I'd like to be clear that my office does not decide that award; I suppose what I can say is that advocacy is a key component of funding awards, as well as geography, and so we know that it can be more costly to serve rural clients, which all these states grapple with. But the short answer is yes – you interpreted those numbers correctly.

Wayne Williams: How are the services provided at the county level monitored? It seems like services vary from county to county sometimes for some support services.

Rob McKenna: The grantees are responsible for monitoring, and for monitoring their sub grantees. Different places can use their monies differently depending on demonstrated needs.

Briana Morgan: For the Part A EMA [Eligible Metropolitan Area], our allocations are divided among persons living with HIV AIDS, so the suburban EMAs are different from the Philadelphia EMA proper.

Rob McKenna: We have time for one more question.

Susan Rubinstein: Any update on the merging of Part C and D?

Rob McKenna: There is no new public update on that. However, both Part C and D providers are invited to upcoming planning meetings.

Linda Frank: Part D will remain a part of Ryan White funding because it's in the current legislation and so that will exist until the reauthorization after the next election.

Rob McKenna: …Yes, but the other side of that discussion is that just because something is authorized doesn't mean it will or necessarily should be funded. So that is the discussion that is going on now. I'd urge everyone not to jump to conclusions based on that line of reasoning.

Now, I'd like to hear from you all what is being done with the expansion of Medicaid in PA.

Tamara Robinson: We are seeing major barriers with backlogs; our agencies are enrolling people and we see them experience long delays with the processing.

Wayne Williams: We see a lot of people getting sent to us, so that's great, but we are seeing the application process and the expansion – problems with understanding who needs to fill out which forms. We seem to be getting conflicting information on what is expected with certain applicants. So we are just submitting applications and see what the responses are.

Ann Stuart Thacker: We are being told that people who do not sign up for Medicaid or Medicare can still receive Ryan White services. We see that Ryan White is still serving people without insurance.

Guest: There should be no changes in the forms or their functions, and providers are required to vigorously try to enroll clients.

Rob McKenna: And people who don't sign up cannot be denied services.

Julia Montgomery: You must have documentation that clients refused to sign up for other insurance, and agencies cannot use Ryan White funding until they can document those efforts in vigorously pursuing other funding sources.

Cheryl Henne: And it certainly is in the clients' best interest to enroll and receive full health care benefits rather than just SPBP [Special Pharmaceutical Benefits Program] or RW [Ryan White] services. It's in their interests.

Rob McKenna: And we can arrange for an ACA [Affordable Healthcare Act] counselor on site. These people are very skilled at speaking with clients and explaining the benefits of enrolling.

Director Ken McGarvey: An important discussion. Thank you all.

We will now hear some updates from the subcommittees, and then break out into the groups.

Wes Anderson: With our emails, we received data from the state, and will be seeing our presentation from University of Pittsburgh and going from there.

Daiquiri Robinson: We will also be seeing an important presentation from the University of Pittsburgh on transgender health and moving forward from there.

Briana Morgan: We had a lot of reading between meetings, and we will be going over that and analyzing peer navigator options.

[Subcommitee meetings]

[Lunch]

Director McGarvey: We will now hear reports from the subcommittees.

Briana Morgan: Access has been looking at issues of peer specialists for various related issues, and today we learned about lot more. So we are going to be looking at MA reimbursable models and discussing that tomorrow, including who would qualify and who could receive services.

Daiquiri Robinson: Disparities accepted our past minutes, finalized our work plan, and got a great presentation from David Givens at the University of Pittsburgh on health issues facing transgendered people. We have homework for reviewing the data from the Department of Health and we'll look at next steps tomorrow.

Wes Anderson: In Incidence, Tony Silvestre was not able to present today, so we reviewed Briana's article. We reviewed personal barriers and institutional barriers the document identified. The article was able to give us a foundation for that perspective. We will have

some conference calls and next time we'll get Tony's presentation and one from the Department of Health dealing with testing.

Director Ken McGarvey: Thank you all. We will have some time for subcommittees tomorrow – 40 minutes. Other agenda items are flexible as well if we need more time for that.

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Department of Health Staff: Virginia Rogers, Elaine Smith, Charlie Howsare

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

Guests: Leah Magagnotti, Bethany

Welcome

Chairwoman Flaherty: Welcome back today, everyone. Now that we've all had a chance to think more about whom we represent here at the table, let's go around and give detailed introductions again.

[This discussion has been removed from record at the request of Director McGarvey.]

Director Ken McGarvey: Thank you all, and welcome. We do have one change in the agenda for today – we will have 1 full hour for subcommittee time.

Moving on, I'd like to introduce our guests from the Office of Long Term Living – Elaine Smith and Virginia Rogers, who will be talking with us about the AIDS Waiver.

Elaine Smith: Thank you! When our colleagues were here last, two years ago, we were getting ready to go out and make home visits to people on our lists with AIDS waivers. Two years later, our update for all of you is this. We realized at the time that our data did not

look right – enrollment vs claims did not add up, and people weren't using services. There are four types of services, covering a large range of home care, and a variety of services. So we went out, met with as many people as we could, and what we found was that out of 659 people on paper we had 52 people actually using services, mostly homemaker services. So at this point, we would like to transition those people to another long term living program. There are four other types of waiver programs they could move into. We have been talking with our peers in the Department of Health about how we might transition so that no services are disrupted. We would like to have a conversation with the participants and case managers about this. We are looking at agencies that are being used and comparing them to agencies in other waiver programs… and that would be a seamless transition if the agencies were registered there already.

For our other waivers, case management is available in those programs. In the outgoing AIDS waiver program, most people get services through aids service organizations. So we don't have any connection with those providers at all. That has been a challenge for us. Individuals can choose case managers from among 98 different agencies. The 52 individuals can choose one of those if they'd like, and/or we can reach out to their current provider if they are not enrolled with us already. So that is a conversation we will have to have with them. We expect that any agency that picks up these new clients will be coordinated with the old agency to ensure continuity of care.

Alicia Beatty: So the AIDS Wavier is going away?

Elaine Smith: Yes, that is what we are proposing. To close the program and serve these people through another Waiver program. So it's not diagnosis specific.

Alicia Beatty: Ok, how will people reach you, or get involved in this new process?

Doyin Desalu: Is there a list of all those agencies you mentioned anywhere?

Elaine Smith: Yes, and we can get back to you with that list. As to the first question, we have independent enrollment brokers, and they can process anyone who is referred to them into the appropriate waiver.

Shannon McElroy: What timeline are you proposing?

Elaine Smith: The next four months, or longer if we need it. We have submitted a renewal for the AIDS Waiver, and they came back with seven pages of issues with the program, so it made sense to us to look at other options that would be best for the individuals involved. One thing we noted about this new plan is that they are actually more comprehensive than the existing AIDS Waiver plan. So we are looking at a 90 day extension, and at that point we would have transitioned people.

Chairwoman Sharita Flaherty: So 52 doesn't seem like a large number, but are we looking at the same 52 people over the last ten years, or are 50 people cycling in and out every 6 months?

Elaine Smith: Good question. We can't tell for sure, but we think that most of them are long term users.

Jeanne Caldwell: First of all, I know that people were discontinued in the past because there were no counselors in people's regions. So many people in our region lost benefits because there were no providers available. So if I understand, you're saying that new nutritional providers will be available under the Independence Waiver?

Elaine Smith: Yes, the other thing is that to be enrolled you need to be enrolled in an ongoing service, which is defined as monthly. So people who need nutritional counseling twice a year won't qualify. It sounds like nutritional counseling is a gap for people.

Jeanne Caldwell: Yes, and as issues with living with HIV change, people will still need that service. I'd also recommend working more closely with case managers for people you're having trouble reaching, and we'd like training on how to recommend other waiver programs. Trainings for case managers; not necessarily for this group.

Director McGarvey: We can coordinate something like that through Linda and the AETC.

Elaine Smith: So we'd really like to hear your feedback, so we will be leaving business cards for you to contact us anytime. If you are serving people with activities of daily living (ADL) needs, please recommend them to the system and we will look to serve them through our other programs. I understand that the Special Pharmaceutical Benefits Program (SPBP) may also be able to serve people in that aspect, and I'll be talking with Ken about nutritional gaps. ADL means activities of daily living, by the way. These types of services are not Medicaid, that's why we have the waivers. They cover physical health benefits, not skilled or therapy needs –that's what the state Medicaid covers. And we will get that list of providers to Ken to forward on to you.

Tony Strobel: Will the waivers still be income based?

Elaine Smith: To be financially eligible, there is a level. It is a higher threshold than Medicaid, but I don't know the specifics.

Guest: We find that we can get clients in for nutritional assistance a few times a year, and we consider that a big win. I'm sure it's not your requirement, but that's what we find if you're going to be talking about it later.

Jeanne Caldwell: I'd just like to comment that we need more providers enrolled for home care in our region – the northwest.

Elaine Smith: Yes, and since we have so many providers, you may actually have an increase in access to care with a different waiver program.

Alicia Beatty: Am I understanding that an AIDS service provider can call your providers and get access to waivers?

Elaine Smith: Not exactly. We can work with agencies to get enrolled with us so that they can then help people enroll clients in waiver services.

Director McGarvey: Our thanks to our presenters today.

Virginia Rogers: Thank you. I know this was not an easy conversation, and we admire your passion and efforts for people with HIV AIDS and we will be looking to you for guidance streamlining this transition and serving people in our state.

Director McGarvey: We will now have our next presentation on addressing an unment need and the resource registry.

Unmet need: resource inventory presentation [Ben Muthambi]

Questions:

Briana Morgan: Part A does have a resource listing; it's a PDF now but is being updated to be searchable.

Benjamin Muthambi: Indeed, and many regions do something like that. It's not the best way to access information, but we hope to combine and improve your efforts.

Comment: I'm assuming that email will be provided somehow, eventually, right?

Benjamin Muthambi: Part C's will identify a point of contact, and that day to day person will receive emails and phone calls for health alert network. It will also eventually be able to do facilitate referrals. The provider site would also have to be registered and have a provider contact. We will have templates for those who do not have them in house. We should not have a situation where people are enrolled in a clinic and the provider cannot get a case manager without additional consent. It's a business associate agreement that will allow agencies to talk to one another and to hospitals in a way that will not violate HIPPA or confidentiality.

Paul Yabor: Where HIV is now Hepatitis C is way behind. Certainly there are resources to find providers, but what about connecting this system to Hepatitis C?

Benjamin Muthambi: Yes, that's funny, we have just hired a new Hepatitis C specialist…

Charlie Howsare: Yes, that's me!

Benjamin Muthambi: Oh! Well, we are looking to combine that effort as well as Drug and Alcohol treatment programs. So we will be collecting that info from Drug and Alcohol and Hepatitis C and we will be getting on that track.

Richard Smith: This sounds wonderful, but a missed opportunity I see is that the University of Pittsburgh spent a lot of time and money trying to develop this. Why did the Department of Health ask them to do this and then not share this info that you say you have now with the new system?

Benjamin Muthambi: That is not the case. We had broken all the information we had into tiers and gave that to University of Pittsburgh, that information was going to show up in the new system eventually. We do have new linkages with other agencies, and that was not available in a timely manner to share with the University of Pittsburgh back then. So you are misinformed about how HASP worked and didn't work. HASP did not fail because we didn't turn things over to University of Pittsburgh.

Richard Smith: Then why wasn't that shared with this planning board? We saw a lot of presentations about HASP – I find it disingenuous that you're telling us now we don't know about HASP.

Benjamin Muthambi: We were asking the university to go after this info, or to sign agreements with so many agencies, and this was causing more barriers. We, inside the state system, do not have those barriers. We have new agreements that have restructured our relationship with Penn State for them to do that with us.

Richard Smith: If this is through Penn State then how will there be any fewer barriers than with Pitt?

Ken McGarvey [with clarification added]: While support for this project is currently provided through a contractual agreement with Penn State, the project is directed and managed by DOH staff in such a manner as to address the challenges and barriers previously encountered. Many lessons were learned from our previous efforts to implement HASP in collaboration with the University of Pittsburgh. Much credit needs to be given to the University of Pittsburgh for their initial efforts to create and implement HASP. Unfortunately, multiple data collection challenges (getting providers to register) and technological difficulties (software and programming) resulted in the termination of the project as the system was non-functional. Termination of the project through the University of Pittsburgh and assignment of this project to the Penn State contract was the decision of the Division Director (Ken McGarvey). The Division of HIV/AIDS fully supported the efforts of the University of Pittsburgh in their work to create and implement HASP (over many years). Any notion that the Division of HIV/AIDS did not fully support the University of Pittsburgh in these efforts is misinformed and inaccurate.

Alicia Beatty: So this will be a tool for both providers and consumers?

Benjamin Muthambi: Yes.

Comment: But – is this being test piloted with consumers?

Benjamin Muthambi: Yes, we are testing it with Penn State's medical center right now, and some case managers. We continue to get more information, so it's not released for public use yet.

Director McGarvey: There are many fruitful conversations to be had here. We do need to break for lunch at this time, however.

[Lunch]

Director McGarvey: We will now meet in our subcommittees.

Report of subcommittees

Briana Morgan: Access established a definition of linkage to care. It is: "attendance at 1 medical appointment within 90 days of confirmation of a positive result."

This aligns with the CDC diagnosis of linkage to care; Sara Luby developed it from existing definitions from the CDC and the Health Resources and Services Administration, etc.

Is there anyone who is opposed to adopting this as a standard definition of linkage to care?

[Motioned, seconded, and approved unanimously as the definition for use by the HPG and as the recommended definition for adoption by the Dept. of Health Division of HIV/AIDS.]

Thank you. The next part of our subcommittee report is a presentation on how to use data in planning.

Planning with Data [Briana Morgan]

Questions:

Briana Morgan: What kind of data would help your groups?

Daiquiri Robinson: David gave a great presentation that used large amounts of studies that go back quite a ways to give us that picture on transgender issues and experiences, and we also had CAREWare data and SPBP data to look at what's happening in PA.

Wayne Williams: Access can look at how the numbers are being used to evaluate peer navigators, for instance, programmatic data.

Paul Yabor: Regional breakdowns would be great to see what works in each area.

Ann Stuart Thacker: We are looking at people staying past the fifth visit, and looking for programs that address dropping out. So that's where the data has pointed us.

Charlie Howsare: I've been looking at data with Benjamin, and a lot of the data is county specific. Those are often historical markers with no relevance on the way people live, and so looking at things that way may cause you to miss important things. People and things cross state, city, travel ways, all the time. Looking at things in a number of different ways may really highlight patterns not immediately obvious.

Briana Morgan: Good point. And sometimes it's also demographic differences.

Chairwoman Sharita Flaherty: We could also look at how other chronic diseases are addressed.

Linda Frank: I don't know whether we've given any thought to using distance outreach for perspectives on trans issues. We might be able to find those kinds of resources for all the committees. Looking at resources in other states can bring in new ideas.

Daniel Haskins: Do we have the resources to do focus groups and do studies to get this kind of information?

Brianna Morgan: Such things do take a lot of time and effort. You need to know very clearly what you're going to ask ahead of time, and it can be challenging. So a lot of time it can be helpful to know what has already been done.

Paul Yabor: There is a statewide EPI for heroin use, and in Central Pennsylvania is there any way that we can correlate overdose rates with rates of infection?

Briana Morgan: That is a good example of using existing data to leverage needs assessments, but any of those kinds of proxy data will never really nail it down exactly. So it can identify hotspots, but not generate usable numbers.

Charlie Howsare: That has been identified in some journals using these types of proxy markers, and that these can act as surrogates to Infectious Disease at risk a population that is good enough to move ahead with initiating risk management strategies. So while it's not exact, it's not useless, either.

Briana Morgan: So please take a Friday night and sit down with American Fact Finder and see what data is available for your community, and also look at the EPI profile and see what that means for Pennsylvania and your community. But not in Google Chrome. The links don't work in that browser.

Statewide progress reports and planning opportunities [Jill Garland]

Jill Garland: For areas that say 'not collected' in this report, it simply means that HRSA does not ask for it on their collection forms, not that we actually don't have it. This is just from a HRSA perspective, and not from everything the state knows or collects. Thank you for clarifying that, Benjamin.

Derick Wilson: I know we have to say we're using evidence based approaches, but we need to think about how we can push back against that too, since it seems CDC tells us we need to use them for a year and a year later they announce that they don't work. We know what works. We can't let the CDC tell us what to do when we know what works and the CDC hasn't figured out how to do it in a lab to get evidence. We can't be too afraid to annoy the CDC officer.

Jill Garland: When I think of high impact prevention, they are looking at a tool kit of possible interventions, so we can think of ways of combining things we know work, to have a more holistic and comprehensive set of tools for prevention and care.

[Comments on Incidence report]

Derick Wilson: The other thing I've noticed is that are no EBIs for those most at risk and those most commonly getting infected. Truthfully, you need all kinds of innovations and no one is sitting down with young black MSM and figuring it out.

Shubra Shetty: We know some people are working with those groups – just look at Project SILK. And when you are sitting down with people, I would encourage you to collect evidence, so that then it can become evidence based for someone else. Write it down and document it, or it may be lost. In medicine we see that all the time where people operate on assumptions that turn out to be wrong. So definitely innovate, but record it as well.

Charlie Howsare: For example: needle exchange clearly reduces HIV transmission. But it doesn't work for Hepatitis C, and everyone thought that this would work well for Hepatitis C reduction, but the measurements show otherwise.

Wayne Williams: I think broad based evidence based is a great approach since then people won't feel like they are being targeted, singled out. We need universal precautions to preventing HIV.

Derick Wilson: I agree. PrEP [Pre-Exposure Prophylaxis] and awareness of that approach could be very useful across the board.

[Comments on steps for access to care report]

Briana Morgan: We are not doing anything about #2 right now. And we don't necessarily need to be right now.

Bethany: I see that as a HRSA push to increase the number and diversity of providers. We are trying to do that in a Part F grant in McKeesport, Pennsylvania.

Chairwoman Flaherty: I see the third point as a microcosm for the AIDS wavier discussion earlier today. Transitioning people in ways that will help them more fully meet more of their needs.

[Comments on steps for Disparities report]

Daiquiri Robinson: We are hoping to use this experience with assessing transgender disparities this year as a template for the future. We have received a large amount of information, particularly from the University of Pittsburgh, and so now we are looking at what next steps ad approaches will be most appropriate.

Chairwomen Flaherty: Any thoughts, comments about the presentations, general process?

Wayne Williams: I just have one point with the forms for people being approved for medical expansion? We're telling all of our patients to enroll in Medicaid before their coverage is discontinued with SPBP….Is a rejection letter needed for that process?

Cheryl Henne: The time that a person enrolls in SPBP: if they are eligible for Medicaid they will receive a card that says they will receive 3 months of benefits instead of 6. If they receive denial letter, they are expanded for 6 months. If they have attempted to achieve that enrollment process, their benefits will not be stopped. They will continue until they complete that process. We won't kick anyone off of SPBP; that will not be an issue.

Chairwomen Flaherty: We have completed all agenda items. Do I hear a motion to adjourn?

[Motion seconded by Derick Wilson. Meeting adjourned at 2:34.]