

Philadelphia Prevention Community Planning Group (CPG)
Meeting Minutes
Wednesday, February 24th, 2010
2:30 – 4:30 p.m.
Office of HIV Planning, 340 N. 12th St., Suite 203, Philadelphia, PA 19107

Present: Dawn Acero, Wesley Anderson, Jennifer Chapman, Terri Clark, Christopher Collins (Co-Chair Elect), Tony Daniel, Antonio Davis, Annet Davis-Vogel, Andrew De Los Reyes, Tricia Dressel, Rick Feely (Co-Chair), Jeffrey Jenne, Andrea Johnson, Tyreef King, Ken McGarvey, Dionna Samuel, Roberta Waite

Excused: David Acosta (Co-Chair), Marné Castillo, Arti Chhabria, Nicholas Deroose, Denette Lienau, Alison Lin, David Powell, Val Sowell, Michelle Teti

Guests: Craig Ashley, Robert Lane, Eleanor Lundy-Wade, Ronald Montgomery, Amy Nuir, Jane Oprea, Darryl Rush, Coleman Terrell, Tye Underdue, Melvin White

Absent: Yexsy Alicia, Khadeja Barnes, Robin Brennan, Wade Briscoe

Staff: Aneeza Agha, Joseph Ellis, Nicole Johns, Debbie C. Law, Michael Milsop

Call to Order/ Introductions

C. Collins called the meeting to order at 2:34 pm. Afterwards, each member of the group took a moment to introduce his or herself. C. Collins asked whether anyone in the group was willing to be a timekeeper for the meeting. T. Daniel volunteered for the task.

Approval of Agenda

Motion: After taking a moment to review the meeting agenda, T. Daniel moved and A. Davis seconded to approve the document. **Motion Passed:** All in favor.

Approval of Minutes (*January 27th, 2010*)

The group took a moment to review a draft of the minutes from their January meeting. E. Lundy-Wade noted that she had been in attendance at the last meeting but was not included in the list of guests. **Motion:** With the noted correction, D. Acero moved and T. Clark to approve the draft of the minutes that was included in handouts. **Motion Passed:** All in favor.

Report of Co-Chairs

C. Collins informed the group that he would be attending the next UCHAPS meeting from February 27th through March 1st. He said that he would report any information he obtained at the meeting when the CPG convened in March.

J. Jenne reported that he was substituting as governmental Co-Chair because D. Acosta was currently unavailable. He then gave the floor to C. Terrell, who had an update on prevention funding from the state. C. Terrell informed the group that, in the previous fiscal year, the city had received 4.8 million dollars from the state for prevention services

through a combination of basic prevention funding, the testing initiative, and the State 656 funds. However, he continued, AACO had learned in January that, for the current fiscal year, state funding for prevention would be reduced by approximately 1.7 million dollars due to Pennsylvania's ongoing budget crisis. He said that the situation was especially serious because, as they were already halfway through the fiscal year, they had been operating under assumption that the city would receive level-funding of 4.8 million dollars. However, he told the group that AACO had been working with CDC project officers to locate overlap funding and shift some programs to different funding sources, such as using Part B funding for prevention with positives programs and including some counseling and testing programs with Ryan White early intervention services. As a result of their efforts, he continued, the city was able to make up all but \$380,000 of their lost funding for the fiscal year. He then told the group that, despite the significant amount of funding they had been able to recover, the loss was still substantial and would cause all State 656 programs to be terminated as of February 28th. He noted that losing the State 656 programs, which were mostly focused on HIV education, meant that a total of approximately 120 of the state's 78,000 HIV tests would not be administered for the year. In closing, he said that he was unsure whether AACO would again be able to make up the loss of funding in the next fiscal year if the situation was repeated.

- **Partner Services Update – A. de los Reyes (PPC)**

A. de los Reyes started his presentation by noting that, although some individuals referred to Partner Services (PS) as Partner Counseling Referral Services (PCRS) or partner notification, PS actually included many other activities. He then told the group that, after he finished with his presentation, he was interested in hearing about their thoughts and experiences with PS (see handouts for more information).

R. Feely asked for a description of the PS notification process. A de los Reyes replied that, contrary to some reports, PS did not travel to individuals' houses in highly identifiable vehicles. He said that, primarily, providers notified either AACO or STD Control whenever an individual tested positive for HIV or an STD. These entities, he continued, notified PS so that its counselors could be present when the confirmatory results were given to discuss transmission, risk reduction and the different ways that individuals who they have had contact with can be notified about their risk of infection. He said that, if the patients were willing and supplied them with contact information, PS first tried to make contact by phone and, if they did not get a response, would confidentially try to contact them at their houses if the information was provided. He clarified that all parties could refuse PS if they so desired.

A. Davis-Vogel asked what the protocol for PS was in the event that someone who had tested positive did not return for their confirmatory test. A. de los Reyes replied that PS was invited by providers to sit with patients when they returned for their confirmatory tests. He clarified that it was not their responsibility nor were they ever requested to track down individuals who did not return for their confirmatory tests, noting that such individuals were lost to care. However, he also stated that if a consumer was able to access care services without a confirmatory test, their providers were to notify PS.

A. Davis-Vogel asked how PS notified partners of teens who tested positive for HIV, noting that the population was at high risk for intimate partner violence. A. de los Reyes replied that PS counselors were trained to identify signs of intimate partner violence and to respond to the needs of individuals who showed signs of such violence. He said that individuals who were the victims of violence might not view HIV infection as a priority and, as a result, would need to be dealt with differently. He also noted that, although PS had never received reports of violence that resulted from their services, they were aware of the possibility.

C. Collins asked what the next step was for PS counselors if they were unable to make contact with someone either on the phone or at their house. A. de los Reyes replied that, while the guidelines did not specify how many attempts should be made, counselors would drop a case if the listed phone line was disconnected and the address was incorrect. C. Collins asked what happened when counselors made contact but the individuals made it clear that they did not wish to speak with PS. A. de los Reyes replied that counselors would try to use their counseling skills or knowledge of motivational interviewing, but only to a degree.

M. White felt that PS should try to use peers more heavily in the notification process. A. de los Reyes replied that, while there were benefits to using either counselors or peers, having providers enact the process had been proven to be far more beneficial. However, he noted that combinations of providers with peers or outside counselors were sometimes used for notification purposes. He then pointed out that using providers was more beneficial because, unlike peers, they were completely free of any biases and because the data they collected for the Health Department was much more thorough.

R. Feely asked for clarification on what was considered a refusal of PS by partners who they had notified. A. de los Reyes replied that refusals were assessed on a case by case basis. However, he said that blatant refusals, such as slamming a door on a provider attempting notification at someone's home, would always close cases. He told the group that the most important aspect of PS was letting someone know that they may have been exposed to the virus because the information might lead them to testing eventually, even if not immediately through PS. He added that, although the location of testing was not as important as notification of risk, there were benefits to being tested through PS.

T. King asked how the consumer protections of Act 148 affected PS. A. de los Reyes replied that PS always ensured total respect of confidentiality. He told the group that notification counselors were thoroughly trained so that partners were never made aware of who named them or when they were potentially exposed to the virus.

T. King asked how the partners of sex workers were identified and notified through PS. A. de los Reyes responded that PS could only work with whatever information sex workers were willing to give on either their clients or their regular partners. He noted that a PS counselor could not simply go to an area in which a sex worker solicited clients in an attempt to locate individuals. He also said that PS required more than just a name for notification and would work with sex workers to try and acquire more identifying information about individuals they had come into contact with, such as cell phone or license plate numbers. In response to another question by T. King, A de los Reyes stated that, if anyone knew of a positive

individual who had not talked with a PS counselor, the best method was to contact PS and tell the individual that a counselor would be in to talk with them.

T. Clark asked how PS followed up on individuals who preferred to be tested at other Community Based Organizations (CBOs). A de los Reyes replied that PS usually worked out arrangements with the individuals so that they could follow up with them and collect their data after they had been tested elsewhere.

A. Davis-Vogel felt that PS framed their notification process in a manner that placed blame for spreading the disease on the initial person who reported names. A. de los Reyes assured the group that the intention of PS was not to place blame on those who reported names. He then thanked A. Davis-Vogel for pointing out the perception and said that he would bring it to his peers for consideration.

D. Acero asked whether name-based reporting helped to ease the responsibilities of PS. A. de los Reyes responded that name-based reporting was more focused on data-sharing agreements and was not used by PS to locate partners of consumers.

D. Samuel asked whether PS could contact an individual whose name had been given to them if they were only able to locate the person through a social media web site, such as Facebook. A. de los Reyes replied that PS would require more identifying characteristics about a person, such as tattoos, before they would attempt making contact through social media sites.

D. Samuel asked whether the PS counselor who first was given names when an individual tested positive was also the same person who attempted to contact the partners. She noted that such a protocol could complicate the situation because counselors could not honestly say that they did not know who had reported the partners. A. de los Reyes responded that, while some jurisdictions did use such a procedure, Philadelphia never used the same individuals who had received names for notifying partners. He said that, although counselors had sometimes been accused of knowing who the initial reporter was, there had never been a reported breach of confidentiality in the city.

J. Chapman asked whether counselors could test partners at their homes since the ultimate goal of PS was testing and linkage to care. In response, A. de los Reyes informed the group that PS counselors could perform serum-based testing, which required drawing blood, on site. However, he noted that staff shortages were a problem as there were currently only four full-time PS workers in Philadelphia. As a result, he said that they preferred to have testing performed in clinics and would only test on site if partners were not willing to go elsewhere for it.

K. McGarvey informed the group that the state of Pennsylvania had made PS a priority in an effort to focus on programs that produced results following the recent budget crisis. He then supported the statement that PS produced its best results when it was delivered by trained counselors from the Health Department. As a result, he encouraged providers to notify those who received their first HIV tests about PS in order to have them return for their

confirmatory tests. A. de los Reyes closed his presentation by thanking the group for their time and questions.

Discussion Item:

• **Reinstating the Youth Roundtable (YRT) – C. Collins & T. Daniel**

C. Collins reminded the group that, at the last CPG meeting, they had held a discussion on reinstating the YRT. He said that he had not been able to contact those who had signed up for further discussion at the last meeting; however, he said that the current discussion item would be used to further develop the idea and to possibly vote on any plans they created. Pointing out that current funding shortages would complicate reinstatement of the YRT, he asked whether organizations that already had programs for youth would be willing to write grant proposals or couple the YRT with existing programs.

T. King said that the message of the YRT would have to be changed from what it had been before the group was dissolved. He said that current prevention messages for youth tended to include attractive individuals and he felt that the messages should instead give a more honest depiction of the effects of HIV/AIDS. Additionally, he suggested getting youths' opinions about what they wanted to see in prevention messages, noting that young adults were usually not interested in the opinions of adults. He suggested focusing on outreach and working to bring in underrepresented populations, such as those from the ballroom community. Lastly, he said the YRT would have to be restructured because youth had not been comfortable in the previous meeting environment, which caused poor attendance. C. Collins noted that, through outreach, he and T. Daniel had been able to get some youths to the last CPG meeting. He said that some other young adults – transients and those who were connected with Y-HEP programs – had said that 3:00 – 5:00 pm would be a good time for them for a meeting. A. Davis Vogel suggested trying to convene focus groups at Y-HEP or other youth-centered organizations in order to get the opinions of young adults on the matter.

A. Johnson informed the group that she had just come from an after-school meeting in which the school board had asked for help in dealing with the numerous epidemics facing youth, such as truancy, drugs, and STDs. She said that numerous experts on the matter simply did not know how to deal with the syndemic. She then gave her support to asking youths how they wanted to address the issues that faced them.

R. Feely suggested scaling back the conversation to focus on available resources and next steps. He said that, primarily, they needed to find out whether the YRT could be reinstated at the OHP or whether any other groups would be willing to convene a meeting. D. Samuel agreed, saying that the group could easily try to take on too much and prevent their efforts from being effective. She also felt that, if they tried to convene too many different types of youths into a single meeting, there could be trouble resulting from groups that did not like each other.

T. Daniel commended the group for holding a discussion that was focused on incorporating youth into prevention efforts. He then suggested that the group select a time to hold a drop-in at the OHP, to which they would invite organizations, the school district, and youths outside of the school district. D. Samuel proposed developing a survey primarily, because

she believed that a focus group would be difficult to convene and that a survey could be accessed by a larger sample of youths.

C. Collins suggested convening a committee to continue the current discussion and come to a decision on how to reinstate the YRT. A. Agha clarified that, as the YRT had been funded by the state, a new meeting on the group would have to be convened as an ad hoc committee of the CPG in order to take place at the OHP. **Motion: D. Samuel moved and A. Johnson seconded to convene an ad hoc committee of the CPG in order to continue discussion on reinstating the YRT. Motion Passed: 13 in favor, none opposed, no abstentions.**

Review Committee and Workgroup Reports

C. Collins took a moment to read the *CPG Subcommittees Report* for the month of January (see handout for more information). Afterwards, T. Daniel directed the group's attention to the handout entitled, *Factors Selected for CPG Target Populations*. He informed the CPG members that, at their next meeting, they would be weighting each of the factors on the handout, which would then be used to prioritize target populations for the next prevention plan. He suggested that the group take some time to familiarize themselves with each of the factors before the process took place at the next meeting. M. Milsop added that, as part of the regular process for prioritizing populations, the PPC had selected the factors in the worksheet based on whether the related data was available.

T. Dressel reiterated that applications for new CPG members would be accepted until March 9th. She then encouraged the group to recruit individuals who would fill gaps in the CPG membership, namely, African American males; representatives from governmental agencies involved with education, substance abuse, mental health, and corrections; epidemiologists, representatives from the education community, MSM/IDUs, MSM, mothers with or at-risk for HIV infection, and adolescents.

Report of Staff

D. Law reported that the Empowerment Workshop scheduled for March 9th would give information on the basics of HIV planning. She said that the event was primarily intended for consumers but that providers were encouraged to attend as well. She noted that, although the event was free, an RSVP was required.

M. Milsop reported that there would be two consumer town halls in Philadelphia, on March 16th and April 1st, to collect data on HIV/AIDS care services in the city.

Old Business

None

New Business

None

Research Update

None

Announcements

- T. King announced that GALAEI's 20th Anniversary Celebration would take place on April 16th at the Gershman YMCA.
- T. Daniel announced that, on March 18th at the National Constitution Center, there would be an event to mark the two-year anniversary of President Obama's speech on race.
- A. Johnson announced that there would be a kickoff event for Women's and Girl's HIV Awareness month at the Women's Coalition.

Adjournment

The meeting was adjourned by general consensus at 4:20 pm.

Respectfully submitted,

Joseph Ellis, Staff

Handouts Distributed at the Meeting:

- Meeting Agenda
- Meeting Minutes (*January 27th, 2010*)
- Handouts for Presentation on Partner Services
- CPG Subcommittee Report – February 2010
- Factors Selected for CPG Target Populations
- OHP Meeting Calendar

Philadelphia Prevention Community Planning Group (CPG)

Wednesday, February 24th, 2010

2:30 – 4:30 p.m.

Call to Order

Welcome/Introductions

Approval of Agenda

Approval of Minutes (*January 27th, 2010*)

Report of Co-Chairs (5 minutes)

Presentation: (45 minutes)

- **Partner Services Update** – *A. de los Reyes (PPC)*

Discussion Item: (30 minutes)

- **Reinstating the Youth Roundtable (YRT)** – *C. Collins & T. Daniel*

Review Committee and Workgroup Reports (5 minutes)

Report of Staff (5 minutes)

Old Business

New Business

Research Update

Announcements

Adjournment

Please contact the office at least 5 days in advance if you require special assistance

The next meeting date of the CPG is scheduled for Wednesday, March 24th, from 2:30 – 4:30 p.m.

Office of HIV Planning, 340 N. 12TH Street, Suite 203, Philadelphia, PA 19107

(215) 574-6760 • FAX (215) 574-6761 • www.hivphilly.org

Philadelphia Prevention Community Planning Group (CPG)

Meeting Minutes

Wednesday, January 27th, 2010

2:30 – 4:30 p.m.

Office of HIV Planning, 340 N. 12th St., Suite 203, Philadelphia, PA 19107

Present: Dawn Acero, David Acosta (Co-Chair), Wesley Anderson, Wade Briscoe, Marné Castillo, Jennifer Chapman, Arti Chhabria, Terri Clark, Christopher Collins (Co-Chair Elect), Tony Daniel, Annet Davis-Vogel, Tricia Dressel, Rick Feely (Co-Chair), Jeffrey Jenne, Andrea Johnson, Denette Lienau, Alison Lin, David Powell, Val Sowell, Roberta Waite

Excused: Antonio Davis, Andrew De Los Reyes, Nicholas Deroose, Tyreef King, Ken McGarvey, Michelle Teti

Guests: Henry Bennett, Jonathan Keel, Ronald Lassiter, Ronald Montgomery, Judith Peters, Melvin White, Jacquelin Whitfield

Absent: Yexsy Alicia, Khadeja Barnes, Robin Brennan, Kai Chandler, Tyrone McQueen, Nicole Quinn, Dionna Samuel

Staff: Joseph Ellis, Nicole Johns, Debbie C. Law, Michael Milsop, Mari Ross-Russell

Call to Order/ Introductions

D. Acosta called the meeting to order at 2:35 pm. Afterwards, each member of the group took a moment to introduce his or herself.

Approval of Agenda

Motion: After taking a moment to review the meeting agenda, T. Daniel moved and T. Clark seconded to approve the document. **Motion Passed:** All in favor.

Approval of Minutes (*December 16th, 2009*)

The members of the CPG spent some time reviewing a draft of the minutes from their last meeting. J. Jenne pointed out that, in the first full paragraph on page two of the minutes, the document that had had some language changed was the HIV case reporting form and not a new counseling and testing form. Additionally, in response to a question by J. Jenne, J. Peters clarified that the YRBS, which was mentioned under new business, stood for Youth Risk Behavior Survey. **Motion:** With the noted correction and clarification, T. Dressel moved and V. Sowell seconded to approve the draft of the minutes that was included in handouts. **Motion Passed:** All in favor.

Report of Co-Chairs

D. Acosta informed the group that Dr. Kevin Fenton had recently given a presentation at Drexel University that focused on PCSI (Program Collaboration and Service Integration). He said that Dr. Fenton had also examined Philadelphia's own collaborative efforts and reported that the city was far ahead of many other jurisdictions in integration. He noted that Philadelphia's success in integration was an achievement because all of the various disease systems had separate offices in the Health Department. He told the group that PCSI would become increasingly important in the next few years as the language was already starting to

appear in federal grants and CDC proposals. T. Clark asked whether Dr. Fenton's presentation could be made available to the members of the CPG. D. Acosta replied that, although AACO had not yet received a copy of the presentation, they would share it with the members of the CPG when it became available.

D. Acosta also reported that AACO was working on completing the 2009 APR (Annual Progress Report), which was due on March 29th. Additionally, he informed the group that he, along with C. Collins and J. Jenne, would be attending the next meeting of UCHAPS (Urban Coalition of HIV/AIDS Prevention Services) in Houston at the end of February. Lastly, he reported that, according to recent data, there had been an 11% reduction in late presenters – individuals who were already in advanced stages of HIV/AIDS by the time they were tested – in Philadelphia. He said that the reduction was an exciting achievement for the city's prevention efforts because it showed that the focus on testing was working. He told the group that, at their request, Dr. Kathleen Brady would be able to give them a more formal presentation on the matter.

C. Collins reported that he had attended the State CPG meeting in the previous week. He told the CPG that he was now interested in working to reinstate the YRT (Youth Round Table) after seeing how well the group's meetings operated and were attended at the state level. He said that he had already mentioned the idea to some young adults and was told that Monday evenings from 3:00 – 5:00 pm would work well for a meeting time. He felt that, with a bit more outreach, more youth could be attracted to the process and he therefore asked the members of the CPG for their assistance.

R. Feely supported the idea of reinstating the YRT in Philadelphia but he felt that it was unfair to base attendance expectations on the number of members at state meetings. He explained that it was easier to attract youth to such functions in more rural areas because, as was not the case in larger cities, there was less competition from other activities. A. Davis-Vogel felt that it would be unrealistic to expect that youth from all over the city would come to a single meeting in a central location. As a result, she suggested holding a few meetings in different parts of the city to attract more youth. M. Castillo supported the idea but noted that the meetings might be more successful if the group took some time to directly ask youth groups what would draw them to YRT meetings. She then suggested putting the matter on the agenda for the next CPG meeting to allow for more discussion. R. Hayward noted that recent reports of increasing teen pregnancy rates indicated that unprotected sex among youth was still a problem. As a result, he supported C. Collins' efforts and suggested using churches across the city to hold YRT meetings. A. Johnson pointed out that Y-HEP ran a successful program for youth and suggested looking into their outreach model. C. Collins brought the discussion to a close by thanking the group for all of their suggestions and promising to put the discussion on the agenda at a future CPG meeting.

Presentation:

- **Introduction to the Ryan White HIV/AIDS Treatment Extension Act of 2009** – *Matthew McClain*

M. Ross-Russell introduced M. McClain, informing the group that he had been a resident of Philadelphia who worked in community planning and consulting with both the care and prevention systems. She said that he had been asked to give his presentation to the CPG

because the new updates in the last reauthorization of the Ryan White Care Act would impact prevention efforts.

M. McClain showed the group a video of President Obama signing the Ryan White legislation. Afterwards, M. McClain commented on the speech the president gave before the signing, noting that he had used the word “gay,” envisioned eliminating the epidemic, discussed the national HIV/AIDS strategy, and spoke about stigma, which had been unprecedented in presidential discussions on HIV/AIDS. He also said that, while the budget called for a three-year freeze on discretionary spending, the president’s ideas on the national strategy for the disease would require some money. As a result, he said it would be interesting to see what the plan would specifically include when it was announced on February 1st. He then took a moment to explain the accompanying handouts – *Introduction to the Ryan White HIV/AIDS Treatment Extension Act of 2009* and *Public Law 111-87* – before beginning his presentation (see handouts for more information).

D. Lienau asked whether there were any previous reports on MAI (the Minority AIDS Initiative). M. McClain replied negatively but said that the upcoming examination would be comprehensive because the GAO (Government Accountability Office) was required to report to congress on MAI activities across departmental agencies. He noted that their report was due by October 30th, 2010.

R. Hayward asked how major cities, such as Philadelphia, should respond to the fact that positive individuals in rural areas were likely to move to urban centers in order to receive better care services. M. McClain replied that organizing focus groups or other studies to better understand migration patterns would be an important part of cities’ responses. However, he stressed the need to start the discussions early. He also said that arguments could be made to HRSA concerning the needs of cities near TGAs (Transitional Grant Areas) for better resources. However, he noted that reports on budget cycles would be required to support such arguments. R. Hayward pointed out that, since the disease was now more of a chronic illness than a fatal disease, more funding was already required by EMAs (Eligible Metropolitan Areas). M. McClain agreed and told the group that they needed to be diligent in their efforts to request more funding.

M. White asked why developments in lifting the syringe-exchange ban had taken so long when, during the Clinton presidency, it had been demonstrated that syringe-exchange programs did not encourage drug use. M. McClain replied that politics were to blame for the delay in lifting the ban. D. Acero asked whether any of the laws that criminalized people with HIV/AIDS were going to be revised, such as those that allowed for the arrest of positive individuals who spit in public. M. McClain replied that many of the laws that criminalized a positive serostatus were locally derived and would not be affected by changes in the new federal strategy. However, he said that, in light of some of the other changes, such as the lifted travel ban and the fact the US was about to host the International AIDS Conference for the first time, local changes were possible in the near future as well. He then brought his presentation to a close by thanking the members of the CPG for all of their work and encouraged them to reinstate the YRT, as C. Collins had proposed in his report.

Review Committee and Workgroup Reports

C. Collins took a moment to read the *CPG Subcommittees Report* for the month of January (see handout for more information).

Report of Staff

None

Old Business

R. Feely reminded the group that the Monitoring Committee had decided that the two community seats at UCHAPS meetings should be filled by one of the CPG's Community Co-Chairs and one staff person from the OHP. As a result, he asked why two governmental Co-Chairs and only one community Co-Chair would be attending the next meeting, as D. Acosta had mentioned in his report. D. Acosta replied that his travel to UCHAPS meetings was paid for by the CDC, which would pay for an OHP staff person to attend if no governmental representatives were able. M. Ross-Russell noted that the OHP had paid for community and staff members to attend the meetings until the city froze all funding for travel. Afterwards, she continued, UCHAPS started paying for the travel but, as a result, it was up to the coalition to decide who would attend.

New Business

None

Research Update

None

Announcements

V. Sowell announced that planning for AIDS Education Month had begun at Philadelphia FIGHT. She said that anyone who was interested in participating should contact her.

Adjournment

The meeting was adjourned by general consensus at 4:01 pm.

Respectfully submitted,

Joseph Ellis, Staff

Handouts Distributed at the Meeting:

- Meeting Agenda
- Meeting Minutes (*December 16th, 2009*)
- Introduction to the Ryan White HIV/AIDS Treatment Extension Act of 2009
- Public Law 111-87
- CPG Subcommittees Report – January 2010
- OHP Meeting Calendar

Philadelphia Department of Public Health Partner Services Update

Presentation to:
Philadelphia Community Planning Group

Drew De Los Reyes
Assistant Program Manager/Special Projects
STD Control
Andrew.DeLosReyes@phila.gov

February 24, 2010



Disclaimer

The views expressed in this presentation are those of the author and are not necessarily those of the Centers for Disease Control



2

Presentation Content

- Background
- Overview of the *Recommendations for Partner Services Programs for HIV Infection, Syphilis, Gonorrhea, and Chlamydial Infection*
- Overview of CDCs Revision Process
- Partner Services in Philadelphia



3

PS – Functions¹

- Service
 - Persons with STDs/HIV: helps them notify partners and access services
 - Partners: helps them recognize risk, learn infection status, and access services
- Ethical
 - Addresses partners' "right to know" their risk
- Public Health
 - Provides information that may be valuable for reducing transmission at the community level



1. Viall, A., "Partner Services: Background and Rationale", 2008 National STD Conference: 2008

4

Why Partner Services?

- A rapid interview allows partners to be identified and notified of possible exposure as soon as possible so they can:
 1. Obtain HIV counseling and testing
 2. Take steps to avoid becoming infected^[1] or, if already infected, to avoid infecting others; and
 3. Access medical care and other services as soon after infection as possible².



[1]. If notification occurs within the 1st 72 hours of exposure, nPEP may be an option]
2. MMWR, November 7, 2008/Vol. 57 / No. RR-9, Recommendations for Partner Services Programs for HIV Infection, Syphilis, Gonorrhea, and Chlamydial Infection

5

Impetus for Revised Recommendations for Partner Services


- ~1.0 - 1.2 million persons living with HIV in the US ~25% are unaware
- ~56,300 new infections per year
 - ~54-70% from persons not aware of their infection
- Multiple, case-finding strategies needed
- Partner services increases
 - access to high-prevalence population
 - identification of HIV-infected persons



6

Impetus for Revised Recommendations for Partner Services

- Poor uptake of PS for HIV (~32% of reported cases interviewed)
- Two separate guidelines and training related to PS:
 - Duplication, discrepancies, and confusion
- Guidelines integration allows for:
 - Improved services at the client level
 - Economies of scale and improved coverage




7

Revision Process

| | |
|-----------------------------------------|----------------------------------------------------|
| • Cross-division workgroup | • PCRS program reviews |
| • Guidelines comparison | • Mini-consultations with PCRS stakeholders |
| • Letter to stakeholders | • Focus groups with private sector clinicians |
| • Literature Review | • Assessment of state PCRS legal and policy issues |
| • National conferences listening groups | • Consumer focus groups |


Culminated in November 2006 Consultation



8

Key Features - I

- Health department model
- Integration of recommendations for HIV and other STDs
- Target audience → program managers
- Program design & management, not operational details
- Background and rationale
- Partner services for all persons testing positive for HIV



9

Key Features - II

- Emphasis on
 - Direct health department involvement (provider referral vs. self referral)
 - Active linkage to care and prevention services
 - Integration of services at the client level
 - Data security
 - Collaboration with external partners (e.g., providers, CBOs, CPGs)



10

Surveillance Program Connection

Programs should:

- Use surveillance and disease reporting systems to help identify persons with newly-diagnosed or reported HIV infection
- Strongly consider using individual-level data (if appropriate security and confidentiality procedures are in place)
- Work with providers--clients/patients should be offered PS as soon as possible after diagnosis.



11

Common Goals

- **For infected persons:**
 - Maximize access to partner services by providing all infected persons with support to ensure that their partners are confidentially informed of their exposure;
 - Maximize effective linkage to medical care, treatment, and prevention interventions to reduce the risk for transmission to others, and other services.
- **For partners of infected persons:**
 - Maximize the proportion of partners who are notified of their exposure;
 - Maximize early linkage of partners to testing, medical care, prevention interventions, and other services.
- **For the community:**
 - Reduce future rates of transmission by aiding in early diagnosis, treatment – or, in the case of HIV, linkage to treatment – and provision of prevention services to infected persons.




12

Notification Strategies

- Provider referral
- Self referral
- Contract referral
- Dual referral
- Third-party referral


Insufficient data regarding effectiveness of these strategies to support them as a first-line approach to providing PS



13

Provider Referral


- “Classic” STD approach—the syphilis model for PS
- Benefits:
 - More partners notified of their exposure;
 - Partner notification verifiable;
 - More likely partner will receive accurate information about risk and referrals to services
 - Protects index patient’s confidentiality



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Patient Referral

- Often perceived as better aligned with HIV programs’ emphasis on putting the client 1st
- Benefits:
 - Helps client develop disclosure skills
 - Less resource intensive for PS programs
 - Partner may be more comfortable with a person he/she knows



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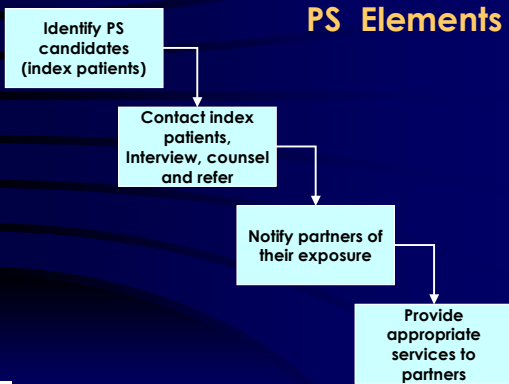
Patient Referral

- Costs of the approach:
 - Fewer partners notified
 - Index patient loses anonymity
 - Index patient may not be able to answer partner's questions, or may answer them incorrectly



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PS Elements



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Identifying Candidates

- Goal = Find candidates for partner services
 - Use *all* the resources available to find candidates:
 - Partner services programs should use surveillance and disease reporting systems to assist with identifying persons who are potential candidates for partner services.
 - Strongly consider using individual-level data,
 - With appropriate security and confidentiality procedures in place.



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Highest Priority Candidates

| ORIGINATING PATIENT/S | PARTNER/S |
|----------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|
| Pregnant women and male originating patient (OP) with pregnant partner/s | Female partners who are/may be pregnant |
| OPs suspected of or known to be engaging in behaviors that substantially increase risk of transmission to multiple other persons | Partners suspected of or known to be engaging in behaviors that increase the risk of transmission to multiple other persons |
| OPs co-infected with HIV and one or more other STDs | Partners of OP who is diagnosed with an STD |
| OPs with recurrent STDs | Partners of OP known to have an HIV viral load >50,000 HIV RNA copies/ml |
| OPs with a high HIV viral load (>50,000 RNA HIV copies/ml) | Partners of OP who is acutely or newly infected |
| OPs with evidence of acute or recent infection | Partners with whom originating patient (OP) has had unprotected anal or vaginal sex |
| OPs requesting assistance in notifying their partners | |



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Program Effectiveness

- ~250,000 (25%) of HIV infections are undiagnosed
- Routine Counseling and Testing
 - <1% HIV Prevalence
- Social Networks¹
 - 6% HIV Prevalence
- Various Targeted Testing Initiatives
 - 3% to 14%
- Partner Services...



1. CDC, Social Networks Testing, 2006

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Program Effectiveness Los Angeles

2006

- Overall Positivity - 13.7% (34/249)

2007

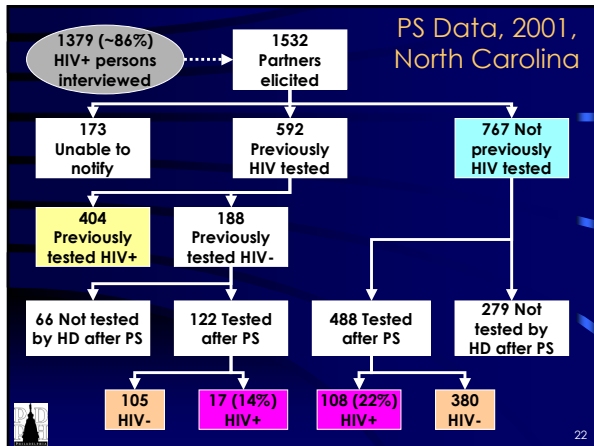
- Overall Positivity - 13.9% (32/231)

2008

- Overall Positivity - 17.4% (58/333)



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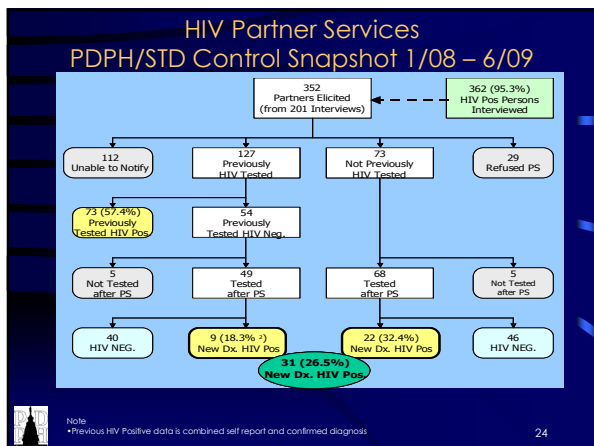


Program Effectiveness – NC Study

- Overall Positivity – 20.5% (125/610)
 - Previously HIV-negative
 - 14% (17/122)
 - Not previously tested
 - 22% (108/488)

1. CDC, Social Networks Testing, 2006

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Program Effectiveness – Philadelphia

- Overall Positivity – 26.5%
 - Previously HIV-negative
 - 9/49 = 18.3%
 - Not previously tested
 - 108/488 = 32.4%



1. CDC, *Social Networks Testing*, 2006

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Philadelphia Program

- Clients referred to STD Control
 - The assigned DIS follows up on referrals received from:
 - City-wide District Health Centers and AACO funded screening sites
 - Philadelphia Prison Systems
 - Insurance companies
 - Provider referrals
 - Out of Jurisdiction Areas (OOJ)



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Increasing the Acceptability of Partner Services

- The DIS is introduced as a part of the care team
- The DIS introduces the idea of PS to the client
- The care provider does not bias the patient about partner services



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Acknowledgments

- AACO
- Division of Disease Control, Epidemiology Unit
- STD Control DIS & Field Operations staff
- Providers, clinicians, and line staff across all participating programs



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Special Thanks

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- Rheta Barnes, MSN, MPH
- Cindy Getty
- Matthew Hogben
- Abigail Viall, M.A.



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CPG Subcommittees Report – February 2010

Monitoring Committee

- The Monitoring Committee did not meet in February; their next meeting date and time are TBD.

Planning Priorities Committee

- At the last PPC meeting, the group continued planning the process by which the CPG would weight the factors for prioritizing populations.
- The next meeting of the PPC is scheduled for Monday, March 22nd, from 1:00 – 3:00 pm.

The Literature & Education Committee

- At their February meeting, the Lit & Ed Committee continued with their review of interventions, making decisions on the following programs: ARK, INSIGHTS, POL, Safer Sex, RAPP, Positive Choice: Interactive Video Doctor, WHP, Willow, Teen Health, Horizons, Female Condom Skills Training, SSSB, and REMAS
- Their next meeting will be held on Wednesday, March 24th, from 12:00 – 2:00 pm.

CPG Nominations Committee

- In February, the Nominations Committee reviewed the current membership and gaps of the CPG in preparation for their upcoming review of applications.
- Additionally, the committee reviewed CPG members' attendance and recommended that three members be removed from the planning body because they had yet to attend a meeting since being seated in April.
- Lastly, N. Johns gave an update on the Empowerment Training for consumers, noting that she would hand out CPG applications at the event.
- Their next meeting is scheduled for Wednesday, March 10th, from 1:00 – 3:00 pm.

The Points of Integration Workgroup

- At their February meeting, the Points of Integration Workgroup watched and discussed a video of Dr. Fenton's recent Grand Rounds presentation on PCSI (Program Collaboration and Service Integration).
- In addition, Ann Ricksecker and Marcelo Fernandez-Viña gave the workgroup an update on the last meeting of the Health Department's Integration Workgroup.
- The next meeting date and time of the Points of Integration Workgroup are TBD.

The Positive Committee

- In February, The Positive Committee discussed stigma and watched a video of a lecture by Regan Hofman, Editor of Poz Magazine.
- The Committee also discussed prevention needs of current and former drug users, as a part of a series of conversations about the prevention needs of the community. Results will be forwarded to the CPG to be considered in the prioritization process.

- In March, the committee is preparing for the Consumer Empowerment Workshop on March 9th. The committee will also continue the discussion about prevention issues, with a focus on prevention with positives.

Factors Selected for CPG Target Populations

The following factors have been selected by the Planning and Priorities Committee to help make decisions about target populations and to identify sources of information about each factor. These factors will be used to set priorities for the CPG's target populations. The PPC would like the CPG to review and approve these factors. The next step in this process is to assign a weight to these factors. Please familiarize yourself with these factors for next month's meeting.

| Factor | Description | Example |
|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|
| HIV/AIDS Surveillance: <i>These factors show the extent of the HIV/AIDS epidemic among the target population.</i> | | |
| HIV Prevalence | This factor shows the total number of people diagnosed with HIV, minus those who have died, at a given point in time. Diagnosed HIV prevalence includes only people who have been tested, diagnosed, and reported; people who were tested anonymously are not included. Almost all areas now have HIV reporting; however, two years of HIV reporting data are considered the minimum for projecting trends. Diagnosed HIV (not AIDS) prevalence represents those people living with HIV infection but not AIDS. | How many people in the target population are living with HIV? |
| HIV Incidence | The number of HIV infections diagnosed among people who received HIV tests during a specified period of time, usually a year. The data do not show the total number of HIV infections because not everyone is tested. Nor do the data show when HIV infections occurred, for people may be tested years after infection. To distinguish between HIV incidence among people with and without AIDS, we refer to diagnosed HIV (including AIDS) incidence and diagnosed HIV (not AIDS) incidence. In general, diagnosed HIV (not AIDS) incidence represents people infected with HIV more recently than people represented by AIDS incidence data. | How many people in the target population tested positive for HIV in the past year? |
| AIDS Prevalence | AIDS prevalence data show the number of people living with advanced HIV disease. While AIDS incidence data show the total number of AIDS diagnoses in a specified period in time, prevalence data show how many people are living with AIDS, regardless of when they were diagnosed. | How many people in the target population are living with AIDS? |
| AIDS Incidence | Because of a comprehensive national AIDS surveillance system, AIDS incidence data are among the most reliable and complete population-based epidemiologic data available. AIDS incidence data may help CPGs understand the extent to which AIDS has affected a given population relative to another. In considering AIDS incidence data, however, CPGs should be aware that recent declines in AIDS incidence are attributable in large part to antiretroviral therapies. Currently, differences in AIDS incidence among groups (e.g., by race/ethnicity or age) may represent differences in treatment success or in access to or use of health care. | How many people in the target population tested positive for AIDS in the past year? |

| Factor | Definition | Example |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Documentation of HIV-Risk Behaviors: <i>This group of factors provides data about behaviors that may lead to HIV transmission.</i></p> | | |
| <p>Key indicators of risk behaviors: STDs (*Syphilis selected)</p> | <p>Although it's impossible to know how often target populations engage in HIV-risk behaviors, CPGs may use a variety of data to estimate occurrences. Sexually transmitted diseases (STDs): Gonorrhea, Syphilis, and Chlamydia are reportable STDs in most project areas. Because STD rates are reliable indicators of high-risk behavior (unprotected sex), groups with high rates of STDs are potentially at increased risk for HIV infection. Additionally, some STDs increase the risk of transmission in individuals who are exposed to HIV. The extent to which STD rates correlate with HIV risk will depend on the HIV prevalence (diagnosed) within the sexual network of persons practicing unsafe sex and on the local dynamics of STD transmission.</p> <p>Note: STD data alone do not indicate a risk for HIV infection. For example, if HIV prevalence (diagnosed) is extremely low, even high STD rates do not indicate a high risk. If HIV prevalence (diagnosed) is extremely high, even low STD rates do not indicate a low risk for HIV infection.</p> | <p>What were the reported Syphilis cases among the target population?</p> |
| <p>Key indicators of risk behaviors substance use injection drugs.</p> | <p>Other behavioral data: Depending on local data collection and research systems, CPGs may be able to access local population studies of behaviors associated with HIV transmission, such as anal intercourse or needle sharing, and studies of the determinants of high-risk behaviors.</p> <p>CPGs should work with epidemiologists, behavioral scientists, etc., to determine whether other studies that collect behavioral data exist (especially any funded by federal — e.g., NIMH, NIDA, CDC — or state agencies).</p> | <p>How many people in the target population obtained substance abuse treatment for injection drugs or are identified as injection drug users through prevalence data?</p> |
| <p>Riskiness of population behaviors</p> | <p>This factor considers the relative risk of behaviors among target populations. The risk for HIV transmission and acquisition associated with the highest risk behaviors is well understood. The three most risky behaviors for transmitting HIV are, in descending order of risk, the use of HIV-infected injection equipment, unprotected receptive anal sex with an infected partner, and unprotected vaginal sex with an infected male partner.</p> | <p>What is the primary HIV risk behavior known to occur among the target population?</p> |
| <p>Multiple high risk behaviors (PENDING**)</p> | <p>This factor considers the occurrence of more than one high-risk behavior within a given population. For example, men who have unsafe sex with men and inject drugs are engaging in multiple high-risk behaviors.</p> | <p>Are there multiple high-risk behaviors occurring within the target?</p> |
| <p><i>* Syphilis selected as the STD most reliable for indicating high risk behavior</i> <i>**Multiple high risk behaviors is pending while the PPC determines what types of data/resources are available to quantify this factor.</i></p> | | |

| Factor | Definition | Example |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|
| <p><i>Socio-demographic characteristics: This group of factors examines complex issues that may affect the provision of HIV prevention interventions.</i></p> | | |
| <p>Difficulty of meeting population needs</p> | <p>CPGs may use a variety of data sets, such as racial/ethnic composition, population density (urban, rural, frontier), education (especially level of completion and literacy rates), socioeconomics, service utilization data (services mapping, services access and utilization, etc.) to determine risk in a population. Review all available data and information sets, including the results of the gap analysis. If data gaps exist, your CPG may want to commission original research as part of the needs assessment. In addition, CPGs may need to “qualify” which information/data sets they will consider.</p> | <p>Has the target population’s complex needs been reached by current programs?</p> |
| <p>Barriers to reaching the population</p> | <p>CPGs may consider the following socio-demographic characteristics when looking for indicators of barriers — cultural, linguistic, socioeconomic status, family or social network structures, gender and sexual orientation studies, religion and spiritual beliefs, consumer preferences, provider preferences, and community norms and values. Studies that focus on knowledge, attitudes, behaviors, and beliefs will also provide information about barriers. Review all available data and information sets. If data gaps exist, your CPG may want to commission original research as part of the needs assessment. In addition, CPGs may need to “qualify” which information/data sets they will consider.</p> | <p>Are there significant barriers to reaching the target population with HIV prevention interventions?</p> |