Points of Integration Workgroup
Meeting Minutes
Tuesday, March 17th, 2009
10:00 a.m. - 12:00 p.m.
Office of HIV Planning, 340 N. 12th St., Suite 203, Philadelphia, PA 19107

Present: Tony Daniel, Ann Ricksecker, Nurit Shein (Chair)

Excused: David Acosta, Jay Grant, Jeffrey Jenne, Ken McGarvey Susan Spencer

Staff: Joseph Ellis, Michael Milsop

Call to Order
N. Shein called the meeting to order at 10:05 am.

Approval of Agenda
<u>**Motion:** A. Ricksecker moved and N. Shein seconded to approve the agenda. **Motion Passed:** All in favor.</u>

Approval of Minutes (*November 25th, 2008*)
<u>**Motion:** After the group took a moment to review the minutes from their last meeting, A. Ricksecker moved and N. Shein seconded to approve the document. **Motion Passed:** All in favor.</u>

Report of Staff
None

Report of Chair
None

Discussion Items:

- **Outstanding Issues**

M. Milsop directed the group's attention to the handout entitled *Points of Integration Workgroup Outstanding Issues*. He explained that he had compiled the list because, as part of the prevention application, he had to determine what the workgroup's accomplishments had been over the course of the past few years. In so doing, he continued, he had discovered a number of unresolved items and so he brought them to the group so that they could determine whether to drop or follow up on them. He said that the current list was incomplete; however, he felt that there were enough items to discuss to start the process. Getting to the first item on the list, he reminded the group that they had considered creating an assessment tool to ascertain whether an individual in care was ready and/or willing for prevention services. N. Shein stated that system-wide changes in the intake process were already dealing with the issues that such an assessment tool would address. She clarified that the changes, which were being integrated as a standard part of case management, were designed to notify providers that a patient required prevention services. A. Ricksecker confirmed that there was a new risk assessment

indicator in Careware as part of quality improvement. She also noted that most clinics that dealt with prevention with positives had another instrument for risk assessment. As a result, the group agreed to remove the item from their list of outstanding issues.

Moving on to the second issue, M. Milsop noted that there had been some developments in embedding PCRS into case management. He informed the group that the new partner services guidelines would separate the elicitation and notification modules, which would prevent testing agencies from having to do the notification while still allowing them to inquire about one's partners. N. Shein added that there had also been some pilot projects by AACO and the Health Department that used community agencies for partner notification. She said that the impetus for the projects was the fact that PCRS had become a major component in identifying exposed individuals. However, she was unsure as to whether the pilots had been completed. A. Ricksecker supported the statement that a pilot project had been initiated; however, she too was unsure of its current status. N. Shein suggested that the group check up on the pilot project before making any determinations about what to do with the outstanding issue. The rest of the group agreed.

A. Ricksecker noted that items 1 and 3 from the handout were basically the same issue. The rest of the group agreed; however, N. Shein did not recall the discussion around exploring the role of PCRS in family planning. A. Ricksecker stated that she had some updates on the matter, adding that they would also address the fourth item on the handout. She informed the group that DIS workers would be conducting STD testing in family planning clinics and that local family planning clinics were already funded and trained for HIV testing. Nationally, she continued, there was a grant out to evaluate the integration of family planning services in an HIV clinical setting and vice versa, with part of the project being conducted through a clinical residency training at Drexel University. She said that she would be attending a HRSA meeting in the next week where the model would be discussed. She offered to report on the discussion so that the group could decide whether to further pursue PCRS in family planning.

M. Milsop informed the group that they had a few other unresolved issues to discuss, including PEMS variables and the grid of prevention services in care settings. He said that he would bring the remaining issues to the Points of Integration Workgroup at their next meeting.

- **Update on Health Dept. Integration Meetings**

A. Ricksecker provided an update on the ongoing Health Department Integration Workgroup meetings; however, she said that she had not brought an updated copy of the collaboration grid because the group's next meeting was scheduled for later in the week. She started her report by lamenting the group's loss of T. Brickham, who had relocated to Houston. However, she informed the group that T. Brickham had agreed to provide Philadelphia with information on Houston's integration efforts, which were greatly advanced. Additionally, she reported that Los Angeles had contacted Philadelphia for information on the integration efforts resulting from the Health Department meetings. She said that, as a result, another student working with M. Fernandez-Viña was also compiling information on Los Angeles' integration efforts.

Continuing her report, A. Ricksecker detailed some of the changes that had taken place at the Health Department level as a result of the integration workgroup. She said that routine HIV testing was now available through the TB, Hepatitis, and STD systems and that the TB system's Flick Center was now conducting rapid testing. She noted that the Health Department's Integration Workgroup was investigating ways to combine the various data sets for better service planning. A. Ricksecker also reported that the workgroup had a great deal of interest in San Francisco's consumer-driven website. N. Shein asked whether Inspot would be included in the website, noting that Philadelphia had its own Inspot site that was being updated and revamped. A. Ricksecker said that Inspot would be a part of the updated Philadelphia site, noting that the Health Department's representative from the STD system was in charge of the project. Lastly, she reported that OAS had been included in the Health Department Integration discussions and that M. Fernandez-Viña had done an inventory of the newly added system and included it in the grid. She then praised the work that M. Fernandez-Viña had done, saying that the process would be much more complicated without his tracking of the data. In closing, she told the group that she would have more information after the meeting on Friday and promised to forward the updated grid.

- **San Francisco Practices for Prevention with Positives**

N. Shein directed the group's attention to the excerpts from the draft *Prevention with Positives: Best Practices Guide*. She said that she had learned about the document at the last CAEAR Coalition meeting in San Francisco and had a copy forwarded to M. Milsop. She explained that only the table of contents and introduction had been included in the handouts to give the group a sense of the document without having to print multiple copies of the entire thing. M. Milsop noted that the timing of the document's arrival was convenient because the CPG would soon prioritize populations and the Points of Integration Workgroup would likely be the best source for information on prevention with positives.

After the group had a chance to review the introduction, N. Shein gave her support for the document, saying that it was thorough, sensibly organized, and readable. She agreed with the idea of adopting the document locally, but stressed the need for it to be introduced systematically and with training provided. A. Ricksecker informed the group that two EBIs had already been introduced locally for the purpose of prevention with positives, namely, Healthy Relationships and Ask, Screen, Intervene. She then gave her support to the best practices guide but said that the issue would be to ascertain the role of the planning bodies and the grantee in introducing the document locally. N. Shein replied that the Points of Integration Workgroup would first review the document and make any revisions they felt were necessary for it to be adopted locally. Afterwards, she continued, the group would recommend it as the guide for standard procedures of prevention with positives. M. Milsop noted that, after the group had made its revisions, the guide would then go to the CPG and the RWPC for approval before going to the Health Department for implementation.

N. Shein felt that the group would not have to put much work into revising the document because it already seemed exhaustive. She then reiterated her support for its

implementation locally, noting that a best practices guide on the issue would help funding for both the care and prevention systems in Philadelphia. A. Ricksecker wondered whether the individuals who had created the document in San Francisco would be opposed to other jurisdictions adopting it. M. Milsop said that he would investigate the matter at the next UCHAPS meeting.

- **Next Steps/Next Meeting Date**

After discussing their schedules, the group scheduled their next meeting for Monday, April 27th, from 11:00 am – 1:00 pm.

Old Business
None

New Business
None

Announcements
None

Adjournment
The meeting was adjourned by general consensus at 10:44 am.

Respectfully submitted,

Joseph Ellis, Staff

Handouts Distributed at the Meeting:

- Meeting Agenda
- Meeting Minutes (*November 25th, 2008*)
- Points of Integration Workgroup Outstanding Issues
- Excerpts from the Prevention with Positives: Best Practice Guide (draft)
- OHP Meeting Calendar

Ryan White Part A Planning Council (RWPC) & Philadelphia Community Planning Group (CPG) Points of Integration Workgroup

Meeting Agenda
Tuesday, March 17th, 2009
10:00 am - 12:00 pm
The Office of HIV Planning, 340 N. 12th Street, Suite 203, Philadelphia

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Call to Order/Introductions

Approval of Agenda

Approval of Minutes (*November 25th, 2008*)

Report of Staff

Report of Chair

Discussion Items:

- **Outstanding Issues**
- **Update on Health Dept. Integration Meetings**
    - **Overlap Grid**
- **San Francisco Practices for Prevention with Positives**
- **Next Steps/Next Meeting Date**

Old Business

New Business

Announcements

Adjournment

The next meeting of the Points of Integration Workgroup is TBA
Please refer to the Office of HIV Planning's attached Calendar of Events or its website, www.hivphilly.org, for updated committee meeting information.
Please contact the office at least 5 days in advance if you have any special needs

Points of Integration Workgroup
Meeting Minutes
Tuesday, November 25th, 2008
11:00 a.m. - 1:00 p.m.
Office of HIV Planning, 340 N. 12th St., Suite 203, Philadelphia, PA 19107

Present: Tamara Brickham, Tony Daniel, Ann Ricksecker, Nurit Shein (Chair)

Excused: David Acosta, Jeffrey Jenne, Susan Spencer

Absent: Jay Grant, Ken McGarvey

Guests: Marcelo Fernandez-Viña

Staff: Joseph Ellis, Michael Milsop

Call to Order
N. Shein called the meeting to order at 11:09 am.

Approval of Agenda
Motion: A. Ricksecker moved and N. Shein seconded to approve the agenda. **Motion Passed:** All in favor.

Approval of Minutes (*August 18th, 2008*)
After the group took a moment to review the minutes from their last meeting, they approved the document by general consensus.

Report of Staff
M. Milsop reported that the prevention provider survey had been distributed. He said that the initial responses appeared to contain some worthwhile information, though he noted that they had not been fully analyzed.

Report of Chair
None

Discussion Items:
- **Update on CTR Model**

M. Milsop informed the group that Patricia Jones had met with the CPG in September to discuss possible sources of data for their planning purposes. He said that, as part of the conversation, the CPG had asked P. Jones for an update on how the CTR model, which was included in the handouts, was being used to gather information. The response, he continued, was that the grantee had not been aware of the model. N. Shein asked how the model could have been overlooked since a presentation had accompanied its recommendation. M. Milsop replied that the model had only been presented as a suggestion and that the grantee had never notified the group of their intentions for the model, even though such a response had been offered.

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N. Shein stated her desire to revisit the discussion on the CTR model and the grantee's response to it. She suggested doing so in a joint meeting with both the CPG and the RWPC in order to give the matter more weight. A. Ricksecker agreed with the suggestion for holding a joint meeting to respond to the follow up for the CTR model. However, she noted that there had been some changes in CTR programming since the model was recommended.

N. Shein asked the group whether they wanted to restate their request for a response to the model from the grantee. A. Ricksecker felt that the CTR model should be updated before the group made a decision on what they wanted to do with it. She then stated that she was not sure how to approach the grantee on the matter because they were not required to implement recommendations made by the workgroup. However, she noted that a great deal of work had gone into the production of the model. M. Milsop pointed out that the group had legitimacy in asking for a response to the matter because the initial recommendation had come from the RWPC, which carried more weight with the grantee. N. Shein asked whether having the CPG include the model in the next RFP recommendations would strengthen the request for a response. M. Milsop clarified that the CPG was only responsible for the development of the Prevention Plan. He pointed out that the grantee was only mandated to follow CPG recommendations when ensuring that the RFP was concurrent with the plan. However, he assured the group that, since the CPG supported following the CTR model as general practice, they would do what they could to make it a reality. N. Shein suggested that both the CPG and the RWPC reiterate their recommendation for implementation of the CTR model and the rest of the group agreed by general consensus.

- **Update on Health Dept. Integration Meetings**

A. Ricksecker started the discussion by reviewing some of the updates that had been reported at the May meeting of the Points of Integration Workgroup (see minutes for more details).

  - **Overlap Grid**

  M. Fernandez-Viña passed out draft copies of the *Philadelphia Inventory of Collaboration and Service Integration of HIV, STD, Hepatitis, and Tuberculosis*. A. Ricksecker stressed that the grid was just a draft and that it was consistently being updated. In response to a question by N. Shein, she then explained that the sites referred to in the document currently consisted only of those that were funded by the city. However, she pointed out that once the systems reached the level of "expanded integration," programs funded by AACO would also be included. M. Fernandez-Viña added that, as was indicated by the title PCSI (Program Collaboration and Service Integration), the CDC's Green Paper, the internal workgroup was mostly working at the program level. T. Brickham felt that the CDC was starting the process only in sites funded by the Health Department because it would be easier to enact change in areas in which they held more control.

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A. Ricksecker noted that "Distribution of Hepatitis Resource Guide" could be removed from the next steps column as the document had just been distributed a few days earlier. M. Fernandez-Viña pointed out that the grid was in constant need of updating because progress was being made so regularly. He then informed the group that both items listed under next steps in limited integration could also be moved to the "Current Status in Philadelphia" column.

A. Ricksecker took a moment to report the next steps of the Health Department's Integration Workgroup. She said that at the next meeting, which was scheduled for January 28th, the group would review the updated version of the grid as well as another document being developed by M. Fernandez-Viña, which would show change occurring over time. She felt that the documents would help to notify the rest of the nation about the high level of work being performed in Philadelphia.

N. Shein asked whether anyone knew about the level of integration at CBOs (Community Based Organizations). She said that she was not aware of any organizations in the prevention system that were conducting integrated screenings. T. Brickham reiterated that the integration process was starting with sites funded by the Health Department because it would be easier to locate the necessary resources. However, A. Ricksecker reported that Carolyn Johnson had already told all sites that they needed to move towards integrated testing. In response to a question by N. Shein, T. Brickham stated that the Hepatitis system was working to include Hepatitis training in a pilot integration program.

N. Shein asked what the next steps of the Points of Integration Workgroup would be concerning the Health Department Integration Workgroup. As the group was still unable to attend the meetings, they decided to simply continue receiving updates on the progress.

- **Universal Intake Form**

M. Milsop reminded the group that, at a previous meeting, they had decided to develop a universal intake form. He asked whether they wanted to revisit their decision as they had not made any progress on the matter since the initial discussion. A. Ricksecker reported that the Health Department Integration Workgroup was working on the development of a universal intake form, collecting all the intake forms in use by the various systems and making notes of the overlaps they found. N. Shein asked whether there had been any discussion of integrating PEMS with other data systems. A. Ricksecker replied that the workgroup had decided to drop that discussion for the time being as it was too daunting a task. However, she said that there was a chance that they would revisit the issue after some of their more pressing goals were accomplished. She then said that the universal intake form would be discussed at the January meeting and that she would report on any decisions made.

- **Next Steps/Next Meeting Date**

M. Milsop suggested proceeding to the discussion under old business as it would likely affect the group's decision about their next steps.

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Old Business

- **Outstanding Recommendations**

M. Milsop informed the group that he had reviewed some of their decisions from the past few years and noticed a number of unfinished matters. As a result, he said that the group could schedule a meeting for January even though the Health Department workgroup would not be convening until later in the month. The group accepted the suggestion and scheduled their next meeting for Thursday, January 15th, from 3 – 5 pm.

After a brief discussion on the difficulty involved in coordinating a meeting by email, the group decided to regularize their meeting schedule. They opted to convene on the third Thursday of every other month. Therefore, they scheduled another meeting for Thursday, March 19th.

New Business

T. Brickham distributed the latest Hepatitis resource guide.

Announcements

None

Adjournment

The meeting was adjourned by general consensus at 11:52 am.

Respectfully submitted,

Joseph Ellis, Staff

Handouts Distributed at the Meeting:

- Meeting Agenda
- Meeting Minutes (*August 18th, 2008*)
- CTR model
- The Philadelphia Inventory of Collaboration and Service Integration of HIV, STD, Hepatitis, and Tuberculosis (draft)
- OHP Meeting Calendar

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Points of Integration Workgroup
Outstanding Issues

January 2009

1. Assessment tool to determine a person's prevention needs? (2/04)

2. PCRS in Case Management? (currently, the system is orientated to provide PCRS in counseling and testing) (2/04)

3. Readiness assessment to show if clients have prevention needs? (2/04)

   - Prevention services should focus on disclosure and then lead to adherence support (in a care setting). (2/04)

   - Explore the role of PCRS in local family planning **(NOTE: AACO has a working PCRS group and initial work has been completed)** (4/05)

4. Explore the possibility and feasibility of cross training in family planning and prevention

Prevention with Positives: Best Practice Guide

DRAFT – November 24, 2008

acknowledgements

We would like to thank all who contributed to the process of developing the Prevention with Positives Best Practice Guide. Special thanks goes to the Points of Integration/Prevention with Positives workgroup members who contributed their knowledge and experience to make this guide useful. We would also like to thank the HIV Prevention Section and HIV Health Services for funding this effort and the HIV Prevention Planning Council (HPPC) and HIV Health Services Planning Council (HHSPC) for lending their support.

creating the guide

The Prevention with Positives (PwP) Best Practice Guide is intended to serve as a "tool kit" of resources and guidelines for providers and program managers working with persons living with HIV/AIDS. The creation of the Best Practice Guide involved an innovative approach that brought together HIV Prevention and Care sections, resulting in a comprehensive perspective on PwP. Providers, community members and consumers from diverse agencies and backgrounds met monthly to develop and review the content of the guide. In addition, input was gathered through a community forum held toward the end of the process. An extensive review of the existing literature and guidelines on PwP also contributed to the content (see end of document for a list of resources consulted).

This document is the result of ongoing efforts by the San Francisco Department of Public Health HIV Prevention Section and HIV Health Services to develop tools for carrying out PwP. This work builds on the work done for the 2004 HIV Prevention Plan and the 2005 "Thinking Big" document created by the 2004 and 2005 PwP committees of the San Francisco HPPC.

This guide is designed to be flexible enough to meet the needs of the many types of providers who work with HIV positive individuals, including but not limited to medical doctors, case managers, health educators, peer educators, and mental health and substance use service providers. Different types of providers will engage in PwP to varying degrees depending on their level of training, comfort level and time constraints. **It is not expected that all providers will carry out in-depth PwP activities.** Rather, the goal is that providers at every point of care engage in PwP to some degree, finding the appropriate place on the continuum from screening and referral, to brief interventions, to in-depth PwP counseling. For example, in busy medical practices, identifying patients who are at risk of transmitting HIV is a significant accomplishment. Consequently, different types of providers will use the information in this guide to varying degrees.

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1. Introduction: Laying the Foundation

HIV prevention strategies can be inconsistent in addressing the distinct prevention needs of HIV positive persons, and service providers working with these individuals have a significant opportunity to ensure that prevention services prioritize persons living with HIV/AIDS. In order to highlight the importance of engaging in prevention with HIV positive persons, the Centers for Disease Control and Prevention (CDC) published "Advancing HIV Prevention" (AHP) in 2003, which identified Prevention with Positives (PwP) as a key strategy for preventing new infections. Since then, the San Francisco HIV Prevention Planning Council and the HIV Health Services Planning Council have worked to draw attention to and develop goals for PwP. This Best Practice Guide is the next step in making sure providers have the tools to effectively integrate prevention into services for persons living with HIV/AIDS.

Definition: Prevention with Positives is any strategy or intervention that addresses the specific prevention needs of HIV positive persons.

The San Francisco HIV Prevention Planning Council defines the goals of PwP as follows:

1. To reduce the spread of HIV and STDs;
2. To help HIV positive persons achieve and maintain physical, emotional, mental, sexual and reproductive health, economic stability and well-being; and
3. To assist those HIV positive persons who do not know they are positive in learning their HIV status when they are ready.

The UCSF Center for AIDS Prevention Studies states, *"HIV positive persons live with both the experience of being infected…and the tremendous responsibility of knowing that they can infect other people."* Prevention strategies for HIV positive persons can address the weight and complexity of this responsibility through HIV education and skills-building interventions, counseling and emotional support, disclosure support, and support and testing for partners of HIV positive persons.

> **"HIV positive persons live with both the experience of being infected…and the tremendous responsibility of knowing that they can infect other people."**
>
> UCSF Center for AIDS Prevention Studies

It is important to think of prevention broadly, from a perspective that includes STD screening and treatment, substance use and mental health assessment, and an assessment of clients' immediate concerns and associated issues including homelessness, hunger, violence and stigma. PwP services must see the whole person, not just sexual risk behaviors and drug use behaviors. PwP practices should be validating, empowering, sex positive and efficacy enhancing for clients. Services should be linguistically and culturally competent and client-centered. HIV positive persons should be involved in the planning and implementation of all prevention with positives programs, and should be included in a way that is respectful of their skills and experiences and does not "tokenize" them.

Why a Best Practice Guide?

A Best Practice Guide for PwP programs is important because there is currently no common structure for PwP, and PwP is not being implemented among providers and across provider types in a consistent, evidence-based way. The Best Practice Guide is intended to serve as a "tool kit" of resources and guidelines for providers and program managers. The guide is intended to address the prevention needs of HIV positive persons in the SF Eligible Metropolitan Area (EMA)[1] and to ensure consistency and high standards across the multiple services utilized by persons with HIV/AIDS.

The goals of this document are to provide a set of standards that address the following questions:

- What type of qualifications and training do providers need in order to carry out PwP?
- What interventions, activities and strategies best address the prevention needs of persons who are HIV positive?
- What needs to happen to ensure that providers, agencies and systems are ready to carry out PwP?

Overview of the document

Chapter	Description
Provider Preparedness	Identifies standards for provider skills and knowledge
Positive Prevention	Describes PwP interventions and strategies
Ensuring Readiness	Recommends changes to ensure agency and system readiness for PwP
Provider Resources	Provides scripts for providers based on potentially challenging situations; lists community resources and model local programs

[1] The San Francisco EMA includes the counties of San Francisco, San Mateo and Marin.

2. Provider Preparedness

As PwP services continue to be integrated into diverse care settings, and as the number of persons living with HIV/AIDS increases with improved medical care/life expectancy, greater numbers of both HIV and non-HIV service providers are going to be working with persons with HIV/AIDS. In order to ensure consistency and high standards across the multiple services utilized by persons with HIV/AIDS, it is necessary that providers have common knowledge, language and skills about PwP-related topics.

While different types of providers will be able to carry out PwP with clients/patients to varying degrees depending on their level of training, comfort level and time constraints, **at a minimum, all providers should be able to screen and identify individuals at risk of transmitting HIV and be familiar with community resources for individuals in need of further PwP services.** This section lays out standards for the skill set and knowledge providers should have in order to carry out PwP, broken down into the following categories:

A. Core skills related to client/patient engagement
B. Core skills specific to PwP
C. Core knowledge of PwP-related topics

Providers should use what is applicable based on the degree to which they will be carrying out PwP. See the *Provider Resources* chapter for specific examples of tools and scripts for providers.

For **medical providers**, *screening, identifying* and *referring* those in need of further PwP services is the primary goal. Medical providers should be able to engage with patients in discussions about sex and drug use; identify individuals who are at risk of transmitting HIV; and be familiar with existing PwP programs to enable appropriate referrals for clients.

A. Core skills related to client/patient engagement

Providers should be capable of using active listening techniques to build rapport and create a safe, trusting and comfortable environment for clients/patients using a nonjudgmental, harm reduction approach. It is also essential that providers are aware of their own comfort level, limitations and assumptions when working with HIV positive persons.

1. Allow time and space to **build rapport and trust** before delving deeper into sensitive topics.
2. Use a **harm reduction approach** by meeting clients "where they're at."
3. Use **active listening and motivational interviewing** techniques.
4. Engage in **nonjudgmental discussion** with clients/patients. It is critical for healthcare providers to maintain a nonjudgmental tone about situations and behaviors with HIV positive clients. Providers should be supportive, empathic, and focus on the client's strengths and resiliencies.
5. Assess the situation and the **client's comfort level** – the client sets the limits.
6. **Keep clients engaged** in prevention – "keep the spark alive" long enough to engage clients and make necessary referrals.
7. Conduct a **provider self-assessment/personal inventory**. Providers should be aware of their own comfort level, limitations and assumptions when it comes to engaging in PwP.

8. Provide services in a **culturally competent** manner. When providing services, providers should understand and respond to clients'/patients' culture, beliefs, language, gender, sexual identity, education level and values.

B. Core skills specific to PwP

Providers should be capable of engaging with clients around topics that are of particular importance and relevance for persons living with HIV/AIDS.

1. Initiate and maintain an **open dialogue around sexual risk behaviors and drug use behaviors**.
2. Help clients make **informed decisions about HIV status disclosure**. The traditional message has been that HIV positive persons should always disclose their HIV status to their partner(s). In reality, disclosure is complex and difficult. Providers should be able to help clients make responsible decisions about disclosure.
3. Help clients **negotiate safer sex** in a way that is sex positive.
4. Therapeutically address **stigma, shame and power.**
5. **Communicate medical information** in language that is appropriate and understandable.

C. Core knowledge of PwP-related topics

One of the goals of the PwP Best Practice Guide is to ensure that clients/patients can receive consistent responses from a variety of providers. Clients should feel that they can go to any provider and either have their question answered or be referred to the appropriate place. Providers of PwP services should have common knowledge about PwP-related topics, including but not limited to the following:

1. The **continuum of risk and safety**, including "more risky" and "less risky" behaviors. The continuum cuts across the primary modes of transmission defined by the HPPC: needles, insertive or receptive anal intercourse, and vaginal intercourse.
2. **Substance use as a co-factor** that increases transmission risk across all sexual risk behaviors. In particular, this includes sex while using crystal meth (a co-factor highly associated with HIV transmission).
3. **Basic sex education on HIV transmission** for clients who may not have this knowledge**.**
4. The relationship between **HIV and STD transmission/susceptibility.**
5. The relationship between **viral load and HIV transmission.**
6. The relationship between **antiretroviral therapy and HIV transmission,** including the importance of medication adherence**.**
7. Awareness of **structural factors that impact behavior**, including housing instability, mental health issues, substance use, incarceration, domestic violence, disempowerment, racism and homophobia.
8. **Community resources and referrals.** Because not all providers will be able to carry out PwP in depth, it is essential that, at a minimum, providers are knowledgeable about appropriate community resources where they can refer clients who need further assistance (see *Provider Resources* section for specific resources).