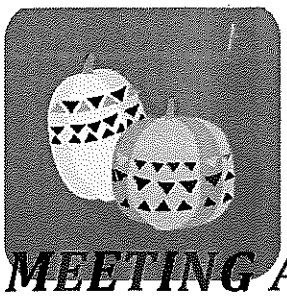
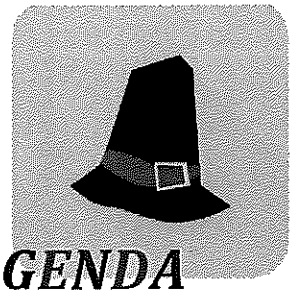




MEETING AGENDA

THURSDAY, NOVEMBER 9, 2017
2:00-4:00 P.M.

Welcome/Introductions

Call to Order/Moment of Silence

Approval of Agenda

Approval of Minutes*(October 12,2017)*

Report of Chair

Report of Staff

Action Items
- Reallocation Request

Discussion Items

Special Presentation:
- Trauma-informed Care

Report of the Committees:
- Comprehensive Planning— Adam Thompson, Chair
- Executive Committee
- Finance Committee—Alan Edelstein and Dave Gana, Co-Chairs
- Needs Assessemnt—Gerry Keys, Chair
- Positive Committee— Keith Carter and Jeanette Murdock Co-Chairs
- Nominations Committee— Kevin Burns and Michael Cappuccilli, Co-Chairs
- Prevention Committee— Lorett Matus and Clint Steib, Co-Chairs

Old Business

New Business

Announcements

Adjournment

Please contact the office at least five days in advance if you require any special assistance. The next meeting of the HIV Integrated Planning Council is Thursday, December 7, 2017 from 2:00-4:00 pm at the Office of HIV Planning at 340 N. 12th Street, Suite 320, Philadlephia, PA 19107. (215)574-6760 •FAX (215)574-6761•www.hivphilly.org

HIV INTEGRATED PLANNING COUNCIL

HIV Integrated Planning Council
Meeting Minutes
Thursday, October 12, 2017
2:00-4:00p.m.
Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia, PA 19107

Present: Katelyn Barron, Juan Baez, Henry Bennett, Johnnie Bradley, James Breinig, Michael Cappuccilli, Martha Chavis, Mark Coleman, Alan Edelstein, David Gana, Pamela Gorman, La'Seana Jones, Gerry Keys, Lorett Matus, Dorothy McBride-Wesley, Nicole Miller, Christine Quimby, Joseph Roderick, Samuel Romero, Terry Smith-Flores, James Tarver, Coleman Terrell, Leroy Way, Lorrita Wellington, Melvin White

Excused: Tre Alexander, Tiffany Dominque, Peter Houle, Ann Ricksecker, Clint Steib

Absent: Bikim Brown, Kevin Burns, Keith Carter, Jen Chapman, Karen Coleman, Cheryl Dennis, Lupe Diaz, Tessa Fox, Gus Grannan, Sayuri Lio, George Matthews, Abraham Mejia, Jeanette Murdock, Carlos Sanchez, Nurit Shein, Gail Thomas, Adam Thompson

Guests: Chris Chu, Ameenah McCann-Woods

Staff: Mari-Ross-Russel, Nicole Johns, Debbie Law, Briana Morgan, Stephen Budhu

Call to Order: K. Baron called the meeting to order at 2: 09 p.m.

Welcome/Introductions/Icebreaker Activity: K. Baron welcomed the HIPC members, and guests. Those who were present introduced themselves.

Approval of Agenda: K. Baron presented the agenda for approval. N. Johns stated the agenda needed to be updated to reflect the team building activity. **Motion:** M. Cappuccilli moved, L. Way seconded to approve the updated agenda. **Motion passed**: All in favor.

Approval of Planning Council Minutes: (September 14, 2017): K. Baron presented the minutes for approval. **Motion:** L. Way moved, J. Whitfield seconded to approve the September 14, 2017 minutes. **Motion passed:** All in favor.

Report of Co-Chair: K. Baron informed the committee that recently the CDC acknowledged those who were HIV-positive and are undetectable do not pose a risk of transmitting HIV. [1] She explained this was a huge move in the correct direction for the outlook and perception of PLWHA.

Report of Staff: M. Ross-Russell informed the Council that OHP staff member A. Boone is out on medical leave. She stated if any HIPC members wanted to communicate with A. Boone she would be more than happy to pass along any messages and N. Johns will support Positive and Prevention committees for the interim.

M. Ross-Russell stated she had a request from building management. She explained they have requested that no HIPC members smoke in front of the main entrance or side entrance of the building.

1. On September 27' 2017 the CDC issued a letter acknowledging those who are virally suppressed pose no risk of sexual transmission to their partner. For more info visit: https://www.hivplusmag.com/undetectable/2017/9/27/breaking-cdc-officially-recognizes-undetectableuntransmittable-hiv-prevention

D. Law stated the Nominations Committee has recommended 7 new members for appointment by the Mayor's Office. She noted new member orientation was prior to today's HIPC meeting.

N. Johns stated the Consumer Survey Report is in progress. She noted the Comprehensive Planning Committee would get a first look at the report before it is presented to the HIPC.

B. Morgan stated OHP is working on a new website to reflect integration of the two planning bodies. She explained the new website will include an HIV resources inventory, an update to the Epi Profile, and new social determinants of health maps based on new census data. She explained the new website will be designed with ease of use in mind, and she will seek feedback from HIPC members regarding the website.

Discussion Item: N. Johns invited the council to partake in a teambuilding exercise. She explained the council would be doing an activity centered on important events in the HIV timeline. N. Johns steered the council's attention to the posted timeline. She introduced the timeline as follows:

1. June 5, 1981 CDC publishes report describing cases of PCP[2]
2. 1984 Human Immunodeficiency Virus identified as cause of AIDS
3. 1987 FDA approves AZT, AIDS quilt displayed first time on the National Mall
4. 1990 Ryan White dies. CARE Act is passed
5. 1998 Congress funds Minority AIDS Initiative
6. 1999 CDC releases new HIV case definition
7. 2006 CDC recommends routine testing for everyone 13-64
8. 2010 ACA becomes law, NHAS released, PrEP is proven effective (iPrEX)[3]
9. April 2017 Philadelphia HIV Integrated Planning Council is formed.

After introduction of the timeline N. Johns invited the council to share two important events in their lives to add to the HIV timeline. Council members wrote down their two important personal events on index cards and handed them back to N. Johns upon completion. N. Johns organized the index cards by chronological order and placed them into the HIV timeline. N. Johns shared the new timeline with the council. When N. Johns read each index card council members raised their hands to claim their event. Some council members shared personal anecdotes relating to their event and the individual importance. N. Johns thanked the council for their participation in the exercise and stated she would leave the timeline on display in case anyone wanted to add events later on.

Report of Committees

Executive Committee K. Baron stated the Executive Committee has not met. No further report.

Finance Committee— *A. Edelstein and D. Gana, Co-Chairs*

D. Gana stated the Finance Committee met last Thursday and reviewed EMA spending. C. Chu distributed the Second Quarter Underspending Report A. McCann-Woods reviewed the underspending report. She explained the EMA was underspent by 19% or $1,700,429.00. She noted the figures in the report were premature, since there are outstanding invoices. She asked the council to look at page 1 of the underspending report. She explained page 1 was the summary of net underspending in the EMA, and noted the majority of underspending was from Philadelphia. She pointed out the spending in the outpatient/ambulatory health services was where most of the underspending occurred. The net underspending was 36% for the service category.

2. PCP is in reference to Pneumocystis pneumonia (PCP) is a serious infection that causes inflammation and fluid buildup in your lungs.

3. iPrex Study The iPrEx study started in 2007and results were presented in November 2010.This randomized, double-blind, placebo controlled trial studied the safety and efficacy of taking Truvada (emtricitabine/*tenofovir* disoproxil fumarate)to prevent HIV infection.

She moved discussion onto page two of the report, the net underspending in Philadelphia. She reiterated the majority of underspending was from Philadelphia. She stated the majority of underspending could be attributed to late invoicing. She referenced the medical transportation service category net underspending was 100%, and the figure would be updated as more invoices were received. A. McCann-Woods explained if the service category was consistently underspent, the funds could be reabsorbed, and that service category would be re-budgeted. M. Cappucilli inquired about the spending in the drug reimbursement program service category in Philadelphia. He pointed out the net underspending was 0% for the second quarter but it was underspent in the past quarter. C. Chu responded the report is comprised of information given to the Health department. He noted the grantee distributes money to the ambulatory health services with the assumption that it will be spent. He explained then in turn the city gives AACO spending information and the information is compiled and analyzed. He reiterated to the council invoices were still outstanding.

A McCann-Woods asked the council to turn their attention to the New Jersey spending on page 4. She reiterated to the council 6 months of invoices were outstanding so it was too early to make inferences from the data. She stated if the service category was being underspent after the end of the fiscal year, the grantee could reabsorb funding and redistribute the funds across the service categories as long as the net change was not greater than ± 10%. She noted if the change would be greater than 10% the grantee would have to submit a reallocation request to the Finance Committee.

Needs Assessment — *G. Keys, Chair*
K. Baron stated Needs Assessment is still meeting with the Comprehensive Planning Committee. No further report.

Positive Committee— *K. Carter, Chair*
N. Johns stated the Positive Committee will meet Monday, October 16, 2017. She announced Positive committee will conduct co-chair elections.

Nominations Committee— *K. Burns and M. Cappuccilli, Co-Chairs*
M. Cappucilli stated the Nominations Committee did not meet in October. He noted the committee recommended 7 applicants for appointment by the Mayor's Office, and there was new member orientation before today's council meeting.

Comprehensive Planning Committee— *A. Thompson, Chair*
K. Baron stated A. Thompson was unable to attend. She informed HIPC members the Comprehensive Planning Committee planned their calendar for the year. She invited all HIPC members to attend future meetings.

Prevention Committee— *L. Matus and C. Steib, Co-Chairs*
L. Matus stated the Prevention Committee was work planning as well. She stated the Prevention Committee has decided to work on objective 1, 2, 3 of HIV integrated care plan. L. Matus stated the PrEP work group will have its 1st meeting November 15, 2017, and an email would soon be sent out to all HIPC members.

Old Business: None

New Business: None

Announcements: L. Matus announced Sunday, October 15, 2017 is National Latino AIDS Awareness Day[4]. She stated there would be events in Kensington, and she invited all to attend.

J. Whitefield announced Sunday, October 15, 2017 is the AIDS Walk Philly[5]. She explained the event was a 5 kilometer walk/run fundraiser. She invited all to attend.

K. Baron informed the council there were some job openings in the St. Christopher Hospital system. She encouraged all to apply.

Adjournment: Motion: J. Whitfield moved, R. Lassiter seconded to adjourn the meeting at 2.55pm. **Motion passed:** All in favor. .

Respectfully submitted by,

Stephen Budhu, Staff

Handouts distributed at the meeting:

- Meeting Agenda
- September 14, 2017 Meeting Minutes
- Second Quarter EMA Underspending Report
- OHP Calendar

4. For more information on the Latino AIDS Awareness Day visit https://aidsinfo.nih.gov/understanding-hiv-aids/hiv-aids-awareness-days/169/national-latinx-aids-awareness-day
5. For more information on the AIDS Walk Philly event visit http://www.aidswalkphilly.org/

CITY OF PHILADELPHIA
DEPARTMENT OF
PUBLIC HEALTH

Office of HIV Planning

HIV Integrated Planning Council

Ryan White Part A

Recipient 2016-17 Reallocation Request

November 9, 2017

The Recipient has experienced personnel vacancies this contract year which have resulted in System Wide Allocations underspending for the following categories:

- **Information and Referral** **39,563 or 7.6%**
- **Quality Management Activities** **60,437 or 11.14%**
  $100,000.00 or 3.9%

Acting proactively to mitigate underspending at the conclusion of the contract year, the Recipient requests approval to reallocate the underpent $100,000.00 into the Food Bank/ Home Delivered Meals service category of the Philadelphia Region.

Historically there is a surge in utilization of this service during the holidays and cold winter months. Other regions of the EMA appear to be adequately funded at this time.

As per the Recipient's 2nd quarter underspending report the New Jersey Region was underspent by 13% and although the PA Counties were overspent by 30% the regions's food service category funding has been supplemented with carry over dollars from the 2016-17 contract year.

This represents a 32.5% increase to this category. The Recipient is assured that the Philadelphia region currently has the capacity to expend these funds by the end of this contract year.

EMA-Wide FY2017

Philadelphia EMA Ryan White Part A

November 2, 2017

TOTAL

Service Categories	FY 2017 Allocations	Adjustment	Revised FY 2017 Allocations
Outpatient/Ambulatory Health Services	$ 6,815,037	$ -	$ 6,815,037
Drug Reimbursement Program	$ 505,196	$ -	$ 505,196
Medical Case Management	$ 5,693,671	$ -	$ 5,693,671
Substance Abuse Services - Outpatient	$ 359,604	$ -	$ 359,604
Mental Health Services	$ 554,895	$ -	$ 554,895
Medical Nutrition Therapy	$ 60,531	$ -	$ 60,531
Oral Health Care	$ 787,375	$ -	$ 787,375
AIDS Drug Assistance Program (ADAP)	$ -	$ -	$ -
Health Insurance Premium & Costs Sharing Assistance	$ -	$ -	$ -
Early Intervention Services	$ -	$ -	$ -
Medical Transportation Services	$ 429,163	$ -	$ 429,163
Food Bank/Home-Delivered Meals	$ 307,171	$ 100,000	$ 407,171
Housing Services	$ 573,203	$ -	$ 573,203
Other Professional Services/Legal Services	$ 410,779	$ -	$ 410,779
Care Outreach Services	$ -	$ -	$ -
Emergency Financial Assistance	$ 70,458	$ -	$ 70,458
Emergency Financial Assistance	$ 1,102,398	$ -	$ 1,102,398
Treatment Adherence (Case Management)	$ -	$ -	$ -
Linguistics Services	$ -	$ -	$ -
Psychosocial Support Services	$ -	$ -	$ -
Home Health Care	$ -	$ -	$ -
Respite Care	$ -	$ -	$ -
Child Care Services	$ -	$ -	$ -
Refferal for Health Care/Supportive Services	$ 82,241	$ -	$ 82,241
Total	**$ 17,751,722**	**$ 100,000**	**$ 17,851,722**

SYSTEMWIDE ALLOCATIONS

	FY 2017 Allocations	Adjustment	Revised FY 2017 Allocations
I & R	$ 520,329	$ (39,563)	$ 480,766
QM Activities	$ 524,638	$ (60,437)	$ 464,201
Systemwide Coordination	$ 193,538	$ -	$ 193,538
Capacity Building	$ 113,102	$ -	$ 113,102
PC Support	$ 501,776	$ -	$ 501,776
Grantee Administration	$ 1,280,104	$ -	$ 1,280,104
Total	**$ 3,133,487**	**$ (100,000)**	**$ 3,033,487**

EMA-Wide FY2017
Philadelphia EMA Ryan White Part A
November 2, 2017

PHILADELPHIA

Service Categories	FY 2017 Allocations	Adjustment	Revised FY 2017 Allocations
Outpatient/Ambulatory Health Services	$ 5,015,205	$ -	$ 5,015,205
Drug Reimbursement Program	$ 505,196	$ -	$ 505,196
Medical Case Management	$ 4,153,032	$ -	$ 4,153,032
Substance Abuse Services - Outpatient	$ 237,575	$ -	$ 237,575
Mental Health Services	$ 329,740	$ -	$ 329,740
Medical Nutrition Therapy	$ -	$ -	$ -
Oral Health Care	$ 430,898	$ -	$ 430,898
AIDS Drug Assistance Program (ADAP)	$ -	$ -	$ -
Health Insurance Premium & Costs Sharing Assistance	$ -	$ -	$ -
Early Intervention Services	$ -	$ -	$ -
Medical Transportation Services	$ 12,249	$ -	$ 12,249
Food Bank/Home-Delivered Meals	$ 210,147	$ 100,000	$ 310,147
Housing Services	$ 545,884	$ -	$ 545,884
Other Professional Services/Legal Services	$ 305,574	$ -	$ 305,574
Care Outreach Services	$ -	$ -	$ -
Emergency Financial Assistance	$ 48,662	$ -	$ 48,662
Emergency Financial Assistance/AIDS Pharma Asst.	$ 883,159	$ -	$ 883,159
Treatment Adherence (Case Management)	$ -	$ -	$ -
Linguistics Services	$ -	$ -	$ -
Psychosocial Support Services	$ -	$ -	$ -
Home Health Care	$ -	$ -	$ -
Respite Care	$ -	$ -	$ -
Child Care Services	$ -	$ -	$ -
Refferal for Health Care/Supportive Services	$ 82,241	$ -	$ 82,241
Total	**$ 12,759,562**	**$ 100,000**	**$ 12,859,562**

EMA-Wide FY2017
Philadelphia EMA Ryan White Part A
November 2, 2017
PENNSYLVANIA COUNTIES

Service Categories	FY 2017 Allocations	Adjustment	Revised FY 2017 Allocations
Outpatient/Ambulatory Health Services	$ 669,713	$ -	$ 669,713
Drug Reimbursement Program	$ -	$ -	$ -
Medical Case Management	$ 1,096,387	$ -	$ 1,096,387
Substance Abuse Services - Outpatient	$ 122,029	$ -	$ 122,029
Mental Health Services	$ 48,340	$ -	$ 48,340
Medical Nutrition Therapy	$ 60,531	$ -	$ 60,531
Oral Health Care	$ 152,478	$ -	$ 152,478
AIDS Drug Assistance Program (ADAP)	$ -	$ -	$ -
Health Insurance Premium & Costs Sharing Assistance	$ -	$ -	$ -
Early Intervention Services	$ -	$ -	$ -
Medical Transportation Services	$ 248,674	$ -	$ 248,674
Food Bank/Home-Delivered Meals	$ 39,698	$ -	$ 39,698
Housing Services	$ 27,319	$ -	$ 27,319
Other Professional Services/Legal Services	$ 17,328	$ -	$ 17,328
Care Outreach Services	$ -	$ -	$ -
Emergency Financial Assistance	$ 21,796	$ -	$ 21,796
Emergency Financial Assistance	$ 219,239	$ -	$ 219,239
Treatment Adherence (Case Management)	$ -	$ -	$ -
Linguistics Services	$ -	$ -	$ -
Psychosocial Support Services	$ -	$ -	$ -
Home Health Care	$ -	$ -	$ -
Respite Care	$ -	$ -	$ -
Child Care Services	$ -	$ -	$ -
Refferal for Health Care/Supportive Services	$ -	$ -	$ -
Total	**$ 2,723,532**	**$ -**	**$ 2,723,532**

EMA-Wide FY2017

Philadelphia EMA Ryan White Part A

November 2, 2017

NEW JERSEY COUNTIES

Service Categories	FY 2017 Allocations	Adjustment	Revised FY 2017 Allocations
Outpatient/Ambulatory Health Services	$ 1,130,119	$ -	$ 1,130,119
Drug Reimbursement Program	$ -	$ -	$ -
Medical Case Management	$ 444,252	$ -	$ 444,252
Substance Abuse Services - Outpatient	$ -	$ -	$ -
Mental Health Services	$ 176,815	$ -	$ 176,815
Medical Nutrition Therapy	$ -	$ -	$ -
Oral Health Care	$ 203,999	$ -	$ 203,999
AIDS Drug Assistance Program (ADAP)	$ -	$ -	$ -
Health Insurance Premium & Costs Sharing Assistance	$ -	$ -	$ -
Early Intervention Services	$ -	$ -	$ -
Medical Transportation Services	$ 168,240	$ -	$ 168,240
Food Bank/Home-Delivered Meals	$ 57,326	$ -	$ 57,326
Housing Services	$ -	$ -	$ -
Other Professional Services/Legal Services	$ 87,877	$ -	$ 87,877
Care Outreach Services	$ -	$ -	$ -
Emergency Financial Assistance	$ -	$ -	$ -
Emergency Financial Assistance	$ -	$ -	$ -
Treatment Adherence (Case Management)	$ -	$ -	$ -
Linguistics Services	$ -	$ -	$ -
Psychosocial Support Services	$ -	$ -	$ -
Home Health Care	$ -	$ -	$ -
Respite Care	$ -	$ -	$ -
Child Care Services	$ -	$ -	$ -
Refferal for Health Care/Supportive Services	$ -	$ -	$ -
Total	**$ 2,268,628**	**$ -**	**$ 2,268,628**

GMHC Treatment ISSUES SEPTEMBER 2013

Untangling the Intersection of HIV & Trauma: Why It Matters and What We Can Do

by Naina Khanna and Suraj Madoori

Despite the widespread availability of anti-retroviral therapy (ART) in the U.S., more than half of people living with HIV (PLHIV) in the U.S. are not engaged in regular medical care. Strikingly, only about one-fifth of the U.S. HIV-positive population has a suppressed viral load. Barriers to retention in care and anti-retroviral adherence range from financial and logistical, to actual and perceived discrimination in health care settings. However, these public health challenges reflect deeper-level determinants that drastically undercut HIV prevention efforts and the health care of PLHIV. Most notably, individual and community-level experiences with trauma negatively impact the health outcomes of PLHIV.

This article investigates ways in which unaddressed trauma in the lives of PLHIV negatively impacts access to and engagement in care, further complicating health outcomes as a consequence. In doing so, this article analyzes the existing evidence base for intervention, and posits recommendations for further research and action. In particular, we urge expansion of trauma-informed care practices (TIC) as a high-impact structural intervention to facilitate healing from trauma, improve individual health outcomes, and achieve progress towards public health goals, including those of the National HIV/AIDS Strategy.

Trauma & HIV: What's the Connection?

The term "trauma" denotes negative events and circumstances that produce psychological distress and may have adverse effects on the well-being of an individual. Trauma has always been an experience shared by many PLHIV prior to diagnosis. And as the U.S. HIV epidemic has increasingly become a public health crisis disproportionately impacting communities who also face the detrimental effects of systemic racism, homophobia, transphobia, classism, and patriarchy, U.S. PLHIV have become increasingly impacted and burdened by lifetime individual and community-level trauma.

It is well documented that traumatic experiences, including histories of childhood sexual and physical abuse, are far more prevalent among PLHIV than in the general U.S. population. And trauma is all-too-frequently perpetuated by the health care and service delivery system itself, especially for communities of color, sexual minorities and others who suffer from the intentional and unintentional effects of discrimination, prejudice and bias in the very settings entrusted to assure their well-being.

Recent data demonstrates that trauma experienced in adulthood and post-HIV-diagnosis is also significantly higher among PLHIV than among the general population. In part, this may stem from pervasive racism, homophobia, transphobia, classism, patriarchy, and policies that criminalize sex work and drug use, which in and of themselves perpetrate trauma and trauma-related stress, independently of interpersonal violence.[1] One study undertaken by the Center for AIDS Prevention Studies at UCSF, in collaboration with the Global Forum on MSM and HIV, demonstrated that past-year experiences of racism and homophobia were associated with depression and anxiety among U.S. racial/ethnic minority men who have sex with men (MSM).[2]

Numerous studies have demonstrated the adverse impact of trauma upon the health outcomes of PLHIV. The Coping with HIV/AIDS in the Southeast (CHASE) Study found that among 490 HIV-positive women and men from five rural Southern states, patients with more categories of lifetime trauma had almost twice the all-cause death rate as those below the median levels of trauma.[3,4] Furthermore, the CHASE Study showed that trauma was also associated with faster development of an opportunistic infection or AIDS-related death.[3,4]

In another study of 765 women living with HIV, women with chronic depressive symptoms were about twice as likely to progress to AIDS as those who had never experienced depression.[5,6] Chronic depression, which is associated with trauma, has been demonstrated to be associated with clinical and immunological progression of HIV/AIDS.[3,6] One study of 85 HIV-positive gay men illustrated that those whose close friend or partner died of AIDS had more rapid decline in CD4 count during a three to four year follow-up period.[3,7]

Another study by Leserman et al., revealed that HIV-positive individuals with less income, elevated childhood trauma, more recent stressful events, and increased depressive symptoms were more likely to rate high on intensity of fatigue and impairment in daily functioning. Leserman's study further demonstrated that recent stresses were a more powerful predictor of fatigue than childhood trauma.[8]

path toward healing, as well as a commitment to minimizing retraumatization, in particular by employing a "do no harm" approach that is sensitive to ways in which institutions may inadvertantly re-enact traumatic dynamics. This requires building cultural competence among staff and institutional capacity to respond to trauma as key components of a successful system.

Trauma-informed care is not limited to the delivery of Trauma-specific services—interventions designed to directly address the impact of trauma, with the goals of decreasing symptoms and facilitating healing—although it may support, facilitate or refer to delivery of those services.[16] Rather, trauma-informed care requires creating an environment which can sustain delivery of such services and further supports positive outcomes for clients receiving those services. Importantly, trauma-informed care operates on an empowerment model, emphasizing strengths and resiliency of clients, and seek to minimize the power imbalance between the individual seeking services and the provider.

Considering the historical and collective trauma inflicted on communities of color, LGBT communities, and other communities vulnerable to acquiring HIV, minimizing the power imbalance and promoting a trauma-informed response require high levels of cultural competency, which should prioritize employment of peers and leadership by people from disproportionately impacted communities in service delivery.

Trauma-informed care practices may allow health providers to fully support healthy expressions of gender, sexual orientation, and self-efficacy.

Promising Elements for HIV Care

The majority of models addressing trauma-informed service delivery have been designed and evaluated for users of mental health and substance use services, or for use in correctional or domestic violence shelter settings. A 2008 paper by the National Center for Trauma-Informed Care at the Center for Health Services asserts that integrating a trauma-informed response into mental health systems is likely to be cost-effective for the service delivery system, and that many of the existing trauma-based integrated treatment approaches are effective and can be replicated within public service sector settings.[18]

Because of the population overlap between PLHIV and populations in which trauma-informed service delivery has been evaluated, and because of HIV's strongly collaborative service delivery networks in the U.S., it is logical that elements of evaluated trauma-informed service delivery may be applicable to HIV outpatient care and service delivery settings.

Resources that may be worth exploring include the Sanctuary Model, a framework for intervening with trauma survivors and for facilitating organizational change originally developed for traumatized adults in inpatient settings and adapted for use in domestic violence settings. Organizations and agencies that seek to become more trauma-informed can look to resources including Creating Trauma-Informed Systems of Care: Facilitating Recovery in Mental Health Services Settings and Developing Trauma-Informed Organizations: A Tool Kit, both designed for use by mental health provider agencies.

The integration of peers (defined, in this case, as trauma survivors and those in trauma recovery) throughout program design and implementation, has been widely acknowledged as key to the success of trauma-informed service delivery. The Substance Abuse and Mental Health Services Administration's (SAMHSA) Women, Co-Occurring Disorders and Violence Study (WCODVS) set out to explore the development of comprehensive, integrated service approaches and the effectiveness of those approaches for women whom they deemed "high-end" users of publicly funded services.[19]

This nine-site study found that it was critical and necessary that programs actively integrated consumer/survivor/recovering (C/S/R) women as program staff, on project committees, and/or to provide trainings and support for other C/S/R women.[19] Other key lessons from the WCODVS were that becoming trauma-informed is a continuous process, not a one-time event, and that one or two people within a system (a strategically placed "trauma champion" or a "trauma liaision") can help to drive change towards trauma-informed service delivery.[19]

More recently, the Center for Mental Health Services' National Center for Trauma-Informed Care released a 96-page technical assistance guidebook, Engaging Women in Trauma-Informed Peer Support, designed to help organizations strengthen peer-based services.

Future Directions for Research and Advocacy

Trauma-informed practices represent an essential component for the overall health and well-being of impacted individuals and communities, and help create a better-equipped health care system that can more holistically meet the care needs of PLHIV. Trauma-informed practices as a high-impact strategy can help fulfill specific National HIV/AIDS Strategy (NHAS) goals to increase access to health care and improve health outcomes for PLHIV, particularly among groups that are dually and disproportionately impacted by the epidemic and trauma.

Among heavily traumatized populations (including women survivors of violence, LGBTQ communities, and most acutely, the transgender community), trauma-informed care practices may allow health providers to fully support healthy expressions of gender, sexual orientation, and self-efficacy.[20] This allows individuals to live as fully vested members of society, rather than reinforce the marginalization that many in the LGBTQ community experience throughout their lifespan.[20]

However, additional research is needed to investigate the potential role of trauma-informed care services for people living with HIV and to develop models for the spe-

Being Trauma-Informed in the Care of People Living With HIV

By Marcy Witherspoon, MSW, LSW
Senior Training Specialist
Health Federation of Philadelphia

Health policymakers and practitioners across the country are increasingly recognizing the effects of trauma on the health status of individuals … let's examine why.

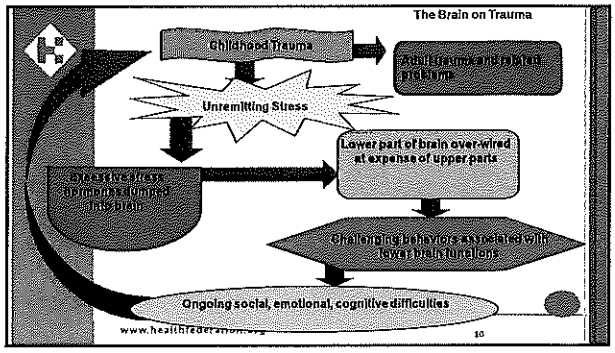
Session Objectives

- To relay the profound impact of childhood trauma on brain development, temperament and adult-specific behavior.
- To discuss the Adverse Childhood Experiences (ACE) Study and its potential effects over the life course.
- To provide trauma-informed principles to reduce the negative sequelae associated with HIV diagnosis, disclosure, and treatment

Childhood decides …

Jean Paul Sartre


Trauma can occur at any age.
Trauma can affect any:
•race
•gender
•ethnicity
•religion
•socio-economic group
•community
•workforce
•sexual orientation
•gender identity
www.healthfederation.org


The Brain on Trauma
Childhood Trauma
Unremitting Stress
Lower part of brain over-wired at expense of upper parts
Ongoing social, emotional, cognitive difficulties
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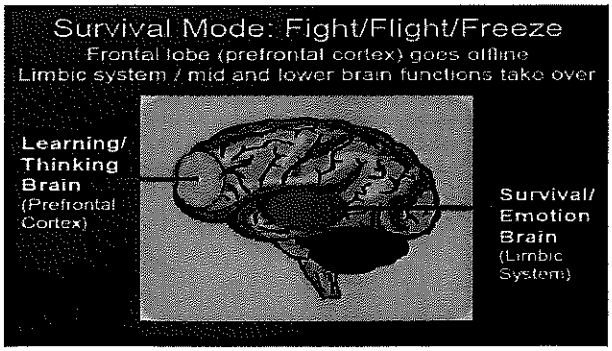
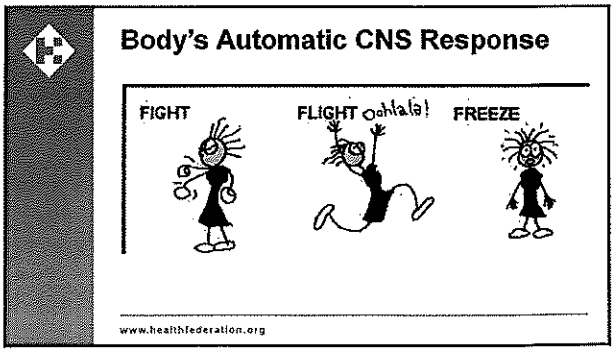

Survival Mode: Fight/Flight/Freeze
Frontal lobe (prefrontal cortex) goes offline
Limbic system / mid and lower brain functions take over
Learning/ Thinking Brain (Prefrontal Cortex)
Survival/ Emotion Brain (Limbic System)


Body's Automatic CNS Response
FIGHT
FLIGHT ohhlala!
FREEZE
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Trauma's Lasting Negative Effects

1) world view
2) feelings of safety
3) sense of future
4) relationships with others
5) health & well-being
6) emotional awareness & expression

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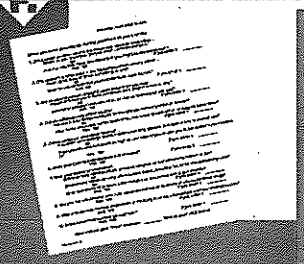
The ACE Study -- the largest public health study of its kind that nobody has ever heard of …

the ACE study

www.healthfederation.org

Study method



17,421 members of the Kaiser Health Plan in San Diego County from 1995-1997

Confidential survey asking questions about childhood trauma and current health status and behaviors combined with physical examination

Demographics:
- primary care setting
- educated
- middle class
- predominantly white

Ten Original ACEs

- 1)physical abuse
- 2)emotional abuse
- 3)sexual abuse
- 4)physical neglect
- 5)emotional neglect
- 6)mother a victim of IPV
- 7) HH member incarcerated
- 8) HH member mental health
- 9) HH member substance use
- 10)one/both bio parents absent

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Philadelphia Expanded ACE Study

THE PHILADELPHIA ACE PROJECT

- Experiencing Racism/Discrimination
- Witnessing Community Violence
- Living in an Unsafe Neighborhood
- Living in Foster Care
- Experiencing Bullying

www.healthfederation.org www.instituteforsafefamilies.org/philadelphia-urban-ace-study

Key Findings

- 33.2 percent of Philadelphia adults experienced emotional abuse and 35 percent experienced physical abuse during their childhood.
- Approximately 35 percent of adults grew up in a household with a substance-abusing member; 24.1 percent lived in a household with someone who was mentally ill; and
- 12.9 percent lived in a household with someone who served time or was sentenced to serve time in prison.

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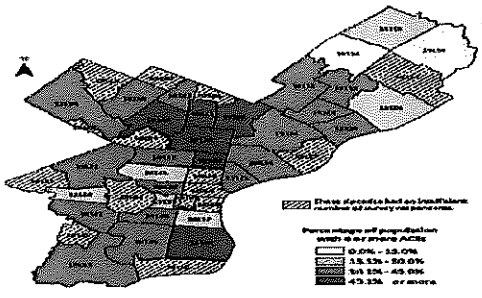
Philadelphia Urban Ace Project - a collaboration of PHMC, CHOP, St. Christopher's, UF, Drexel University



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From Dr. Patty Gerrity and Dr. Roberta Waite, The Healing Project

Original Study vs. 11th Street Results

# of ACEs (ACE Score)	Women		Men		Total	
	11th Street Patients	*Original Study*	*11th Street Patients*	*Original Study*	*11th Street Patients*	*Original Study*
0	6.8%	34.5%	3.9%	38.0%	6.3%	36.1%
1	12.5%	24.5%	9.9%	27.9%	12.0%	26.0%
2	18.5%	15.5%	14.5%	16.4%	17.8%	15.9%
3	14.6%	10.3%	16.4%	8.6%	14.9%	9.5%
4 or more	47.5%	15.2%	55.3%	9.2%	49.0%	12-16%

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HIV and Current Trauma

- Any childhood trauma is worsened by stigma, discrimination, and bias – by others, often in health care settings
- Some settings are re-traumatizing and trigger patients
- For some patients, learning of their status is traumatic.
- A woman living with HIV is 4x more likely to experience treatment failure and not remain virally suppressed.
- Women who had experienced trauma are more likely to have sex with partners whose HIV status is unknown to them, have sex without condoms, and are more likely to spread the infection with unprotected sex.
- 55% of women living with HIV experience IPV

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Due to systemic issues related to homophobia, transphobia, patriarchy and other systemic types of oppression, HIV treatment is often not working for:

- Women living with HIV
- Transgender women
- Young black gay men

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Many clinics work with patients who get to undetectable viral loads, but …

- about 50% are depressed
- almost 50% are using substances
- most are poor
- most aren't fully "out" re: status
- many are living with abusive partners
- many are not working

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What would help?

Please keep in mind there are protective factors available to people to lessen the impact of ACE's on future health outcomes

- This information is important to consider when assessing impact on members of the HIV positive community.
- Focus has been on biomedical model (adherence to medication, getting to an undetectable viral load, etc.) and ignored other pieces of personal health & experiences.
- More helpful focus might be a medical home model where primary care is integrated into HIV treatment
- Routine screening for ACEs would exist – behavioral health consultation would be available on-site
- Health-providing sites would be "safe spaces."
- Harm reduction models would be utilized

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TIC moves from shame, blame and punishment to ...

Understanding (What happened to you and how has it affected you?)

Nurturing (How can I help you?)

Healing (How can I help you to heal, and not create more problems for you?)

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Trauma-Informed Care

- requires universal trauma precautions and screening
- practice changes with patients with known trauma histories
- patient-centered communication and care
- safe clinical environments
- shared decision-making for patients
- provider collaboration across disciplines
- requires awareness of own trauma histories

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Trauma-Informed Care Framework

"The body remembers. Stuffed until an event, a sound, a sight, a touch, a word of a person awakens them."

- requires change to organizational policies, practices and culture
- reflects an understanding of the impact of trauma and paths for recovery
- actively seeks to prevent re-traumatization
- reviews how services can trigger patient
- understands strengths-based approaches that promote resiliency

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For People Living with HIV

- Know this is a real and present phenomenon
- Have patience with yourself
- Re-evaluate your coping strategies
- Seek out safe, stable and nurturing supports
- Engage your allies (peer, personal, and professional)
- Explore, identify and manage your triggers (as much as is possible)
- Multiply your connections
- Handle yourself gently
- Seek consistency
- Consider trauma specific services

GMHC Treatment ISSUES SEPTEMBER 2013

Untangling the Intersection of HIV & Trauma: Why It Matters and What We Can Do

by Naina Khanna and Suraj Madoori

Despite the widespread availability of anti-retroviral therapy (ART) in the U.S., more than half of people living with HIV (PLHIV) in the U.S. are not engaged in regular medical care. Strikingly, only about one-fifth of the U.S. HIV-positive population has a suppressed viral load. Barriers to retention in care and anti-retroviral adherence range from financial and logistical, to actual and perceived discrimination in health care settings. However, these public health challenges reflect deeper-level determinants that drastically undercut HIV prevention efforts and the health care of PLHIV. Most notably, individual and community-level experiences with trauma negatively impact the health outcomes of PLHIV.

This article investigates ways in which unaddressed trauma in the lives of PLHIV negatively impacts access to and engagement in care, further complicating health outcomes as a consequence. In doing so, this article analyzes the existing evidence base for intervention, and posits recommendations for further research and action. In particular, we urge expansion of trauma-informed care practices (TIC) as a high-impact structural intervention to facilitate healing from trauma, improve individual health outcomes, and achieve progress towards public health goals, including those of the National HIV/AIDS Strategy.

Trauma & HIV: What's the Connection?

The term "trauma" denotes negative events and circumstances that produce psychological distress and may have adverse effects on the well-being of an individual. Trauma has always been an experience shared by many PLHIV prior to diagnosis. And as the U.S. HIV epidemic has increasingly become a public health crisis disproportionately impacting communities who also face the detrimental effects of systemic racism, homophobia, transphobia, classism, and patriarchy, U.S. PLHIV have become increasingly impacted and burdened by lifetime individual and community-level trauma.

It is well documented that traumatic experiences, including histories of childhood sexual and physical abuse, are far more prevalent among PLHIV than in the general U.S. population. And trauma is all-too-frequently perpetuated by the health care and service delivery system itself, especially for communities of color, sexual minorities and others who suffer from the intentional and unintentional effects of discrimination, prejudice and bias in the very settings entrusted to assure their well-being.

Recent data demonstrates that trauma experienced in adulthood and post-HIV-diagnosis is also significantly higher among PLHIV than among the general population. In part, this may stem from pervasive racism, homophobia, transphobia, classism, patriarchy, and policies that criminalize sex work and drug use, which in and of themselves perpetrate trauma and trauma-related stress, independently of interpersonal violence.[1] One study undertaken by the Center for AIDS Prevention Studies at UCSF, in collaboration with the Global Forum on MSM and HIV, demonstrated that past-year experiences of racism and homophobia were associated with depression and anxiety among U.S. racial/ethnic minority men who have sex with men (MSM).[2]

Numerous studies have demonstrated the adverse impact of trauma upon the health outcomes of PLHIV. The Coping with HIV/AIDS in the Southeast (CHASE) Study found that among 490 HIV-positive women and men from five rural Southern states, patients with more categories of lifetime trauma had almost twice the all-cause death rate as those below the median levels of trauma.[3,4] Furthermore, the CHASE Study showed that trauma was also associated with faster development of an opportunistic infection or AIDS-related death.[3,4]

In another study of 765 women living with HIV, women with chronic depressive symptoms were about twice as likely to progress to AIDS as those who had never experienced depression.[5,6] Chronic depression, which is associated with trauma, has been demonstrated to be associated with clinical and immunological progression of HIV/AIDS.[3,6] One study of 85 HIV-positive gay men illustrated that those whose close friend or partner died of AIDS had more rapid decline in CD4 count during a three to four year follow-up period.[3,7]

Another study by Leserman et al., revealed that HIV-positive individuals with less income, elevated childhood trauma, more recent stressful events, and increased depressive symptoms were more likely to rate high on intensity of fatigue and impairment in daily functioning. Leserman's study further demonstrated that recent stresses were a more powerful predictor of fatigue than childhood trauma.[8]

path toward healing, as well as a commitment to minimizing retraumatization, in particular by employing a "do no harm" approach that is sensitive to ways in which institutions may inadvertantly re-enact traumatic dynamics. This requires building cultural competence among staff and institutional capacity to respond to trauma as key components of a successful system.

Trauma-informed care is not limited to the delivery of Trauma-specific services—interventions designed to directly address the impact of trauma, with the goals of decreasing symptoms and facilitating healing—although it may support, facilitate or refer to delivery of those services.[16] Rather, trauma-informed care requires creating an environment which can sustain delivery of such services and further supports positive outcomes for clients receiving those services. Importantly, trauma-informed care operates on an empowerment model, emphasizing strengths and resiliency of clients, and seek to minimize the power imbalance between the individual seeking services and the provider.

Considering the historical and collective trauma inflicted on communities of color, LGBT communities, and other communities vulnerable to acquiring HIV, minimizing the power imbalance and promoting a trauma-informed response require high levels of cultural competency, which should prioritize employment of peers and leadership by people from disproportionately impacted communities in service delivery.

Trauma-informed care practices may allow health providers to fully support healthy expressions of gender, sexual orientation, and self-efficacy.

Promising Elements for HIV Care

The majority of models addressing trauma-informed service delivery have been designed and evaluated for users of mental health and substance use services, or for use in correctional or domestic violence shelter settings. A 2008 paper by the National Center for Trauma-Informed Care at the Center for Health Services asserts that integrating a trauma-informed response into mental health systems is likely to be cost-effective for the service delivery system, and that many of the existing trauma-based integrated treatment approaches are effective and can be replicated within public service sector settings.[18]

Because of the population overlap between PLHIV and populations in which trauma-informed service delivery has been evaluated, and because of HIV's strongly collaborative service delivery networks in the U.S., it is logical that elements of evaluated trauma-informed service delivery may be applicable to HIV outpatient care and service delivery settings.

Resources that may be worth exploring include the Sanctuary Model, a framework for intervening with trauma survivors and for facilitating organizational change originally developed for traumatized adults in inpatient settings and adapted for use in domestic violence settings. Organizations and agencies that seek to become more trauma-informed can look to resources including Creating Trauma-Informed Systems of Care: Facilitating Recovery in Mental Health Services Settings and Developing Trauma-Informed Organizations: A Tool Kit, both designed for use by mental health provider agencies.

The integration of peers (defined, in this case, as trauma survivors and those in trauma recovery) throughout program design and implementation, has been widely acknowledged as key to the success of trauma-informed service delivery. The Substance Abuse and Mental Health Services Administration's (SAMHSA) Women, Co-Occurring Disorders and Violence Study (WCODVS) set out to explore the development of comprehensive, integrated service approaches and the effectiveness of those approaches for women whom they deemed "high-end" users of publicly funded services.[19]

This nine-site study found that it was critical and necessary that programs actively integrated consumer/survivor/recovering (C/S/R) women as program staff, on project committees, and/or to provide trainings and support for other C/S/R women.[19] Other key lessons from the WCODVS were that becoming trauma-informed is a continuous process, not a one-time event, and that one or two people within a system (a strategically placed "trauma champion" or a "trauma liaision") can help to drive change towards trauma-informed service delivery.[19]

More recently, the Center for Mental Health Services' National Center for Trauma-Informed Care released a 96-page technical assistance guidebook, Engaging Women in Trauma-Informed Peer Support, designed to help organizations strengthen peer-based services.

Future Directions for Research and Advocacy

Trauma-informed practices represent an essential component for the overall health and well-being of impacted individuals and communities, and help create a better-equipped health care system that can more holistically meet the care needs of PLHIV. Trauma-informed practices as a high-impact strategy can help fulfill specific National HIV/AIDS Strategy (NHAS) goals to increase access to health care and improve health outcomes for PLHIV, particularly among groups that are dually and disproportionately impacted by the epidemic and trauma.

Among heavily traumatized populations (including women survivors of violence, LGBTQ communities, and most acutely, the transgender community), trauma-informed care practices may allow health providers to fully support healthy expressions of gender, sexual orientation, and self-efficacy.[20] This allows individuals to live as fully vested members of society, rather than reinforce the marginalization that many in the LGBTQ community experience throughout their lifespan.[20]

However, additional research is needed to investigate the potential role of trauma-informed care services for people living with HIV and to develop models for the spe-