Connecticut HIV Planning Consortium

17 February 2021 Meeting Summary

Location:	Zoom virtual meeting		
Date:	17 February 2021	**Recorders:**	Michael Nogelo/Dave Bechtel
Start Time:	9:35 a.m.	**End Time:**	10:54 a.m.
Presiding Chairs:	Nilda Fernandez, Dante Gennaro, Barry Walters		
Attendance:	See end pages for roster of CHPC members and public participants		

MEETING AT A GLANCE

- CHPC Co-Chairs announced Peta-Gaye Nembhard as the new chair for the Quality and Performance Measures (QPM) Team.
- The group reviewed the updated Connecticut HIV Fact Sheet.
- Dr. A.C. Demidont delivered a presentation covering a compassionate and comprehensive sexual health history.
- Oscar Mairena delivered a presentation covering a status-neutral approach to HIV testing and care.
- CHPC committees conducted virtual meetings from 11:00 a.m. to as late as 12:30 p.m.

CALL TO ORDER and MOMENT OF SILENCE

CHPC Co-Chair Dante Gennaro called to order the Connecticut HIV Planning Consortium (CHPC) at 9:35 a.m., offered tips to help create a productive virtual meeting environment, and introduced his fellow CHPC Co-Chairs Nilda Fernandez and Barry Walters.

Ms. Gennaro explained that the CHPC is a statewide HIV prevention and care planning body that exists to reduce the rate of new infections and to help those living with and affected by HIV/AIDS connect to services.

Mr. Gennaro led participants in a moment of silence to remember those who have been lost to HIV and to support those who are living with and affected by HIV.

CHPC LEADERSHIP ANNOUNCEMENTS

Mr. Walters reviewed the agenda for the day's meeting, and announced that:

- CHPC members had voted remotely to approve the January 2021 meeting summary.
- CHPC member Peta Gaye Nembhard will become the next chair of the Quality and Performance Measures (QPM) Team.

Ms. Fernandez reviewed the headline news from the updated Connecticut HIV Fact Sheet: 1) There were 220 new HIV infections in 2019, with gay and bisexual men accounting for more than half; 2) Disparities exist, especially in Black men who have sex with men (MSM) and Black female heterosexuals; 3) Black MSM are the only subpopulation to see an increase over the past five years; 4) Significant disparities (continue) to exist; and 5) The number of new HIV infections continues to decrease. Ms. Fernandez added that too many people living with HIV (PLWH) are still not connected to care or virally suppressed, and said that, as the CHPC develops its next five-year plan, this data will inform decision-making about goals and objectives. Participants used the chat box to thank the Connecticut Department of Public Health (CT DPH) epidemiologists and surveillance team for a high-quality and user-friendly infographic.

CHPC PRESENTATION #1: COMPASSIONATE AND COMPREHENSIVE SEXUAL HEALTH HISTORIES

Mr. Gennaro introduced Dr. A.C. Demidont, DO, AAHIVS, who serves as the Principal Medical Scientist for HIV Prevention Medical Affairs – East at Gilead Sciences. Before the presentation, Mr. Gennaro asked participants to complete three interactive polls. The tables below summarize the results of these polls:

Table 1.

Doctors/healthcare providers should conduct a comprehensive sexual health history at least once each year		
Response	**Number**	**Percent**
Strongly agree	39	72%
Agree	13	24%
Disagree	2	4%

Table 2.

I have completed a comprehensive sexual health history in the last 12 months		
Response	**Number**	**Percent**
No	39	72%
Yes	15	28%

Table 3.

I feel comfortable speaking with my doctor / healthcare provider about my sexual history and activities		
Response	**Number**	**Percent**
Strongly agree	26	48%
Agree	25	46%
Disagree	3	6%

Dr. Demidont responded to the poll results by noting that COVID has had a huge impact on access to services such as comprehensive sexual assessments, as many programs for sexually transmitted infections (STI) and HIV shut down temporarily. Some states still are not testing people for HIV. Dr. Demidont predicted an upswing in HIV diagnoses when testing picks back up. Service continuity should be easier to achieve now because of widespread telehealth capabilities.

Mr. Gennaro asked Dr. Demidont to talk to the group about comprehensive sexual health history as a component of the new five-year plan.

Dr. Demidont discussed strategies to make gender-neutral language the norm. For years, not having a STI or HIV was considered being sexually healthy, but we must broaden that definition. People deserve to have sexual freedom and sexual rights. Historically, the predominant messages have been don't have sex; if you do have sex, use a condom; and there has been lots of shame associated with sex. Dr. Demidont expressed her feeling that it is important that sexual health histories start with sexual rights. Social distancing during COVID-19, for example, would take away the ability of sex workers to make a living, but people should have the right to survive. The World Health Organization (WHO) released a white paper on how to have sex during COVID. The white paper includes an acknowledgement of pleasure as part of sex. Pleasure is part of a healthy sexual experience. People have the right to have sex. The job of a public health worker is to prevent the transmission of STIs, not to impose sanctions on people's sex lives.

Dr. Demidont shared the American Sexual Health Association's definition of sexual health: "Sexual health is the ability to embrace and enjoy our sexuality throughout our lives. It is an important part of our physical and emotional health." Public health workers should develop their skills to accommodate their patients' and clients' sexual rights. When COVID-19 hit, there was an emphasis on only having sex with your primary partner, but that was not an effective public health response.

Dr. Demidont said socioeconomics and social justice is an important factor to keep in mind. Dr. Demidont expressed her belief that the Connecticut zip codes with the highest HIV prevalence are the same zip codes with the highest COVID-19 prevalence. It is hard for a white, cisgender person to go to those neighborhoods and understand what it is like to live there. Dr. Demidont said the first Getting to Zero (G2Z) Commission did a good job listening to communities. Unfortunately, because of COVID-19, everything was set back.

Dr. Demidont reported that between 500,000 to one million additional HIV deaths are expected worldwide this year. Resources were diverted and services were harder to access.

Most providers are not great at taking sexual health histories, so work-arounds may be necessary. A survey taken in May 2020 showed that many people's sexual behaviors changed during the first three months of the pandemic, as people had more sex partners and roughly one-third of people who had been on a pre-exposure prophylaxis (PrEP) regimen stopped (many because they thought they would stop having sex). People with lived experience in the LGBTQ population knew that for many in the LGBTQ population, being unable to work gave them more time to seek out sex partners. Many people with substance abuse disorders reported relapse, as 12-step groups had no way to meet and COVID resulted in trauma and triggering for many people. The job of public health workers is to know which communities will be vulnerable. The importance of taking thorough sexual health histories is greater now because of what has happened during the pandemic.

Dr. Demidont stated that service providers should not be the "HIV police" or the "COVID police," but rather should meet people where they are. Stigma exists for everyone – it is the fuel that fires the HIV epidemic. De-stigmatizing sex and HIV and the de-medicalization of sexual health will help. At-home testing can help to counterbalance the impact of stigma. De-stigmatizing sexual health can be done by making sure people know they have the right to have pleasurable sex, and that getting an STI is not a punishment. Connecticut's five-year plan should promote gender-neutral language and not label people in terms of sexual orientation. Anal and oral STI screens given to men who have sex with men (MSM) should also be given to heterosexual cisgender women. Providers should: a) not use gender language; b) talk properly about genitalia; c) take a social justice approach; and d) ask people with lived experience about how to approach communities with which they are unfamiliar.

Mr. Gennaro thanked Dr. Demidont for an informative and relevant presentation.

CHPC PRESENTATION #2: STATUS-NEUTRAL HIV TESTING AND TREATMENT

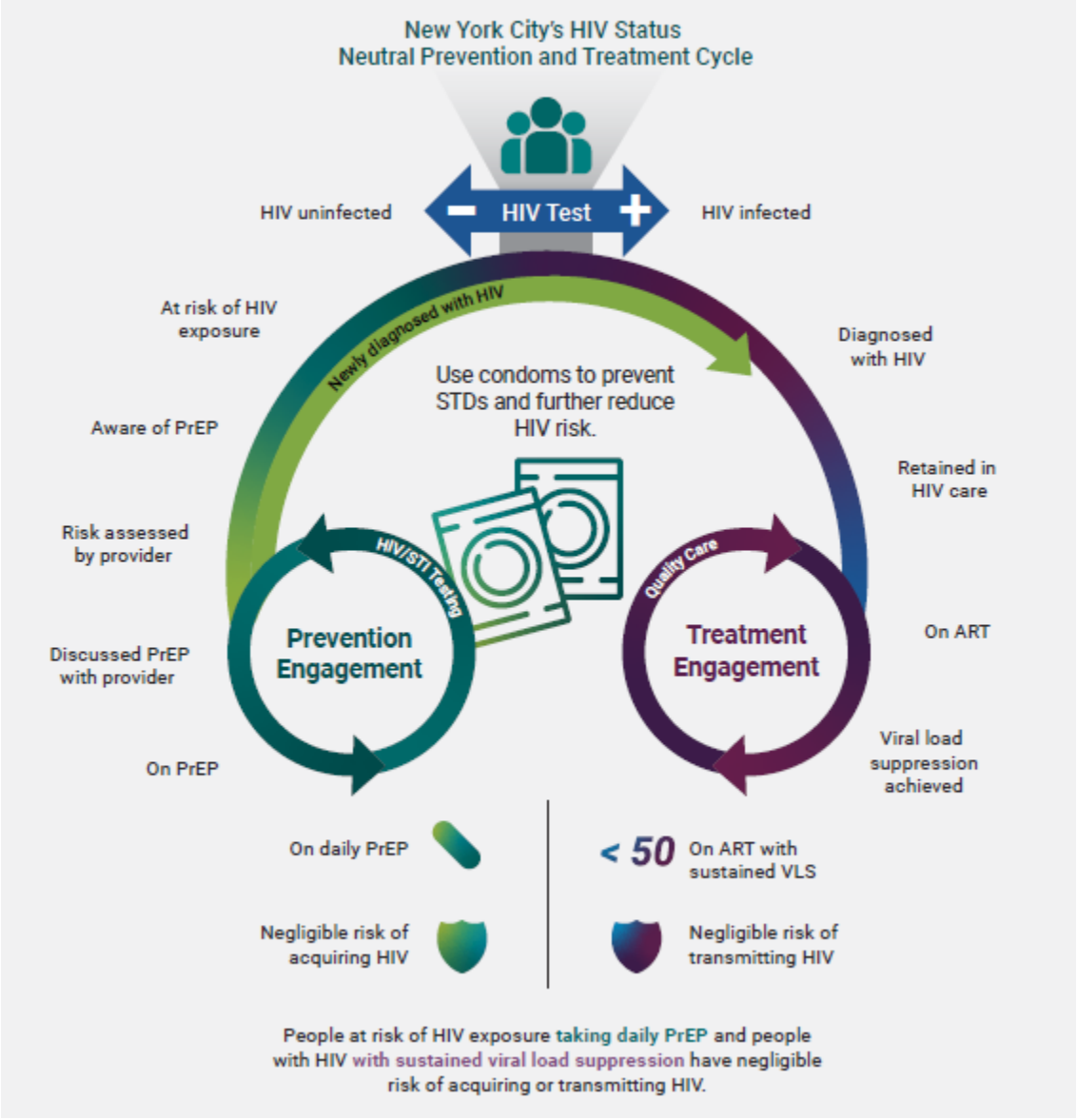
Mr. Gennaro introduced Oscar Mairena, HIV Community Liaison for Gilead Sciences in the Bronx, New York, who works along the continuums of prevention and treatment to help end the HIV epidemic in New York City.

Mr. Mairena said that incorporating status-neutral care is a recommendation of the *HIV National Strategic Plan* for 2021-2025. The Strategic Plan lays out care options for before sex (PrEP medication), during sex (condoms), and after sex (post-exposure prophylaxis (PEP) and Treatment as Prevention). It is important to talk about both the treatment and prevention sides of the continuum.

Mr. Mairena showed disparities in HIV care among various populations, as well as barriers across the HIV care continuum. Individuals clinically indicated for PrEP are defined as "at-risk." Although there is no way to measure how many new infections are prevented by this model, it is still important to include that goal in the framework. There are ways to measure "in care," "lapsed," and "viral suppression" (undetectable viral load). The continuum does not look the same for everyone, as some populations are disproportionately impacted.

Mr. Mairena said that, to provide status-neutral HIV care, service providers must use an approach that incorporates cultural humility, is anti-stigma and anti-racist, and treats the whole person. The new federal *Ending the HIV Epidemic: A Plan for America* has new goals and includes global programs and fast-track cities.

Mr. Mairena walked the group through the HIV status-neutral care continuum (shown below), which is based on offering services regardless of a person's HIV status.[1]



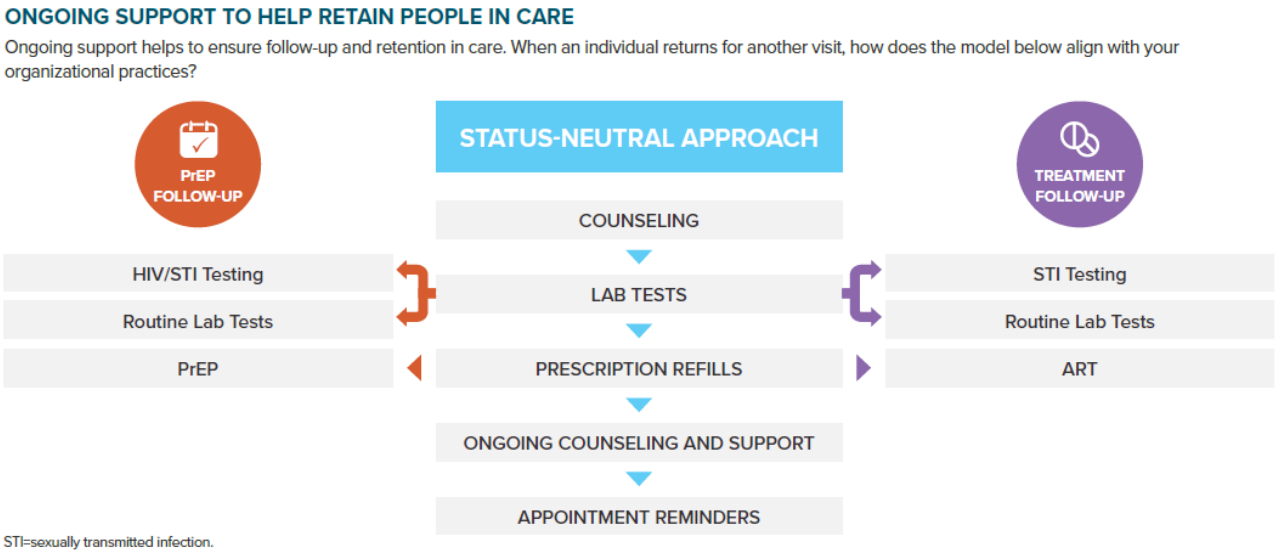
This process starts with HIV testing as a funnel into the continuum, with people offered two paths depending on the outcome of the test: a treatment path for PLWH and a prevention path for people at-risk for HIV, with both sides of the continuum addressed. It is now known that PrEP has up to a 99% reduction in HIV risk from sex and a 74-79% reduction in HIV risk from injection drug use (IDU) (although there is no federally-approved product for reducing IDU risk, this data point is important to know). Research shows that it is important to get people on PrEP when they are in front of a service provider, because many people can get lost in the

[1] Page 28 of the *HIV National Strategic Plan* for 2021-2025. Adapted from Myers et al. Redefining prevention and care: A status-neutral approach to HIV. Open Forum Infect Dis. 2018;5(6):ofy097.doi:10.1093/ofid/ofy097

service system. On the treatment side, the benefits of rapid initiation are known, and it is recommended to get people into treatment after a reactive HIV test rather than waiting for a positive test.

Mr. Mairena discussed the transformation of the New York City (NYC) delivery system using the status-neutral model. NYC went from having STI clinics that only treated STIs (referring out HIV cases and those taking PrEP) to offering treatment to anyone with an HIV reactive test and starting PrEP the same day for anyone identified as high-risk and saying they want PrEP. STI clinics were re-branded as sexual health clinics. Because sexual health encompasses more than STI and HIV prevention, they also rolled out expanded reproductive health services. They promoted more sex-positive messages, because how we message sexual health services is important. The NYC peach emoji was used in messaging campaigns to promote safer, consensual, pleasurable sex. During the first year of implementation of the status-neutral model, 4,700 people were counseled on PrEP. 1,771 people initiated PrEP over the first two years, with 58% of those initiating being Black or Latinx. Over 2,000 people initiated PEP services during the first two years. When providers offer services to everyone, they stop weeding people out based on their own perceptions.

Mr. Mairena explained that building a status-neutral protocol starts by offering people the same services, beginning with testing and ongoing support. Mr. Mairena shared a list of questions for agencies to ask themselves when evaluating the readiness of their intake and re-evaluation process. The CDC recommends testing everyone ages 13-64 at least once as part of routine healthcare. For those with specific risk factors, the CDC recommends annual testing, at minimum. Mr. Mairena presented a framework for ongoing patient support under a status-neutral approach (diagram below), including continuing to test PLWH for STIs because they are still at risk from having sex.



Individuals from any organization who were interested in learning more about the status-neutral approach or how to implement this approach in various service delivery settings could contact Mr. Mairena for additional information.

Mr. Walters thanked Mr. Mairena for the presentation and asked him and Dr. Demidont questions from meeting participants:

- *Question:* How do you convince private suburban primary care doctors who see a variety of patients to adopt these approaches, as many feel they are too busy to stop and ask questions or feel a patient's sexual behavior is none of their business.
- *Answer:* Mr. Mairena responded that this approach being included in the national strategy makes it easier to engage local, non-traditional partners in conversations. This is another tool to present to those types of doctors. Private clinician offices with no HIV programs are often the most challenging to engage, because they do not operate like clinics do.
- *Answer:* Dr. Demidont suggested adopting routine testing laws in Connecticut and performance measures for HIV testing, noting that reimbursement being linked to testing and follow-up has driven improvements in other states and with other health conditions.
- Mr. Walters stated that Connecticut Senate Bill 400 bill is proposing at least annual testing. The language in the bill is modeled after New York City's approach.
- Mr. Mairena offered to share resources, including sexual health discussion starters and activities to think about client flow from arrival to follow-up.
- Mr. Walters said a sexual history app would be great. Mr. Mairena referred the group to healthysexuals.com.

OTHER BUSINESS

Mr. Walters invited any CHPC members or public participants to introduce any other business.

- Mr. Gennaro reported that Positive Prevention CT is looking for individuals with lived experiences to participate in a new messaging campaign aimed to combat stigma.
- Venesha Heron (via the chat box) announced that CT DPH is still accepting participation in the In-home Test initiative, so any agencies wanting to start the self-test program should email Venesha.heron@ct.gov to get kits.

ADJOURNMENT

Mr. Walters encouraged all participants to complete a 1-minute survey to share any feedback on how to improve virtual CHPC meetings. The survey can be accessed by scanning a QR code on the slide or by clicking a link in an email sent to all participants after the meeting. Mr. Walters thanked everyone for a productive meeting, and adjourned the meeting at 10:54 a.m.

CHPC ATTENDANCE RECORDS *(1 = present; 0 = absent; arriving late is counted as an absence for official records)*

First Name	Last Name	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Victor	Acevedo	1	1								
Melanie	Alvarez	1	1								
Laura	Aponte	1	0								
Erma	Benedetto	1	1								
Thomas	Butcher	1	1								
Gigi	Chaux	1	1								
Brian	Datcher	1	1								
Xavier	Day	1	1								
Martina	De La Cruz	1	1								
Natalie	DuMont	1	1								
Taylor	Edelmann	0	1								
Stephen	Feathers	1	1								
Nilda	Fernandez	1	1								
Carl	Ferris	1	1								
Jose	Figueroa	0	0								
Dante	Gennaro	1	1								
Tawana	Guadarrama	1	1								
Cynthia	Hall	0	1								
Marcelin	Joseph	1	1								
Reggie	Knox	1	1								
Ronald	Lee	1	1								
Debra	Lombardo	1	1								
Luis	Martinez	0	0								
Waleska	Mercado*	-	-								
Mitchell	Namias	1	1								
Peta-Gaye	Nembhard	1	1								
Clara	O'Quinn	0	1								
Bob	Sideleau	1	1								
Jeffrey	Snell	0	1								
Roberta	Stewart	1	1								
Barry	Walters	1	1								
	TOTAL	24	27								
	PERCENTAGE	80%	90%								

*On leave while CHPC meetings are virtual

PUBLIC PARTICIPANTS (*1 = present)*

Name	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Alford, Claudia	1									
Jean Brown		1								
Buchelli, Marianne	1	1								
Cole, Christopher	1									
Croasdale-Mills, Angelique	1	1								
Cruz, Ginger	1									
D'Angelo, Gina	1	1								
Karina Danvers		1								
Davidson, Daniel	1									
Del Vecchio, Christina	1	1								
Demidont, A.C.	1	1								
Diaz, Luis	1	1								
Dones-Mendez, Dulce	1	1								
Floyd, Letrell	1									
Gowell, James	1									
Henriquez, Wanda	1									
Heron, Venesha	1	1								
Hong, Grace	1	1								
Hulton, Daniel	1	1								
Doug Janssen		1								
Jean-Baptiste, Clunie	1	1								
Jones, Coley	1	1								
Pat Kelly		1								
Kenny, Will	1									
Kominske, Angela	1									
Kotey, Dionne	1	1								
Linardos, Heather	1									
Maria Lorenzo		1								
Magaña, Luis	1	1								
Major, Susan	1	1								
McDavid, Kiana	1	1								
McMullen, Fran	1									
Mitchell, Gabrielle	1									
Kelly Moore		1								
Oscar Mairena		1								
Moranino, Marlene	1	1								
Erika Mott		1								
Muñoz, Consuelo	1	1								
N, Joe	1									
Novis, Steve	1									
Ostapoff, Michael	1	1								
Pawlow, Dustin	1	1								
Pierre-Louis, Luje	1	1								
Quettant, Francesca	1									
R, Rich	1									
Ramos, Alyssa	1									
Rodriguez-Santana, Ramón	1	1								
Romanik, Christine	1	1								
Ruiz, Angel	1	1								
Salazar, Juan	1									
Smith, Khelsey	1	1								
Speers, Sue	1	1								
Cecil Tengatenga		1								

Name	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Thuillier, Antoinette	1									
Vargas, Jennifer	1	1								
Vazques-Yopp, Melinda	1	1								
Velez, Idiana	1	1								
Warren-Dias, Danielle	1	1								
Wimbish, Roselyn	1	1								
Unidentified participants	8	4								
TOTAL COUNT	**58**	**44**								