Ending the Syndemic (ETS) Committee

Meeting Summary 18 May 2022

Date:	18 May 2022	**Start Time:**	11:02 a.m.	**End Time:**	12:27 p.m.
Chair:	Roberta Stewart	**DPH Liaison:**	Gina D'Angelo	**Location:**	Zoom
Attendees:	Refer to page 7	**Recorder:**	Mark Nickel		

RESULTS

1. The committee approved by consensus with no changes the April 2022 meeting summary.
2. The committee received an update on routine HIV testing legislation and discussed next steps to support implementation – including developing campaigns, resources, and tool kits.
3. The committee received an update on the State Department of Public Health (DPH) Syndemic Partner Group that assembles to address system-level issues and barriers relevant to implementing ETS strategies and priority activities (i.e., hub model).
4. The committee began to build services and activities and identify barriers and challenges relevant to standing up a hub model. The committee identified (preliminary) roles/responsibilities across different groups.

ACTION ITEMS

1. Mark Nickel will draft a meeting summary. Participants will review the draft meeting summary and will provide any additions or corrections.
2. Barry Walters will reach out to A Place to Nourish your Health (APNH) colleagues about the AIDS resource line.
3. Gina D'Angelo will share information with the DPH Syndemic Partner Group.
4. Mark Nickel will add Alixe Dittmore to the ETS invite list.
5. The committee will assemble in June to advance discussion around the hub strategy across the epidemics or syndemic.

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CALL TO ORDER, WELCOME & INTRODUCTIONS

Chair Roberta Stewart called to order the meeting at 11:02 a.m. Roberta used a roll call process to allow participants to make brief self-introductions. Roberta briefly described the charge of the committee.

UPDATES FROM THE COMMITTEE CHAIR

Roberta asked Barry Walters to share the latest information about the routine HIV testing legislation.

- Barry stated that the initial bill was integrated into HB 5500, a general implementer bill that addresses regular matters relevant to DPH. The next step in the process involves the Governor signing the legislation. The date of enactment will be 1 October 2022 with a practical implementation for 1 January 2023.
- Barry stated that the CHPC committees must get organized to support implementation. This includes increasing awareness, building information and resources for providers, and even increasing the amount of education for providers and medical professionals.
- Gina D'Angelo stated that the ETS Committee and DPH had begun assembling information and resources used in other states that encourage or offer routine HIV testing. Gina explained that she also assembled the historical timeline of changes in HIV testing laws in Connecticut. This could be

reformatted to provide context to different audiences. She encouraged the group to reach out to providers in Connecticut that currently offer routine HIV testing and assemble information on their best practices and even billing codes.

- The group discussed how ETS could be involved in reviewing the tool kit and resources, how Positive Prevention Connecticut (PPCT) has been asked to develop messaging campaigns, and how the AIDS Education and Training Center (AETC) can play a role in provider education. Gina shared some information about how Community Health Centers (CHC) perform routine HIV testing and how the results differ by population groups. For example, routine HIV testing does not occur as robustly in the younger populations.
- Roberta pointed out that resources may vary by setting and also by type of test (e.g., point of contact, blood test).
- Alixe Dittmore stated that the Connecticut Harm Reduction Coalition places an emphasis on sharing information and fact sheets and supporting access to important resources through a variety of methods that range from products to non-traditional hours. Individuals need support that may not be medical in nature when learning about a diagnosis. Also, healthcare providers need to know available resources that can help their patients.
- Roberta stated that the hub model identified routine HIV testing and supports as core services and will help providers access services for their patients.
- Barry stated that the hub model responds directly to an area of push-back that occurred during the initial conversations about routine HIV testing – how providers access support for patients after conducting the tests – including follow-up and case finding and care coordination.
- Barry shared that he was involved in another bill involving endometriosis because it was another example of something that remains undiagnosed because of lack of screening. A holistic approach to screening makes sense across multiple chronic and infectious diseases.
- Gina stated that sometimes the nuances of these routine HIV testing processes must be reviewed. For example, with MyChart, patients can sometimes see test results before receiving a call from their healthcare provider. Adjusting the process to include a human touch may make a significant difference.
- Sam Cutaia suggested starting with the endpoint of Undetectable=Untransmittable (U=U) and then reverse engineering the messaging back into the diagnosis to better understand the customer journey.
- Gina stated that DPH had resources available to help produce tool kits and resource materials.

Roberta thanked everyone for sharing their input and stated that the discussion and the movement of the routine HIV testing legislation reinforces the need for and relevance of the hub model.

CONSENSUS APPROVAL OF PRIOR MEETING SUMMARY

The committee approved by consensus the April 2022 meeting summary with no additional changes or corrections.

COORDINATING ENDING THE HIV EPIDEMIC ACTIVITIES

Roberta provided context about the committee's consensus to recommend a hub model and how it approached multiple prevention, care, equity, and coordination goals of the statewide integrated HIV plan. She stated that the ETS will continue to explore the "operational" environment necessary to produce

success, and to share insights with the Syndemic Partner Group led by DPH so they can address policy, system, and structural barriers.

Roberta asked members to share any additional reflections about the hub model recommendation (after having one month to think about this strategy):

- Gina expressed that the hub approach must emphasize all areas of the syndemic, must look at the whole person, and must connect to all resources relevant to the syndemic. Gina thanked Ava for encouraging the group to do more in the area of STIs. Gina felt that resource and tool kits for providers will play an important role in the next 6 months.
- Natalie DuMont agreed that the tool kits should offer a life span approach and interweave SDOH. She explained that young adults may not have access to education on prevention for components of the Syndemic. Also, anytime information can be made available from a trusted source with less stigma creates a more positive experience. She also recommended incorporating CLAS standards – including content for individuals at intellectually appropriate levels.
- Roberta agreed that language matters and must be affirming. This must be addressed in the tool kits, in the campaigns, and in the provider training.
- Multiple individuals stated that the hub approach must include screenings across all syndemic areas and also appropriate tests/screens (e.g., swabs in three places).
- Barry stated that STI language was removed from the routine HIV testing legislation. However, no reason exists to reduce the emphasis on STI screening and testing.
    - The discussion touched upon multi-panel tests across areas of the syndemic. These multi-panel tests exist and are expensive ($140 per person).
    - A discussion occurred on the lack of funding and U.S. Federal Drug Administration (FDA) approval for some swab tests that use self-collection. A.C. stated that some organizations allow self-collection. She stated that not allowing transgender persons to self-collect will result in significant gaps. It took the FDA 10+ years for approval for anybody extra-genitally.
    - Roberta stated this is an example of a system issue that the syndemic partner group must address. Other pilot projects and other cities/states have supported similar efforts.
    - Gina cautioned the group that DPH must adhere to legislative and policy guidelines – including FDA and any laws in place in Connecticut. She stated a clinic was temporarily shut down because it was not in compliance with the FDA requirements. No patients were harmed. More testing options must be available. More funding must be available. More syringe services program (SSP) services must be offered. More persons with lived experience must be engaged in the process.
- Roberta stated that Alex Garbera was not able to attend the meeting and had some comments and questions about the hub model. Specifically:
    - Alex encouraged the ETS to make Treatment as Prevention more visible. He encouraged the CHPC consider adding a goal or measurable objective focus on reducing community viral load (vs. focusing on individual issues or even SDOH). He stated that the plan must focus on systemic

and structural changes that address barriers and challenges documented by research and needs assessments.

Roberta asked individuals to share any findings from the homework assignment of researching the (statewide) AIDS resource line from 20+ years ago:

- Gina canvassed her former colleagues at the Northwest Connecticut AIDS Project. Their process was to use a 1-800 number connected to beepers and an "on-call" schedule. It was not connected to a statewide process.
- Barry stated that he would check with his colleagues as APNH (Nick, Frank).

Roberta stated that the design of this hub must be accessible and provide some type of filtering to help people make those personal connections (i.e., could be virtual, regional, and/or local) and ultimately local connections (i.e., ease of access). If it is not easy to navigate, then people will not use it. She asked the group to share their ideas or thoughts on how this hub should work. Gina then stated that this discussion will help inform what work the ETS Committee does vs. what work the Syndemic Partner Group does.

- Barry agreed that, in the digital era, the hub should offer an affordable solution and even an app with quick-reference tools to direct people to the next step.
- Roberta stated:
  - No single funder supports a comprehensive hub model across all areas of syndemic focus.
  - A structural shift is underway with DPH Ryan White Part B and Ryan White Part A to organize services in regional networks. Perhaps prevention can do the same.
- Gina stated that the hub solution must focus on addressing disparities in health outcomes in persons who are not in the RW-funded care system. These patients have better health outcomes.
- Roberta stated that solutions must be connected to a sustainable business model – which may mean identifying community-based organizations that can deliver services that can be reimbursed by third-party providers.
- Sam suggested focusing on reducing barriers to access that result in other similar disease states, and these solutions could be bundled which would create even more cost savings.
- Dustin Pawlow stated that some disease conditions connect to more funding or more resources such as is the case with Ryan White Part A and HIV. One simple solution is to make certain anyone who can be enrolled in RW services should be enrolled. This may be a provider education issue.
- Roberta agreed that RW clients can access more services. The question becomes how to replicate the hub approach for non-RW patients using a self-sustainable business model and connections to local providers.
- Marie Raynor stated that a mechanism must exist to share best practices across RW parts and also with primary medical settings. Also, we need to figure out how to sequence the services to create the best experience and the best possible health outcomes. Helping RW patients get healthy and increase their income (and shifting them to Medicaid or other insurance) will allow RW resources to serve other people in need. We also need to do a better job of training providers about available resources.
- Roberta stated that it appears the conversation keeps re-centering on a combination of hub services and tool kits/resources for providers plus a short list of issues for the Syndemic Partner Group.
- Roberta stated that funding silos continue to be an issue. For example, Medicaid will reimburse for

housing case management only if you are a Department of Mental Health and Addiction Services (DMHAS)-funded housing provider. Also, Connecticut still does not reimburse for Community Health Workers who could perform these tasks and be reimbursed by a third-party payer.

- Gina suggested that reimbursement codes and processes could be part of a tool kit. Marie agreed.
- Reggie Knox stated that the hub model must offer stigma-free services or it will not work well.
- Kelly Moore shared that Yale New Haven Hospital uses multiple protocols and checklists. She would check with her colleagues to see if they would be willing to share them as best practice examples.
- Sam asked whether RW funds could be used in any way to support non-HIV testing in areas relevant to the syndemic.
    - Gina stated that a person must be HIV positive to be eligible for RW-funded services. However, this would be a natural connection to the hub resources.
    - Roberta stated this is part of the Treatment as Prevention approach Alex pointed out with his comment from earlier in the meeting.
- Kelly stated that connections between providers are critical for prevention and secondary prevention.
- Venesha reminded the group that all partners must incorporate a status-neutral approach.
- Gina and Roberta stated that, depending on the type of setting and the type of test, activities such as screenings could occur during wait times for test results.
    - Barry stated that CHC offers short educational videos in its waiting room lobbies about the benefits of routine testing.

Roberta and Gina summarized the discussion by "sorting" the types of ideas, activities, accelerators, and barriers into different categories. The table (page 7) illustrates how different groups will support standing up this model.

- A.C. reminded the group that this might feel like a "re-cycled" conversation that has occurred many times over the past decades. However, persistence has begun to erode the barriers. We are making progress.

OTHER BUSINESS

- Alixe requested being added to the meeting appointment and e-mail list for the ETS: adittmore@ct-hra.org. Mark stated that he would complete this request.

NEXT STEPS / MEETING FEEDBACK

Participants felt the meeting was productive in uncovering strategies and activities. The group will meet virtually in June.

ADJOURN

Roberta adjourned the meeting at 12:27 p.m.

Hub Model: Preliminary list of Issues, Ideas, and Services	Education & Awareness – Public (PPCT)	Education & Training Providers (AETC)	Provider Tool Kit & Resources	Hub Services (ETS)	Structural, System & Policy (DPH Syndemic Partners)
General public awareness campaign	X		X		
General awareness campaign for providers	X	X	X		
Provider education on status-neutral care approach & care standards (all screening and testing)		X	X		
Patient-centric videos on issues	X		X		
Provider-centric videos on responsibilities		X	X		
Best practices for billing codes / reimbursement		X	X		
Best practices for testing and linkage to care (by setting)		X	X		
Case finding services (DIS integration)				X	
General help desk / help line for patients and providers				X	
Expedite access to screening / testing (include at-home, mobile)				X	
Counseling and testing				X	
Rapid start treatment options				X	
Medication access (short supply)				X	
Interim care coordination				X	
Access to insurance coverage options				X	
Emergency supports (e.g., transportation, child care)				X	
Longer-term care coordination (non-RW patients)				X	
Referrals to community resources – SDOH (Unite Us)				X	
Navigation services (e.g., PrEP, other chronic diseases)				X	
Use of shared referral platform such as Unite Us			X	X	
Integrated approach to funding hubs					X
Policy change for CHW reimbursement by Medicaid					X
Policy change/waiver for housing case management reimbursement by Medicaid (not just DMHAS-approved providers)					X
Funds for access to integrated syndemic testing panels					X
Contract-required syndemic training & professional development					X
Contract-required syndemic screening / referrals					X
Changes in data collection systems to support sharing					X
Changes in roles/responsibilities of DIS workers to support or enhance hub service menu					X
Contract requirement around use of any common or shared referral platform such as Unite Us					X
Changes in policies to facilitate access to medications for rapid-start treatment (prevention or treatment)					X
Changes in data sharing to facilitate real-time, rapid response to hotspots across syndemic areas					X

ATTENDANCE

Name	CHPC Member	1/19	2/16	3/16	4/20	5/18			
E. Benedetto	Yes	x	x		x	x			
M. Bond		x							
T. Butcher	Yes	x	x						
G. Chaux	Yes			X					
C. Cole		x							
A. Cumberbatch				X	x	x			
S. Cutaia				X		x			
G. D'Angelo		x	x	X	x	x			
A.C. Demidont		x			x	x			
A. Dittmore						X			
N. DuMont	Yes	x	x	X	x	x			
L. Ferraro		x	x	X	x				
T. Gaines			x						
A. Garbera			x						
D. Gosselin				x	x				
L. Hunt				x	x	x			
V. Heron			x	x		x			
L. Irizarry	Yes	x							
M. Joseph	Yes	x	x	x					
W. Knox	Yes		x		x	x			
A. McGuire			x						
K. Moore		x		x	x	x			
A. Nepaul						x			
J. Norton		x	x						
D. Pawlow		x	x		x	x			
R. Radicchio		x		x					
B. Reyes				x	x				
M. Raynor						x			
C. Rodriguez			x		x				
J. Sapero		x	x	x	x				
R. Stewart	Yes	x	x	x	x	x			
J. Vargas		x	x	x	x	x			
Y. Velez		x							
B. Walters	Yes	x	x	x		x			
D. Warren-Dias		x	x	x	x				
	TOTAL	20	19	18	17	17			