Connecticut HIV Planning Consortium

May 20, 2020 Meeting Summary

*****This is the "pending approval" version of the meeting summary. It contains additions and corrections from individuals who participated at the 20 May 2020 meeting******

CHPC Members will vote virtually on or before Friday 12 June 2020 @ 5:00 p.m. The CHPC Co-Chairs will announce the voting results at the 17 June 2020 meeting.

E-mail: gooding@xsector.com or call 203.605.2968

Voting options: ***Yes, No, or Abstain*** *(not in attendance or did not respond to the vote).*

Location:	Virtual GoToMeeting		
Date:	May 20, 2020	**Recorder:**	Michael Nogelo / Dave Bechtel
Start Time:	9:30 a.m.	**End Time:**	10:45 a.m.
Presiding Chairs:	Gina D'Angelo, Blaise Gilchrist, Barry Walters		
Attendance:	See last page for roster of CHPC members and public participants		

MEETING AT A GLANCE

- CHPC members held the first ever virtual CHPC meeting.
- CHPC Co-Chairs: a) shared insights about how the CHPC and committees intend to adjust to virtual meetings, and b) recognized the level of innovation ongoing in the communities.
- CHPC participants reviewed the term health equity.
- CHPC committees conducted virtual meetings from 11:00 a.m. to 12 noon.
- CHPC participants learned about COVID-19 and HIV from Dr. Onyema Ogbuagu.

CALL TO ORDER, MOMENT OF SILENCE, AND INTRODUCTIONS

CHPC Co-Chair Gina D'Angelo called to order the Connecticut HIV Planning Consortium (CHPC) at 9:30 a.m. and introduced Co-Chairs Blaise Gilchrist and Barry Walters. Ms. D'Angelo noted that she would place all participants on mute to increase the quality of the meeting environment, particularly for those who were joining by audio only. Ms. D'Angelo explained that a question box exists for those who joined the meeting via computer or tablet. Use the question box to share information or ask questions. The practice question to encourage use of and practice with the question function was, "what do you do for self-care during the COVID-19 stay-at home period?"

Ms. D'Angelo welcomed participants to the first virtual meeting conducted by the CHPC. Ms. D'Angelo explained that the meeting agenda has been modified from the typical, in-person CHPC meeting that starts at 9:30 a.m. and ends at 2:00 p.m. This meeting will be approximately one hour long with the majority of the time allocated to a subject matter expert on COVID-19 and HIV. The CHPC meeting will not include introductions, review of meeting summaries, or public announcements. The Executive Committee will be discussing potential options to complete those tasks in a virtual environment. Committee meetings will start at approximately 11:00 a.m., meet for one hour, and focus on one primary agenda topic.

Mr. Walters 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 who are living and affected by HIV/AIDS connect to

services. CHPC is responsible for developing and implementing a statewide integrated HIV prevention and care plan to End the HIV Epidemic. The plan spans the timeframe of 2017 to 2021. The plan places an emphasis on addressing health disparities and inequities so prevalent in HIV.

Mr. Walters led the participants in a moment of silence to honor all of those persons living with HIV and their families, friends, and caregiving/support networks.

CHPC LEADERSHIP ANNOUNCEMENTS

Each CHPC Co-Chair spoke briefly about gratitude and the changing context of HIV and CHPC planning work as a result of COVID-19.

- Ms. D'Angelo offered gratitude to the front-line workers and family members who are taking care of each other, and spoke briefly about efforts by individuals staffing the Command Center at the Department of Public Health. CHPC meetings will continue in virtual formats for the foreseeable future. CHPC and committees will continue to follow their work plans. The CHPC info share process has been used daily to share important updates on changes to services. The HIV Funders Group has and will continue to meet virtually, follow its work plan, and share best practices on how to support innovation. Ms. D'Angelo shared some examples of innovations to service delivery including distribution of HIV home test kits, telemedicine to engage persons living with HIV who were out of care, and loosening of restrictions in areas such as emergency financial assistance.

- Mr. Walters shared appreciation for persons living with HIV and their family members, friends, and support systems – including the HIV prevention and care community. Mr. Walters shared insights from the perspective of a community-based nonprofit about the challenges and rewards of operating in a COVID-19 pandemic. Mr. Walters describe higher participation in virtual support groups, increased uptake of HIV home testing, higher activity in social media, and efforts to engage and reach out to individuals who may not be comfortable using technology.

- Mr. Gilchrist focused his comments on CHPC members and partners, and expressed gratitude for all of the adjustments necessary to delivery services and to check in with staff members and clients. Mr. Gilchrist stated that the HIV community has much to offer and represents a valuable public health asset in terms of knowledge, skills, abilities, and community connections.

PATH TO OUR VISION KNOWLEDGE BUILD: HEALTH EQUITY

The focus of the Path to Our Vision segment builds a common understanding of an important term that has become highly visible during the COVID-19 pandemic, and always relevant to the HIV epidemic: Health Equity. Health equity means that every person has a fair and just opportunity to be as healthy as possible. This may include significant changes to the landscape and/or increasing accessibility to high quality and appropriate services, education, resources, and

Image of Equality (left) and Equity

jobs. Achieving health equity means removing obstacles to health such as poverty and discrimination, and the consequences of poverty and discrimination such as lack of access to: a) good jobs with fair pay; b) quality education; c) housing; d) safe environments; and e) health care.

Ms. D'Angelo noted that people sometimes confuse the terms equality and equity. Equality sounds fair (and does not account for outcomes). Equity is fair. The COVID-19 pandemic has been increasing the visibility of health equity issues. These very same issues will affect our ability to Get to Zero and End the HIV Epidemic.

VOTE: MEETING SUMMARY (*NOT on agenda*)

The virtual meeting agenda did not include an item for review and approval of the February CHPC meeting summary. The CHPC Co-Chairs stated their intention to discuss options with the Executive Committee with respect to approving meeting summaries using a remote voting process. The CHPC will approve February and May meeting summaries using this remote meeting process.

ANNOUNCEMENTS (*NOT on agenda*)

The virtual meeting agenda did not include an item for announcements. The CHPC Co-Chairs stated their intention to discuss options with the Executive Committee with respect to soliciting announcements to share at the meeting. All participants can continue to forward event announcements to Ms. D'Angelo for distribution to the CHPC contact list.

COMMITTEE MEETINGS (Virtual meetings held separately)

Committee Updates. Mr. D'Angelo described the CHPC committee structure, explained that virtual committee meetings will begin at 11:00 a.m., and that each committee chair has adjusted the agenda to include one priority discussion topic that can be accomplished in one hour or less. The committees will not approve meeting summaries this month. Access information to committee meetings can be found on the CHPC website in case someone needs the information. Committee Chairs will share progress at the Executive Committee.

The table below shows a summary of the focus of the committee work for February 2020 (last in-person meeting) and May 2020 (first virtual meeting)

Committee	Focus of the Committee Work	
	February 2020	**May 2020**
Ad Hoc Prevention	• New Haven capacity building grant update • Review inputs from CHPC G2Z activity (Jan)	• Ending the HIV Epidemic framework and guidance to structure the statewide integrated HIV plan • G2Z implementation updates
Membership & Awareness	• Review draft newsletter • Input on "Request the Test" concepts and how MAC supports G2Z messaging	• Review special issue of the News and Notes • Address membership related matters (e.g., attendance, participation)

Committee	Focus of the Committee Work	
	February 2020	May 2020
Needs Assessment Projects	• Using the HIV workforce data to build recommendations for professional development	• Review info graphic from HIV workforce survey and revise workforce development recommendations
Quality & Performance Measures	• Partner services presentation • Revising the progress indicators handout	• PrEP presentation and discussion
Executive	• Review meeting feedback • Committee work plan coordination • March CHPC meeting agenda	• Review and improve virtual meeting experience • Discuss adjustments to operational protocols for virtual environment

CHPC PRESENTATION: COVID-19 AND HIV

Ms. D'Angelo introduced Dr. Onyema Ogbuagu ("Dr. O"), an Associate Professor of Medicine, in the clinician-educator track and Director of Yale AIDS Program Clinical Trials program of the Section of Infectious Diseases of the Yale School of Medicine. Dr. O educates and trains medical students, residents and infectious diseases fellows in various capacities in inpatient and outpatient settings; and through structured course work and other teaching sessions. Dr. O makes significant contributions around the world. For example, for the past 6 years, Dr. O has been on the faculty of the Human Resources for Health program in Rwanda. As the program director of World Bank and HRSA-funded efforts supporting the Liberia College of Physicians and Surgeons (LCPS)–run Internal medicine residency training program, Dr. O oversaw the selection and deployment of faculty to Liberia. More recently, Dr. O has become involved in HIV prevention research for high risk individuals who are engaged in PrEP services.

Dr. O discussed the following themes about COVID-19 and HIV.

- The media places much emphasis on extremes such as mortality and testing. Remember that the majority of people with COVID-19 survive, including those with HIV, elderly, and people with other co-morbidities. Researchers and physicians must always work to relieve symptoms and any suffering.
- Approximately 20% of COVID-19 cases experience severe enough symptoms that they present to hospital. One unknown is how many people are asymptomatic or felt a little ill and it went away. However, community surveillance studies using antibodies tend to surprise everyone with the prevalence of antibodies among community members. For example, a recent study in New York found 20% with antibodies (or who were exposed to COVID-19).
- Nothing distinguishes the way COVID-19 presents. Fever is the top symptom with 90% recording high fevers. Cough and shortness of breath occur in about 30-40% of people. About 10% have other symptoms including a loss of taste or smell and/or other gastro-intestinal tract symptoms such as nausea, vomiting, or diarrhea.

- It is important to remember, however, that access to testing and to healthcare influences the information. For example, even with 90% of patients reporting a high fever, only 30% of patients hospitalized in New York and were hospitalized had experienced a fever. If you believe you are symptomatic in any way, start the process to get a COVID-19 test.
- People living with HIV and managing their health properly do not seem to have worse outcomes from COVID-19. Coronaviruses are not new. Looking historically at SARS, HIV patients did not seem to have worse outcomes. However, it is important to understand the impact of other factors that may be prevalent among people living with HIV.
- Large data sets from other countries such as Brazil, China, Italy, and the U.S. do not report any statistically significant increase in hospitalization rates or mortality for persons living with HIV. Age is a clear risk factor for death - with rates close to 0% among children under 5 and approximately 20% of people over 80. Gender is a predictor. Obesity, lung disease and smoking are risk factors. Therefore, persons living with HIV with other comorbidities and/or who have low CD4 counts should proceed with caution. That said, when taking these co-morbidities into account, HIV patients have no different mortality outcomes.
- Recovery for COVID-19 patients appears to occur over a 2- to 3-week duration. Those who require hospitalization have very predictable disease progression, and may experience symptoms for up to 6 weeks. Sometimes, fevers have lasted for up to two weeks. A small proportion of COVID-19 patients experience hospital stays of 4 to 5 weeks. Some people will experience complications – just like any other situation. This might be in the form of a blood clot or children with toxic syndrome symptoms. Again, this will occur in most every situation to a small percentage of individuals.
- No FDA approved treatment exists for COVID-19. Hydroxychloroquine (HCQ) has received media attention. This is not an approved treatment and has recently been taken off of treatment lists because of side effects. Other drug trials involving Remdesivir appear promising. For example, one study showed quicker recovery and lower death rates for people taking Remdesivir – not statistically significant but numerically significant. A second study with 5-day treatment shows encouraging results. Emergency use authorization exists for use of Remdesivir for people with severe symptoms. This emergency use authorization should not be confused with FDA approval. Over 200 clinical trials for various treatments are underway with a fast-pace race to identify more compounds that work.
- Vaccines typically take years between testing and various phases of study and producing enough for everyone. A significant amount of effort has been placed on fast tracking a vaccine. This means scientists weaken the virus and introduce the weakened form into the body. The body generates an immune response to the weakened virus that then protects the body over time. An interesting candidate appears to be Moderna. Moderna uses messenger RNA to signal your own body to produce virus-like protein that sends message to immune system to attack it. This would be the first mRNA vaccine ever, and might explain the attention it has received.
- Until a vaccine or FDA approved treatment exists, it will be important that people understand how to and actually behave to protect themselves.
    - Use physical distance.
    - Wash your hands; it's better than using hand sanitizer.

- Disinfect surfaces, doorknobs, and electrical devices.
- Wearing masks help protect "us" from "you" when you are sick. Data on masks remains weak.
- Persons living with HIV: take your medication to stay virally suppressed. Manage the other aspects of your health including any co-morbid conditions.

Dr. O opened the floor for questions. The following paragraphs summarize the **Q** (question) and the **A** (answer) information

Q: *Is the lower infection rate due to HIV medications they are on?*

A: We know there is a lower infection rate, but clinical trials are exploring if HIV meds can lower infection rates. Some meds show activity against virus in the lab.

Q: *Is demand for Hydroxychloroquine (HCQ) making it harder for people who really need it to get it?*

A: Haven't heard of shortages of supply in US, but indiscriminate use of HCQ can create shortages. This is not an FDA approved treatment for COVID-19.

Q: *Any data about outcomes of COVID-19 for people living with AIDS?*

A: Most people with COVID reported have had undetectable or controlled virus. A few people with low CD4 counts also tended to do quite well. Waiting for data from Africa, where more individuals live with low CD4 counts.

Q: *Have you heard more about kidney damage and failure as a result of COVID-19 (or its treatments)?*

A: Small minority of people who have kidney injury. Hydration can help some, but small minority may have kidney injury requiring dialysis or other treatment.

Q: *Can you discuss and/or confirm the fact that COVID is detected in semen and can it be transmitted this way?*

A: Many tests use genetic tests to confirm the presence of COVID in fecal matter or semen. However, this does not confirm that the virus can be transmitted in these ways. Sex is not seen as a major method of transmission for COVID-19; more data will be forthcoming.

Q: *Why is there such a disparity among brown and black folks? Why is hospitalization seen as a sign of progress?*

A: Everyone was asking why Africa didn't have more cases. US experience has debunked that. Minorities (black, Hispanic, native) are getting hit harder. COVID-19 is the new poster child for health inequities.

Q: *Can a vaccine that creates a response to the spike protein create a situation where body attacks viable proteins?*

A: Can have unintended side effects; this is not an area of expertise for Dr. O. Also could have cross-protection.

Q: *Any evidence that is impacts black and brown people differently?*

A: Some issues around ace receptor and how it's expressed or how many are in body; did not find impact. Unaware of any genetic basis for racial differences in infection or outcomes.

Q: *Once you get it, can you get it again?*

A: Jury remains out. Some people have tested positive, then negative, then positive again. We don't know how long-lasting antibodies are. Will learn more.

Q: *If symptoms have cleared, does that mean you are cured?*

A: Don't need a repeat swab to make sure virus is gone. In most people, virus tends to peak 7-10 days after infection and in about 2 weeks, virus tends to go down. Clinical symptoms often outlast virus being detectable. 2 stages – virus and then immune response to the virus. Narrow circumstances in which you need to do 2nd test to do proof of cure.

Q: *Talk more about long-term implication on people's organ and aerosol sprays on respiratory systems*.

A: From first countries that experienced waves, people are describing persistent lung issues. Feared complication is acute respiratory distress syndrome (ARDS). If you had blood clot or stroke, you may need long-term treatment.

Ms. D'Angelo thanked Dr. O for his sharing his time, knowledge, and insights with the CHPC, and for all of the contributions Dr. O continues to make to the field both locally and globally.

OTHER BUSINESS (*NOT on agenda*)

The virtual meeting agenda did not include an item for other business. CHPC Co-Chairs and staff monitored the question box throughout the webinar to identify any other business topics raised by meeting participants.

ADJOURNMENT

Mr. Gilchrist reminded all participants that they would receive an online link to a 1-minute feedback survey. Please fill out this survey and also share any feedback you have on how to improve the virtual CHPC meetings. Mr. Gilchrist thanked everyone for a productive and highly energetic meeting, and adjourned the meeting at 10:45 a.m.

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

* = Attendance not officially marked as an absence due to circumstances affecting capacity and availability to participate during COVID-19 pandemic.

First Name	Last Name	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Victor	Acevedo	1	1			*			
Laura	Aponte	1	1			1			
Susan	Bouffard	1	1			1			
Thomas	Butcher	1	1			*			
Angelique	Croasdale-Mills	1	1			1			
Gina	D'Angelo	1	1			1			
Brian	Datcher	1	1			1			
Xavier	Day	1	1			1			
Stephen	Feathers	0	1			1			
Nilda	Fernandez	0	1			1			
Carl	Ferris	1	1			1			
Jose	Figueroa	0	0			*			
Lauren	Gau	1	1			1			
Dante	Gennaro	1	1			1			
Corey	Gerena	1	0			1			
Blaise	Gilchrist	1	0			1			
Cynthia	Hall	1	1			*			
Reggie	Knox	1	1			1			
Ronald	Lee	1	1			*			
Luis	Magana	0	0			*			
Luis	Martinez	0	1			1			
Waleska	Mercado	0	1			*			
Mitchell	Namias	1	1			1			
Clara	O'Quinn	1	1			1			
Bob	Sideleau	1	1			1			
Jeffrey	Snell	1	1			1			
Roberta	Stewart	1	1			1			
Barry	Walters	1	1			1			
	TOTAL	22	24			21			
	PERCENTAGE	79%	86%			N/A			

PUBLIC PARTICIPANTS (*1 = present)*

Name	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Alvarez, Melanie		1			1			
Barlow, Cinque	1							
Bartlette, Beasha					1			
Batson, Clifford	1	1						
Binford, Monique		1						
Blaschinski, Ellen	1							
Boone, Joyce	1	1						
Bowens, Samuel		1						
Brown, Jean					1			
Buchelli, Marianne	1	1			1			
Burns, Sara		1			1			
Carbonell, Carlos	1							
Castro, Christian	1							
Cataquet, Jimmy		1						
Chung, Latasha		1						
Ciborowski, Lauren	1							
Clark, Belinda		1						
Colbert, David		1						
Cordero, Reina	1	1						
Cruz, Johanna					1			
Danvers, Karina					1			
Davidson, Daniel	1	1			1			
Davidson, Megan	1	1						
DeJesus, Emely		1						
De La Cruz, Martina	1	1			1			
Del Vecchio, Christina	1	1			1			
Delgado, Sabrina					1			
Demidont, A.C.		1						
Diaz, Luis		1			1			
Diaz, Mildred		1						
Dones-Mendez, Dulce	1							
Dunbar, Wanda		1						
Edelmann, Taylor		1			1			
Ferraro, Linda		1						
Francis, Shannon					1			
Gardner, Brittany	1	1						
Gibson, Lynette	1				1			
Gonzalez, Monica		1						
Gosselin, Deborah		1			1			
Gowitzke, Elizabeth		1						
Hall, Shanay	1	1			1			
Heron, Venesha	1	1			1			
Hernandez, Juan	1							
Hulton, Daniel					1			
Jenkins, Heidi	1							
Jean-Baptiste, Clunie	1	1			1			
Jones, Coley	1							
Joseph, Marcelin	1	1						
Kelly, Abbie					1			
Kotey, Dionne	1	1						

Name	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Lane, Stuart		1						
Ligon, Barbara		1						
Linardos, Heather		1						
Lombardo, Debra	1	1						
Lorenzo, Maria		1						
Mairena, Oscar					1			
Major, Sue	1				1			
McAllistor, Keiva	1				1			
Millet Saez, Myrna					1			
Morgan, Nicole					1			
Moore, Kelly		1						
Morales, Fernando		1						
Moranino, Marlene	1							
Mott, Ericka		1						
Muñoz, Consuelo		1			1			
Muñoz, Kay		1						
Nembhard, Peta-Gaye	1	1			1			
Nieves, Maribel	1	1						
Novis, Steve		1			1			
Ogbuagu, Onyema					1			
Pigatt, Shaquille	1	1						
Pope-Wiggins, Lorrie	1	1						
Pulliam, Cedric					1			
Quettant, Francesca					1			
Quintero, Eduardemar		1			1			
Robertson, Jackie		1						
Rodriguez-Santana, Ramon	1	1			1			
Rodriguez, Joselyn		1						
Rodriguez, Rosie	1							
Rosa, William		1						
Rose-Daniels, DeLita	1	1			1			
Ruiz, Angel		1			1			
Sauza, Ben		1						
Speers, Sue	1				1			
Thuillier, Antoinette					1			
Torres, Abigail		1						
Vargas, Jennifer								
Velez, Idiana		1						
Velez, Yolanda	1							
Warren-Dias, Danielle	1	1			1			
Yopp, Melinda					1			
[name not legible]		1						
TOTAL COUNT	**38**	**59**			**40**			