**Date** March 20, 2019

**Location** Chrysalis Center - Hartford, CT **Time** 12:35 p.m. – 1: 45 p.m.

**Attendance**  See team summaries for roster of CHPC members and public participants.

**Welcome**

DAC members moved directly into their team meetings after lunch, at roughly 12:35 p.m.

**Team Meeting Accomplishments**

The DAC participants assembled directly into two teams [Needs Assessment Projects (NAP) and Quality Performance Measures (QPM)] and did not meet as a full DAC group. Each team:

* Completed tasks as described in the first page of the meeting summaries for each team (page 2 and page 6).

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* Identified next steps and tasks for completion prior to the April 2019 DAC meeting.

**Other Business**

No other business was introduced at the team meetings.

**Adjournment**

Team meetings adjourned at or before approximately 1: 45 p.m.

**Meeting Notes**

**Participants:** Shakira Acevedo, Clifford Batson, Susan Bouffard, David Colbert, Tamara Corley, Daniel Davidson, Dulce Dones-Mendez, Taylor Edelmann, Deborah Gosselin, Daniel Hulton, Clunie Jean-Baptiste, Katie Laviero, Heather Linardos, Sarah Macone, Luis Magaña, Susan Major, Erin Malgioglio, Angel Medina, Mukhtar Mohamed, Consuelo Muñoz, Peta-Gaye Nembhard, Hilary Norcia, Jackie Robertson, Hector Rosa, Noemi Soto, Sue Speers, Roberta Stewart, Danielle Warren-Dias

**Facilitator:** Nilda Fernandez  **Recorder:** Dave Bechtel

**Meeting Accomplishments:**

The team accomplished the following tasks:

* **STD Data Presentation**. Mukhtar Mohamed shared data on trends in gonorrhea and chlamydia infections. The team decided to revisit the selection of its STD indicator at the April QPM meeting.
* **Trends in HIV Risk Factors Presentation**. Sue Speers presented data on trends in HIV risk factors, with particular emphasis on HIV infection via injection drugs. The team discussed other connections to the opioid crisis (e.g., high-risk heterosexual contact via the sex trade) and Connecticut’s ongoing efforts to identify emerging clusters.
* **Quality Summit**. Dave Bechtel provided a brief update on planning for the summit. The Quality Summit workgroup held its first conference call on March 13th and revised the initial plan for the summit (see Handout 3 for details).

**Identified Tasks:**

1. All team members will consider presenting a relevant improvement project at the Quality Summit, and/or recruiting presenters among their colleagues.
2. Noemi Soto will email Dave Bechtel the housing brief mentioned at the meeting.
3. The Quality Summit workgroup will continue planning the summit (the next conference to be scheduled).
4. CHPC staff will email Handouts 1 and 2 to the team.

**Welcome**

Given time constraints, Dave Bechtel gave a brief welcome and reviewed the agenda for the meeting.

**Gonorrhea and Chlamydia in Connecticut, 2013 – 2017**

Mukhtar Mohamed presented trends in gonorrhea and chlamydia infection rates from 2013 through 2017. QPM selected infection rates for young people ages 13-24 as a performance measure in 2018, and reviewed baseline data in order to set a goal for 2021.

Mr. Mohamed discussed the increasing infection rates for both STDs, including the increasing (and very high) infection rates among people ages 13 to 24. Mr. Mohamed noted that this was part of nationwide trend. (See Handout 1 for details.)

Susan Bouffard asked why the infection rates were increasing? Mr. Mohamed stated that some of the increase could stem from different screening tests that are now being used, which can detect more cases. Danielle Warren-Dias stated that males are getting screened for chlamydia more often, which could also contribute to increased infection rates.

Hector Rosa asked if increased infection rates could be linked to PrEP, where people stop practicing safe sex after starting PrEP. It would be interesting to see data that linked STDs and PrEP. Sue Major stated that their current data systems do not include who is on PrEP, so DPH (Connecticut Department of Public Health) is not able to connect PrEP with STD data. Ms. Warren-Dias noted that early studies on PreP and STDs found no correlation with unsafe sex, but more recent studies have indicated a rise in STDs with use of PrEP. Roberta Stewart stated that PrEP requires regular testing for STDs, so it may result in more detection of STDs, rather than a change in risk behaviors.

Ms. Stewart asked why QPM was not looking at syphilis? [Note that QPM selected gonorrhea and chlamydia at its July 2018 meeting; the meeting notes did include details on why syphilis was not also included.]

Nilda Fernandez asked the team what goals to set for 2021 for gonorrhea and chlamydia? Daniel Davidson suggested the team **reconsider using infection rates as our measure**, given the uncertainty about what is causing the increase. If higher infection rates are the result of increased testing (and better tests), this may be a good thing (i.e., we are identifying a higher percentage of the actual STD cases). Testing can also provide opportunities to educate people about PrEP and HIV. Ms. Warren-Dias asked if QPM can use **STD treatment as a measure**? An effective strategy is partner notification and getting partners treated.

Ms. Major stated that DPH does know if people who test positive are being treated, but does not have data on whether partners are being treated. DPH also does not collect data on all STD tests, so this would also be difficult to track. DPH does have data on tests at DPH-funded sites. Heather Linardos stated that DPH is trying to get data on negative HIV tests.

Tamara Corley stated that given the high infection rates for young people, **interventions needs to start in school**. What can DPH do to work with schools and school-based health clinics? Ms. Major noted the challenge with local control of schools; prevention efforts vary from district to district. Ms. Corley suggested focusing efforts in the five Getting To Zero cities. Ms. Fernandez described a past grant where they visited with the Stop AIDS Mobile Theater and did screenings. They found a 10% positivity rate for STDs and these schools saw an increase in utilization of their school-based-health clinics after these events (through increased awareness).

Ms. Corley asked how we can reduce the infection rate given challenges working in schools? Ms. Warren-Dias noted that gonorrhea was a major problem in the 1970s. Over 20 years, the infection rate was reduced by over 70% by **treating the partners** of those infected. It’s basically PrEP for STDs; that needs to be the standard of care. If we act now (while the number of gonorrhea cases is relatively low), we can address the problem. Ms. Major noted that the state does partner therapy, but that this is not included in their database.

Mr. Bechtel suggested that given time constraints, the team continue this conversation at the April meeting.

**Trends in HIV Risk Factors, 2013 – 2017**

Sue Speers presented data on trends in HIV risk factors, with detailed data on PWID (persons who inject drugs). DPH can use a statistical program to impute the risk factors where data is not available. The number of cases where the risk factor is known is slightly lower than the data presented on the first two data slides.

There has been a slight increase in newly diagnosed HIV in PWID, including a spike in new infections among people ages 25-34 in 2017. Ms. Speers noted that overall, the numbers are still low, and are approximately 9% of all newly diagnosed from 2013-2017. (See Handout 2 for details.)

Ms. Speers also described how the HIV Surveillance Program monitors trends in transmission categories, in order to identify any outbreaks or emerging clusters of infections that are unexpected. Ms. Speers and Mr. Mohamed run monthly reports to identify emerging clusters including PWID. If they identify a potential outbreak, they will work with DIS (Disease Intervention Specialists) and potentially with the CDC (Centers for Disease Control) to investigate and (if needed) address the outbreak. Ms. Speers mentioned a recent outbreak in Lowell, MA where the CDC was engaged.

Ms. Stewart suggested a potential risk among older PLWH (people living with HIV) who are not virally suppressed and inject drugs. They could potentially infect a cluster of people. Sue Speers noted that DPH website with [HIV surveillance data](https://portal.ct.gov/DPH/AIDS--Chronic-Diseases/Surveillance/Connecticut-HIV-Statistics) includes data on viral suppression among PLWH by risk factor. Ms. Speers stated that in her analyses of the data, she has not seen this is an issue to date.

Ms. Warren-Dias stated that it’s important to also look at MSM (men who have sex with men) and HRH (high-risk heterosexual) transmission in connection with the opioid crisis. Infections from the sex trade may be connected to opioids (i.e., the need to earn money for drugs). Her agency is seeing more white youth from the suburbs with heterosexual transmission. This may be related to opioids. Increased involvement with the sex trade can affect STDs as well. Ms. Speers stated that their monthly surveillance looks at all risk factors, so would identify clusters related to HRH and MSM.

Noemi Soto asked if DPH generates a list of clusters? Ms. Warren-Dias asked if DPH looks at infections by genotype to identify clusters of the same strain of HIV. Ms. Speers stated that they do look at molecular clusters and time-space clusters. Looking for an increase in numbers of cases is standard practice for most infectious diseases.

Ms. Soto asked if the system identifies the cluster or could people in the field also identify a potential outbreak? Ms. Speers stated that it could be at either level. DPH looks at the data and a DIS worker might also notice a cluster and alert DPH. Ms. Linardos stated that Connecticut has been fortunate that there have not been any outbreaks like those in Massachusetts. But DPH must be careful if there is a spike to make sure it is not just random variation over time. They do not want to raise a false alarm if there is not a real outbreak. We want to direct resources only if the analysis is good.

Mr. Bechtel asked if there were differences in how Massachusetts and Connecticut address the opioid crisis? Ms. Major stated that Massachusetts does not have a state-funded Syringe Services Program (SSP); individual cities may dedicate funds to SSPs. Overall, Connecticut seems to have a more robust system, which may account for differences to date.

Mr. Rosa stated that some states have safe zones for PWID. Ms. Warren-Dias agreed that it is important to set up safe zones. A bathroom can be set up to be safe (e.g., door open outward vs. inward) and that processes can be put in place for safe use (e.g., calling to person every few minutes). This could be a quality improvement project.

**Quality Summit Update**

Mr. Bechtel provided a brief overview on planning for the summit. The Quality Summit workgroup held its first conference call on March 13th and revised the initial plan for the summit. The summit will be on September 18 at the Chrysalis Center. The workgroup has identified potential topics and activities (see Handout 3 for details). Workgroup members are reaching out to potential presenters – including the National Quality Centers, housing providers, and consumers participating on Quality Management teams. Mr. Bechtel also encouraged team members to consider presenting a relevant improvement project – potentially as part of a best practice carousel – and to recruit potential presenters among their colleagues.

Ms. Soto described a housing meeting she attended in connection with the North Central Regional Mental Health Board. This all-CAC (Catchment Area Council) meeting was held in January and featured 211, DHMAS (Department of Mental Health and Addiction Services), and Journey Home among others. They described the state housing picture and changes in homelessness definitions. To be considered homeless, a person needs to be living outside with no place to stay. If a person is doubled up, they are considered “housing insecure.” Ms. Soto will share the housing brief from the meeting, so this information can be included at the summit.

**Meeting Summary Approval**

Ms. Fernandez asked participants to review the February 2019 QPM team meeting summary. In February, Gina D’Angelo shared themes from the Getting To Zero listening sessions, Angelique Croasdale-Mills presented on the CareWare Disparities Project, and the team discussed next steps in planning a Quality Summit.

The team approved the meeting summary without changes.

**Adjourn:**

Ms. Fernandez thanked everyone for their participation. The meeting adjourned at 1:45 pm.

**##End QPM Notes##**

 **MEETING SUMMARY**

 **Date:** March 20, 2019 **Location:** Chrysalis Center (Hartford, CT)

**Start Time:**  12:43 p.m. **End Time:** 1:45 p.m.

**Participants:** Page 3 shows attendance

**Chair:** Barry Walters **Recorders:** Emily Jablonski, Mark Nickel

**Meeting Accomplishments**

* Participants approved by consensus the February 2019 meeting summary.
* CHPC members were encouraged to apply for the open leadership position of NAP Team chair.
* Participants provided input into a preliminary methodology to conduct focus groups as a follow-up to the 2018 statewide needs assessment survey of PLWH (in care).

**Welcome & Introductions**

Mr. Barry Walters (NAP Team chair) welcomed participants to the meeting and asked everyone to introduce themselves by name and organizational affiliation or town. Mr. Walters emphasized the important of creating an environment of acceptance and respect, and organizing the discussion to produce results. Mr. Walters described the NAP Team: a) completes special projects such as needs assessments, focus groups, or briefing papers that help the CHPC develop its plan and achieve its goals; and b) uses a consensus model of decision-making (not voting) to include all voices and perspectives – including public participants in the process. Mr. Walters previewed the meeting agenda and reinforced the importance of making progress on focus group design.

**Review of February 2019 Meeting Summary**

Participants reviewed the February 2019 summary and approved it by consensus with no additions or corrections.

**Needs Assessment Focus Group Design**

Mr. Walters reviewed progress to date on the focus group development from the prior meeting as well as additional design input provided by the CHPC co-chairs to better align and coordinate the process with the approach used to complete the G2Z listening sessions. The G2Z listening session results and recommendations were reviewed during the morning presentation at the CHPC. The participants reviewed the progress to date on the design, refined the approach, and spent the largest proportion of time narrowing down the list of focus group topics to five and developing starter questions. Participants provided suggestions about how to frame questions in meaningful, unbiased ways, as well as ways that would minimize the triggers (for traumatic responses). The table below describes the methodology that emerged from the discussion:

| **Element** | **Description of Proposed Approach to Focus Group Element**  |
| --- | --- |
| ***Purpose*** | * Provide perspectives of 18 to 35 year old “in care” population (and preferably newly diagnosed). This qualitative information will help provide balance and context to the needs assessment results which contained a large proportion of respondents over the age of 50.
 |
| ***# of focus groups*** | * A minimum of three (3)
* Additional focus groups can occur based on findings
 |
| ***# participants*** | * Six (6) to 10 participants per group
* Anticipated reach of 18 to 30 participants from a minimum of three focus groups
 |
| ***Geographic location*** | * At least one (1) focus group in each of the “regions” represented in the needs assessment survey: 1) New Haven / Fairfield County EMA (New Haven or Fairfield Counties); 2) Hartford TGA (Hartford, Tolland or Middlesex Counties); and 3) Balance of the State (Litchfield, New London, or Windham Counties)
* Specific communities to be determined based on recruitment factors
 |
| ***Inclusion criteria*** | * PLWH who receive care from a Ryan White funded service
* 18 to 35 years old
* Preference for PLWH diagnosed on or after January 1, 2016
 |
| ***Incentives*** | * A meal (e.g., pizza) and beverages (e.g., water, soda)
* DPH may have available $10 gift cards from G2Z (incentives or for the meal/beverages)
 |
| ***Recruitment*** | * Final recruitment strategy will be developed with input from DPH, HIV Funders group, and providers willing to participate in the focus group process
* Membership and Awareness Committee (MAC) will assist in identifying names of groups and/or providers with strong programs for 18 to 35 year old PLWH
* DPH data team will run a query in CAREWare to identify the number of PLWH in care who meet the inclusion criteria and to identify the providers most likely affiliated with the individuals
 |
| ***Format*** | * Replicate the G2Z structured format
* One lead facilitator, most likely a CHPC leader (e.g., co-chair, committee co-chair)
* One recorder, most likely a CHPC staff person
* Time for introductions and the meal/beverages
* 10 to 12 minutes of discussion time per focus group topic
* Total time not to exceed 90 minutes
* Distribution of any incentives (if available) or other information
 |
| ***Topics / Questions***  | Focus groups will pursue at least (5) topics of which two (2) topics (denoted with an “\*”) represent G2Z topics. A six topic (housing security) was introduced for consideration and remains open for discussion. The list below shows the topics and the proposed questions to stimulate discussion. 1. Stigma\*
* In the past 30 days, have you felt stigmatized in any way? If yes, share an experience.
* How does stigma affect you and other PLWH living your community?
* What do you need to reduce stigma in your community?
1. Prevention education & PrEP\*
* Have you heard about PrEP? How did you hear about PrEP?
* What type of HIV prevention education services or resources exist in your community?
* What suggestions do you have to increase access in your community to HIV prevention education and PrEP?
1. Engagement in health services & HIV care
* In the past 6 months, have you seen a health provider for your HIV care?
* At the moment you were told of your HIV diagnosis, what, if anything, did the individual who told you do to help you feel supported? What, if anything, did this individual do that led to you feeling unsupported?
* What suggestions do you have to help newly diagnosed individuals engage in health services and feel supported? What role, if any, exists for peer support?
1. Communication & Information sharing
* In the past 30 days, did you seek out any information about HIV prevention or care? If yes, what is your “go-to” source for this type of information?
* How does information about HIV prevention and care services get shared in your community? What gaps exist that prevent you from accessing information in your community?
* What suggestions do you have to increase communication and information sharing about HIV prevention and care services in your community?
1. Mental Health
* In the past 30 days, have you felt sad, worried, stressed, or overwhelmed? Who do you turn to when you need help or support?
* What resources and gaps exist in your community related to addressing any mental health needs you may have?
* What suggestions do you have to increase access to mental health resources in your community?

6. Substance Use and Abuse * In the past 30 days, have you used any alcohol, tobacco, or drugs other than your prescribed medication?
* What resources and gaps exist in your community related to addressing substance use and abuse needs you may have?
* What suggestions do you have to increase access to substance abuse prevention and treatment resources in your community?

7. Housing Security *(Inclusion of this topic was explored and not decided upon)** In the past 30 days, where have you been living? Do you use more than 30% of your income to pay for housing? Do you think of your current housing situation as “stable”?
* What resources and gaps exist in your community related to housing?
* What suggestions do you have to increase access to housing supports in your community?

8. Other - Closing opportunity to share any additional information* What, if any, other thoughts would you like to share as we close out this discussion?
 |

**Next Steps**

* CHPC staff will work with the CHPC co-chairs and the DPH data team to finalize the needs assessment questions and methodology. Mr. Gennaro will provide additional input on the communication questions.
* NAP Team members will review the meeting notes and provide additional input at the April meeting (or by e-mail prior to the meeting).
* Mr. Walters and/or Ms. D’Angelo will update the HIV Funders Group on the proposed approach.
* CHPC staff will coordinate and communicate the approach with the Membership and Awareness Committee.

**Other Business**

Participants did not introduce any new or other business. Mr. Walters encouraged interested CHPC members to apply for the open leadership position as NAP Team chair.

**Feedback**

Mr. Walters thanked everyone for providing input and helping to complete the focus group design tasks. He asked participants to place any additional meeting feedback on the CHPC general meeting feedback form.

**Adjournment**

Mr. Walters adjourned the meeting at 1:45 p.m.

**Meeting Attendance**

Laura Aponte; Samuel Bowens; Reina Cordero; Dante Gennaro; Miguel Gonzalez; Cynthia Hall; Shanay Hall; Venesha Heron; Luis Irizarry; Barbara Ligon; Scott Lopriore; Andrea Lombard; Tatiana Melendez; Erick Burt Carrion Rivera; Jovany Rolon; Nadine Ruff; Jeffrey Snell; Pamela Studley; Barry Walters