Ending the Syndemic (ETS) Committee

Meeting Summary 20 April 2022

Date:	20 April 2022	**Start Time:**	11:01 a.m.	**End Time:**	12:30 p.m.
Chair:	Roberta Stewart	**DPH Liaison:**	Gina D'Angelo	**Location:**	Zoom
Attendees:	Refer to page 9	**Recorder:**	Mark Nickel		

RESULTS

1. The committee watched a short video on how to keep committee meetings productive.
2. The committee approved by consensus with no changes the March 2022 meeting summary.
3. The committee received an update on House Bill 5190 including its advancing out of committee.
4. The committee received an update on a new ETS partner group that will assemble regularly to address system-level issues and barriers relevant to implementing ETS strategies and priority activities.
5. The committee agreed by consensus to develop a recommendation for a (regional) hub strategy that could address priority issue areas (e.g., out-of-care, disparities in outcomes in private medical settings, concerns by Emergency Departments (EDs) to move forward with routine HIV testing).

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 as necessary to engage stakeholders in the House Bill 5190 process.
3. Gina D'Angelo stated that she will conduct due diligence research by reviewing her files and/or talking to individuals who may have information about the AIDS hotline. Danielle Warren Dias stated that she would do the same.
4. Other committee members should send their ideas or information on other models to committee staff (nickel@xsector.com).
5. The committee will assemble in May 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 11:01 a.m. She expressed gratitude and appreciation for the opportunity to lead this group at a very critical time. Roberta used a roll call process to allow participants to make brief self-introductions. Roberta briefly described the charge of the committee.

The Committee watched a short video reminder featuring CHPC Member Peta-Gaye Nembhard about how to create productive CHPC committee environments.

- Participants expressed that the message was well done and contained relevant points.
- Roberta stated that the group will continue to use its meeting etiquette as a guide and will develop a "parking lot" to keep track of discussion topics not specifically related to the agenda as needed.

UPDATES FROM THE COMMITTEE CHAIR

Roberta asked Gina D'Angelo to share an update on House Bill 5190 ("An Act Concerning Testing for HIV").

- House Bill 5190 advanced out of the Public Health Committee process with language revisions by sponsors of the bill. The approach will include routine HIV testing taking effect in January 2023 in all primary care settings and in January 2024 in Emergency Departments (EDs) and Hospitals. The additional year for EDs

and hospitals allows for the formation of a task force to work through some unresolved issues. Gina observed that the additional year for EDs and Hospitals creates an opportunity to work with them and create strategies and resources to educate providers and to establish connections to community resources.

- Multiple participants expressed enthusiasm and appreciation to all of the individuals supporting this process, especially Barry Walters.

CONSENSUS APPROVAL OF PRIOR MEETING SUMMARY

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

COORDINATING ENDING THE HIV EPIDEMIC ACTIVITIES

CT DPH update – Syndemic Coordination & Statewide STD Consortium

- Gina stated that the ETS partners met in March and will meet again next month. The participants will focus on conducting a "mini-SWOT" analysis focused on integrated testing.
- Gina shared an update on behalf of Hepatitis Coordinator Venesha Heron who was attending an out-of-state conference. CT DPH assembled a group of clinical providers as part of the kick-off process to develop a statewide Hepatitis Elimination Plan. The provider group will continue to meet on a quarterly basis and provide input, and the CT DPH will assemble a community-based group or opportunities for public input at a later point in this process.
    - Danielle Warren Dias asked how providers join the Viral Hepatitis Elimination Techincal Advisory Committee (VHETAC) process. Gina shared Venesha's e-mail: Venesha.heron@ct.gov.
- Linda Ferraro shared that the statewide STD Coalition planning process is in its early stages. Linda shared a screen shot of a logic model that outlines the planning process. Linda stated that in the next few months the emphasis will be on getting organized by assembling data, reaching out to potential coalition members, and preparing for a July kick-off meeting. This timing allows her to retire officially (in April) and return in the role of a project consultant for up to 6-months to assist the CT DPH in onboarding and transitioning her replacement into the role. Linda stated that Ava Nepaul will serve as the interim lead (ava.nepaul@ct.gov)

Other Partners

- No other partners reported on syndemic-related planning efforts or activities.

2022 – 2026 PLAN DEVELOPMENT

Roberta provided context for the group's role and responsibilities in developing strategies for the 2022-2026 Integrated HIV Plan. She and Gina shared a brief PowerPoint to set the stage for the specific discussion today focused on exploring the feasibility and interest by the committee for including a strategy that develops regional service hubs. Roberta and Gina shared a recent example of how this type of service hub already operates.

- APNH through its home HIV test kit program was notified of a positive result. APNH contacted the individual and learned that this person: a) was visiting friends in the Hartford region; b) was NOT a Connecticut resident; c) would be leaving Connecticut soon; and d) wanted a confirmatory lab test + a rapid start medication as HIV care is not well coordinated in their country of origin.
- APNH (located in New Haven) contacted the RW Part A Office (Hartford Health Department) to coordinate access to care in the context of these circumstances. Together, the APNH and RW Part A Office: a) connected this person to a clinic; b) the provider completed the confirmatory lab test; and c) the provider

began rapid start therapy and medication to go. APNH and the RW Part A Office continued to check in with the individual throughout.

- Roberta and Gina reiterated that this was a true story that happened in April 2022. Much can be learned from this story: a) the process resulted in a confirmatory test and start of treatment within 72 hours; b) the process involved providers across the state who relied on informal protocols and existing relationships; c) the providers shared a sense of trust and urgency to help this individual; and d) the process met the patient where s/he was at – including asking the individual what they needed at that moment.

Roberta stated that the story represents exactly what this committee had started to explore: strengthening the connections between partners/providers within a region and across the state for the benefit of the patients and to create support and find solutions for providers (e.g., private medical settings, EDs) who may encounter an individual with a positive HIV test and who are not familiar with the extensive, existing resource network. Roberta and Gina challenged the group to explore: a) could and should this type of response be the new normal for the system of care – including for individuals out of care or to improve health outcomes among persons with

HIV (PWH) treated by non-Ryan White providers? b) could the committee see a shared vision for a HUB that expedites services? and c) what changes and barriers exist to this type of approach?

Roberta and Gina shared a visual of this hub approach and its potential functions.

Hub to support diverse settings

- Maximize existing resources across the "ecosystem" and make it "easier" for patients and providers
- Create pathways to "expedite" access to (trusted) services
- Provides supports (e.g., transportation, connection to insurance) to help referrals access services
- Provides "temporary" coordination until a connection can be made
- Provides connection to special functions (e.g., DIS case finding and partner notifications)
- Applies prevention and care expertise most relevant to the field

The content below captures the themes of the discussion:

- Gina stated that an approach like this creates a solution to help PWH who receive services outside of the Ryan White Care System and HIV prevention network. Data tells us that we need to focus on this segment of PWH. This approach can also be applied across the programs in CT's syndemic (HIV, STI, Hepatitis and SUD.)
- Danielle stated that many years ago, a statewide AIDS hotline existed and served a similar purpose. Initially, every service request went through this hotline which "brokered" the process and connected patients to hospitals.
    - Roberta observed that in that model, a call center was used. She stated that the hub approach might include a call center, a help desk, or some type of online notification systems that alerts relevant staff that an action is needed.
    - Roberta also stated that the technology logistics such as getting a telephone number or an online presence represents the easy part. We will need to work through patient confidentiality a release of

information processes in a manner that address the different needs of all partners/providers. Some of this work has already been done at the local level.

  - Gina observed that these are the types of agreements and protocols that the EDs will need to develop to implement routine HIV testing.

- Danielle suggested using the historical model as if it were a baseline model.
- Linda asked for clarification about who was using the hotline: patients, providers, or both?
  - Several individuals shared experiences that indicated it was providers using the hotline to access services for their patients.
  - Some individuals stated that this process was occurring prior to the digital revolution in which phones and faxes were the primary form of communication.
  - Kelly Moore and Carlos Rodriguez stated that it sounds like the 211 system which now offers enhanced services and/or in some instances specialty services for certain customers. They suggested modernizing the concept or even exploring a partnership with 211.
  - Several individuals wrote in the chat box that 211 did not and does not work for PWH.
- Roberta shared that many communities, in an effort to address social determinants of health, are moving to a shared referral system / platform such as Unite Us. This type of process uses standardized release forms and uniform protocols to share information and connect clients to other resources in the community.
- AC Demidont cautioned individuals that research shows call centers may not be the most effective way to engage clients. AC encouraged the group to protect the human touch and involve a Disease Intervention Specialist (DIS) or a case manager in person as well as through other methods such as Zoom.
- Linda stated the concept of organizing one-stop services physically or virtually for patients and providers is the gold standard. This was the way many STI clinics at local health departments were organizing services. It was working. Unfortunately, many of these clinics have or are closing.
  - Roberta stated the one stop service menu would benefit EDs and providers in private medical settings who needed these types of services.
  - AC stated that acute care providers such as urgent care centers are expanding their reach. Connections should be made to these centers as well. These entities do not necessarily perceive themselves as a primary care site but more as a point of service.
  - Gina agreed with ACs observation, especially as more providers begin to “offer” HIV and other testing.
  - Linda stated that urgent care centers are not licensed separately unless they offer comprehensive services that include IV administration of medication; most of these centers fall under the license of an existing provider. This makes it difficult for DIS workers to connect with their patients. This also translates to lower reporting compliance with the CT DPH.
  - AC stated that urgent care centers needed a uniform and strict protocol.
  - Linda stated that CT DPH does not have the influence to instate protocols for private providers. CT DPH can only provide recommendations or suggestions.
  - Gina stated that a group of ED physicians have been and will continue to discuss this issue as it relates to ED settings and perhaps a similar process could work for urgent care centers.

Roberta reminded the group that the committee is developing recommended strategies. It does not need to develop detailed solutions right now. The recommendation could require multiple years – including time for

funders to adjust their contracts that affect providers who might be involved in this type of process. The group continued on with its discussion.

- Roberta stated that the AETC could assist in training providers about routine HIV and other testing and about the resources available through a hub approach. It should be a value-add or benefit that providers can make one contact to a hub to help their patients get what they need and to provide a warm transition.
- Several participants noted that the funders support various navigators, case managers, and other positions such as DIS that represent the core staffing required for such a services.
    - The services could address out-of-care.
    - The services could help support newly diagnosed.
    - The services could create a "soft landing" for any patient because these teams would be able to meet the patient where they are at with personal support and with medical/medication access.
- Natalie DuMont shared that regions look very different in terms of service capacity and needs. She suggested organizing hubs by region. This would also match up to the way DMHAS and other state-level services get organized. She shared that the hub or regional approach can be effective because community partnerships and collaboration is key to effective implementation. People who live and work in the community are aware of the gaps, needs, and barriers in their communities and tend to know what works best for the community or geographical area.
- Linda shared that this model reflects an "enhanced" approach to DIS or involves DIS as a core service. DIS are often limited in the types of services that they can currently deliver. For example, DIS cannot deliver case management services and DIS workers get involved only in confirmed cases.
    - Roberta stated that the first priority is to get these individuals to a soft-landing spot and then connect them with the appropriate menu of services in partnership with the individual. DIS workers may take responsibility or leadership on a specific subset of people. Or, perhaps as part of the plan, the role and responsibilities (and protocols) for DIS workers may be adjusted to fit the strategy. Or, maybe a new type of DIS worker gets introduced that is specific to the hub approach and has the data permissions to support any type of work. All of this can be worked out over time.
    - Gina agreed that a "DIS-like" position could be developed. It might require a policy change or contract changes. These are things that can potentially be changed and the ETS Partner's group should examine.
    - Linda stated that the Community Health Workers (CHWs) might fit somewhere in this approach, especially if the CHWs can generate third party reimbursement.
- Dustin Pawlow shared that some important lessons learned exist from prior efforts to engage DIS workers with out-of-care patients. CT DPH workers did have authorization to navigate around HIPAA and represented some of the most innovative patient-oriented public health specialists. We must also consider when a patient has a bad experience with a doctor, decides not to return to the care setting, and cuts themselves off from all services. DIS "work for the patient" and support finding a solution that fits the patients' needs and concerns. This might include facilitating access to labs, connecting to DSS services, or even connecting them to other healthcare providers to address issues such as diabetes or cancer. The point

is that "navigation" support is different than a one stop shop. It seems like this type of model needs to offer both types of services.

Roberta stated the hub represents the point of "exchange or soft landing" and the connection point to a DIS or navigator or case manager – or whatever job title exists, with the intent to learn what the patient needs and help them access the best fit services available to them.

- Danielle shared that not every provider will use the hub because some providers may have systems already in place.
- Gina stated that the hub model might look different in each region based on the needs by EDs or private medical settings. For example, ED physicians stated that routine HIV testing was not the limiting factor to implementation. They did not want to do a rapid test while treating potentially life-threatening injuries or while the patient and family where possibly in a vulnerable situation. Delivering a positive HIV diagnosis in these circumstances proves challenging. Also, would it be the case that a hub model would be available 24/7 to take these calls and respond immediately (in the context of that 20-minute rapid test and result)? Gina stated that the blood work may actually create a pathway to use the hub network to follow up with a patient and offer support. Some urgent care centers do point of care testing and blood work. It would be up to hospitals to decide what testing modality is used and how to fit it into their workflow.
- AC stated that the biggest issue from public health standpoint relates to getting PWH on medication and other individuals on PrEP. This hub model needs to place an emphasis on access to medication – including immediate supplies in prescriber settings or access to medication vouchers (as a bridge if someone does not yet have insurance) and navigation assistance to get this medication and support adherence. In New York City, health department physicians can write a prescription for a month of medication. The hub should have this type of feature and function.
- Roberta shared that a similar model already exists for a community-based model by EDs to facilitate access to suboxone. ED doctors give a 3-day supply of medication to the patient and connect them with a community provider. The provider then connects them to services that include access to additional medication. The 3-day window creates a sense of urgency for the patient and providers to develop a plan.
- Carolos shared that the approach must be integrated across epidemics. He shared a story of a patient who had gone to the ED for a rash and flu like symptoms. The individual was tested only for COVID. Finally, a blood draw revealed positive results for syphilis and HIV. The patient was discharged before the results were shared. DIS worked for two years to find this individual. The new process cannot allow these patients to get lost. We need to connect them to care, especially if they have already engaged in care.
- Gina shared that people on medication assisted treatment for recovery often received a larger supply of medication during COVID 19. The earlier example of the case study with APNH involved a person who was not a resident of the United States, and this person was given sufficient medication in case it was difficult to access medication. We are already solving these types of problems. We need to bring all of these possible

solutions into a hub approach that can allow a small team within a region to quickly and efficiently connect out-of-care or newly diagnosed with services.

- Roberta stated that the hub could also include a connection to CADAP or possibly some innovations with CADAP to help get people immediate access to medication.
- Carlos reiterated that patients need to be routinely tested for STIs, HIV and hepatitis. He shared stories of patients who had classic symptoms of STIs and were not tested.
- AC stated that an education and awareness campaign should occur to reduce the notion that it is difficult to conduct an HIV test or to support a newly diagnosed PWH. It is stigmatizing and not inclusive medical care.
- Roberta pointed out that the conversation at some point involves addressing stigma and provider comfort level with these topics. A hub approach configured with a sensitive and culturally relevant team who can connect individuals with similar providers can make a significant difference.

Roberta asked the committee to come to a preliminary consensus recommendation with developing a recommendation to organize hubs or soft-landing spaces that benefit patients and providers.

- Everyone agreed to move forward in developing this recommendation.
- Gina loved the idea of creating a soft-landing space for patients and for providers.

Roberta then asked the committee to consider whether this hub strategy would apply to the other areas of focus identify in the syndemic approach:

- Gina thought the approach would work and the resources might look different.
- Natalie agreed that it would be important to have an entry point – including for substance misuse and mental health concerns.
- Danielle stated that this was a syndemic approach and the hub must include all areas of focus.
- John Sapero shared that some jurisdictions have a centralized Ryan white eligibility process in which one entity manages eligibility for Ryan White and other services. In these jurisdictions, the entity services as the "hub" for entry to care.
- Several participants noted that the service process might look different for each area of focus for the syndemic approach. For example, DIS may not be involved in SUDs. Or, medication connections might look different across each syndemic area of focus.
- AC suggested looking into artificial intelligence features such as chat bots to engage people in the chat box.
- Erma stated that she was in agreement with the hub approach and applying it across the areas of focus in the syndemic approach.
- Roberta stated that the soft-landing point, the connection to care and medication can be accomplished without too many additional resources. It may be adjusting workflows, working with funders to support the

model or to build it in a way that maximizes third party reimbursement, and educating partners on the ease of use, compliance with HIPAA, benefits to patients and to their own practices.

Roberta and Gina thanked the group for an excellent discussion and for consensus in moving forward with the hub approach as a core strategy for the 2022-2026 plan.

- Gina stated that she would look through her files and/or talk to individuals who may have information about the AIDS hotline. Danielle stated that she would do the same.
- Roberta suggested that others send their thoughts or other research to Mark.

OTHER BUSINESS

Participants did not discuss any new or other business.

NEXT STEPS / MEETING FEEDBACK

Participants used these words to describe the meeting and discussion:

- Productive
- High energy
- Enthusiastic
- Fund
- Logical
- On point

The group will meet virtually in May.

ADJOURN

Roberta adjourned the meeting at 12:30 p.m.

ATTENDANCE

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