

CALIFORNIA PLANNING GROUP (CPG)

JUNE MEETING NOTES

CPG MEMBERS PARTICIPATING: Jena Adams (Community Co-Chair), Joseph Burke, Angel Bynes, Francisco Cabas (Community Co-Chair), Holvis Delgadillo, Susan Farrington, Matt Geltmaker, Liz Hall (Co-Chair), Dennis Hendrix, Carolyn Kualii, Jesse Lopez, Amanda Mihalko, John Paquette, Juan Rivera, Nilda Rodriguez, Jen Rohde-Budz (Co-Chair), David Selberg, Tony Sillemon, Fred Smith, Deb Suderman, Clarmundo Sullivan, Karl Vidt, Channing Wayne, Michael Weiss

INVITED GUESTS

Mona Bernstein, Pacific AIDS Education & Training Center

MEETING FACILITATORS

Jillian Casey, MPH, Manager, Prevention, National Alliance of State & Territorial AIDS Directors (NASTAD), Isaiah Webster III, Senior Manager, Health Equity/Prevention, NASTAD

OFFICE OF AIDS STAFF

Karen Mark, Brian Lew, Juliana Grant, Amy Kile-Puente, Ayanna Kiburi, Niki Dhillon, Deanna Sykes, Karl Halfman, Carol Crump, John Keasling, Daniel Coronado, Katrina Gonzales, Jill Michel, Theresa Harlan, Marjorie Katz, Patsy Bittle, Susan Sabatier, Rhonda Shields, Vivian Chan

CPG MEETING GOALS

By the end of the meeting, CPG members will:

1. Be better acquainted with other CPG members and OA staff.
2. Have increased knowledge about the Office of AIDS (OA)'s CPG function and the 2014 work plan.
3. Have increased knowledge of the state of the HIV epidemic in California and how OA activities are addressing the epidemic.
4. Vote on five newly developed HIV educational materials.
5. Elect two Community Co-Chairs for the CPG.

DAY 1
JUNE 25TH, 2014

Welcome/Housekeeping

- OA's Division Chief & State Co-Chairs welcomed the group.

Introductions/Ice Breaker Activity

- Members became better acquainted with each other by participating in an ice breaker activity.

Meeting Starters

- The group came up with the following Ground Rules/Guiding Principles for the meeting, which will also be used for future CPG meetings.
 - Be Respectful of Others
 - No Sidebar Conversations
 - Silence Cell Phones and Electronic Items (timers are the exception)
 - Speak Up
 - Repeat So All Can Hear
 - Humor is Welcome
 - ELMO (Enough, Let's Move On)
 - Assume Best Intent
 - Okay to Disagree
 - Honor Your Commitment
 - Respect Confidentiality (keep in mind that all CPG business is public record)
 - Start and End on Time
- An overview of the consensus decision-making model was presented.
 - The consensus decision-making model will be used for future decision making.
 - This method of decision making takes everyone's perspective into account.

Health Resources and Services Administration (HRSA) & Center for Disease Control and Prevention (CDC) Planning Guidance

[\[Presentation slides\]](#)

- Isaiah Webster III, Senior Manager, NASTAD Health Equity/Prevention, reviewed the planning guidance from both HRSA and CDC.
- 39 of 59 jurisdictions in United States have integrated plans. HRSA and CDC are working on an integrated guidance document.
- Nothing can be written in the CPG Governance document that conflicts with the guidance from HRSA and CDC.
- Members cannot change the guidance from HRSA/CDC, but they can amend the CPG Governance document by the process written in the CPG Governance.

Responsibilities of OA & CPG Members

[\[Presentation slides\]](#)

- Jen Rohde-Budz and Liz Hall, the State Co-Chairs, reviewed the OA and CPG responsibilities.
- All CPG business is public record.
- As CPG responsibilities come to fruition, the members will receive more information and guidance.

AIDS Clearinghouse Materials

- Members provided feedback on the materials that were presented, which they had also received prior to the meeting. The members submitted their votes on materials.

Co-Chair Discussion

- The Co-Chair responsibilities were reviewed.
- Co-Chairs are responsible to make sure the meetings take place.

Regional Breakout Activity

- Northern, Central, Bay Area, and Southern California were separated throughout the room – to share challenges and successes on a regional level.

Northern California

- Inadequate funding to meet our basic obligations
- Geographic isolation (transportation, lack of specialty care, food, housing etc.)
- Specialty population venues stigma
- Funding apathy
- Lack of medical attention
- Decreased donation
- Mandates (no funding to enforce them, “unfunded health mandates”)
- Cultural competency (e.g., lesbian gay bisexual transgender (LGBT), language, lack of care by providers)
- Public health systems have different priorities (i.e. more funds for mental health)

Southern California

- Linking people into care (border issues)
- Resources (housing, access to testing, etc.)
- Insurance/Covered California/benefits navigation
- Accessing benefits on time
- Lack of effective doctors
- A lot of misinformation
- Mental health services (GYOB) women’s health

Central Coast

- Fresno:
 - Combining rapid HIV & HCV testing
 - Targeted testing
 - Media campaigns
- Kern:
 - Late testing
 - More linkage to care
 - All counties’ targeted testing are different
- Monterey/Central Coast/Santa Cruz:
 - Expanding and creating more engaged planning groups

- Social media (Facebook, Twitter, etc.)

Bay Area

- No gathering places for San Mateo and other rural and suburban areas
- Data and migration
- Housing (costs exceed Ryan White levels)
- Alameda shadow city
- Mental health
- Substance abuse
- Affordable Care Act (ACA) vs. Ryan White undocumented folks left out
- Change in Denti-Cal
- Co-morbidities
- Doctors not going into ID
- Reliance on general/family practice doctors per ACA
- Provider burnout
- Need more collaboration between providers

DAY 2

JUNE 26TH, 2014

Call to Order/Public Comment

- Sacramento TGA asked for public comment opportunity for future meetings, to be at the end of the day.
- There was a request for posters to be in Spanish.
- There was a request for Community Co-Chairs to represent the North and South regions.

Review of Parking Lot

- Member names will be printed on front and back of name cards at meetings.
- Members discussed their representation on CPG, from a group and community perspective to the State of California as a whole perspective. There was a need expressed to ensure others were aware of individual affiliations and representation. As a result, the membership profiles will be updated to include affiliations and representations and sent to members.

The Integrated HIV Surveillance, Prevention, and Care Plan

[\[Presentation slides\]](#)

- Carol Crump, MFT, Behavioral Health Specialist, presented on *California's Integrated HIV Surveillance, Prevention, and Care Plan* (Integrated Plan), including the history and what the responsibility of the CPG will be.
- Members had comments regarding the combined Integrated Plan guidance that HRSA and CDC are working on and will disseminate in 2015. Members' comments addressed prevention with positives (PWP), blended funding, and reporting challenges. The NASTAD meeting facilitators will share members' comments with CDC and encouraged members to continue providing feedback to HRSA and CDC.

California's Integrated Plan: Using Data to Drive Action

[\[Presentation slides\]](#)

- Dr. Karen Mark, Chief, Office of AIDS, presented on how data is being used to drive programs and improve program implementation.
- The only Prevention money OA has is from CDC.
- ADAP receives both mandatory and voluntary supplemental rebates from drug manufacturers for drugs dispensed to ADAP clients. ADAP drug rebates must be used exclusively to cover costs related to the purchase of drugs and services provided through ADAP. In addition, ADAP must use all mandatory drug rebates before ADAP uses HRSA federal funds.

The Continuum and National Strategy in Context: The Epidemiology of HIV in California

[\[Presentation slides\]](#)

- Dr. Juliana Grant, Chief, Surveillance, Research, and Evaluation Branch, presented the epidemiology of HIV in California in relation to the California Continuum of Care, National HIV/AIDS Strategy, and California's Integrated Plan.

- Transgender data reporting discussion:
 - On surveillance OA collects self-identified sex at birth and current gender.
 - If a male reports that they have had sex with a man, they will be classified as men who have sex with men (MSM). Membership discussed that this a troubling gaping hole in the system. Partners of transgender would not answer that they have had sex with men – because they are women. These men are part of the epidemic, but they are not being captured anywhere. Some partners are exclusively partnering with transwomen. We are making data driven decisions without capturing accurate information on this population. OA Surveillance and Prevention Branch are working on this issue and CDC has a work group on this issue.
 - Local health jurisdictions (LHJ) would like OA to help justify needed additional resources for transgendered individuals given the lack of data and needs assessment. LHJs are unable to get funding outside of OA without data.
 - Self-reporting is a problem because it hides MSM and has limitations on surveillance data. There is still stigma related to drug use and MSM.
 - OA and LHJ surveillance staff gets data from medical charts and not from working directly with clients.
 - Partners of transgender identity are incomplete in surveillance data. We need to rely on program data that directly relates to clients.
 - A recommendation was made to put footnotes on data reports that are incomplete.
 - OA will be releasing 2012 Continuum of HIV Care soon. 15-16% of individuals living with HIV/AIDS are unaware.
- OA defines being in care as having a positive laboratory result because it is surveillance data. Being in care is getting one test in a 12 month period.
- Retention in care – guidelines indicate that if your viral load is low, you only have it monitored every 6 months. Depending on timing of visits, may have

only one visit recorded during a 12 month period (e.g., if visit 1 is in December, visit 2 in July, and visit 3 in January).

- Difference of being undetectable and being virally suppressed – undetectable is a measure of the test and viral suppression is a clinical characteristic. To be consistent, and take into account that tests have gotten more sensitive over time, we define viral suppression as under 200 copies.

Reducing New Infections: Prevention, Diagnosis, and Getting into Care

[\[Presentation slides\]](#)

- Amy Kile-Puente, Chief, HIV Prevention Branch and Dr. Deanna Sykes, Research Scientist III, presented program data and what OA is doing to reduce new infections.
- Partner Services (PS) data tracking is venue- and surveillance-based models.
- OA PS staff will visit LHJs to discuss implementing implementation in areas that currently do not offer PS. OA has worked to ensure that most PS field staff is educated on how to establish linkage to care services.
- Members expressed the need to broaden the way we think about PS and the need to increase involvement and collaboration of prevention staff in retention in care programs. OA ensured that efforts are being made to focus on collaboration between staff in Prevention and Care.

Team Building Activity

- The True Colors assessment was used for members to identify their personality and work styles and those of their peers, which can be helpful in building positive and satisfying relationships and teams.

Improving Access to Care and Improving Health Outcomes for People Living with HIV

[\[Presentation slides\]](#)

- Ayanna Kiburi, MPH, Chief, HIV Care Branch, Karl Halfman, Health Program Specialist, Care, Research and Evaluation, Niki Dhillon, Chief, ADAP Branch presented program data and what OA is doing to improve access to care; and the impact of Health Care Reform on the Ryan White Programs, AIDS Drug Assistance Program and OA-Health Insurance Premium Payment.
- Members had questions regarding undetectable vs. suppression and what the criteria is. Dr. Grant responded we may not want to worry too much about the terminology because in five years, we will be using the test of less than 50 copies to determine if someone is undetectable. We should make sure clients have as low a viral load as possible - less virus means you are less likely to transmit.
- Members discussed concerns about the impact of ACA on Ryan White clients. Discussion focused on the need for provider agencies to screen clients for eligibility to other payer sources and ensure services if they are underinsured. Agencies must be prepared to move funds to other needed services as savings are realized as clients move out of OAMC but still access other support services.

California's Integrated Plan: Using Data to Drive Action - Closing Thoughts

[\[Presentation slides\]](#)

- Brian Lew, M.A., Assistant Chief, Office of AIDS, presented on what OA is doing to achieve a more coordinated response to the HIV epidemic; and the next steps for the Integrated Plan.

Vote on Community Co-Chairs

- Two Community Co-Chairs will serve until February 2015.
- Nominations were made:
 - John Paquette nominated Channing Wayne
 - Tony Sillemmon nominated Joe Burke.
 - David Selberg nominated Francisco Cabas.
 - Carolyn Kual'i'i nominated Angel Bynes.
 - David Selberg nominated Jena Adams.

- Nilda Rodriguez nominated Holvis Delgadillo.
- Results: Francisco was elected as a Community Co-Chair and there was a tie between Joe, Angel, and Jena for the other seat. A tie-breaker vote resulted in Jena Adams elected as Community Co-Chair

Next Steps

- Teleconference calls will be held with the newly elected Community Co-Chairs.
- The Prevention Progress Report will be distributed to members in August.
- Next in-person CPG meeting will be held in San Diego in October.
- OA will make changes to the Governance document and then submit the revised version to the members for feedback.
- Meeting notes and correct PowerPoint slides will be posted online.
- Clearinghouse materials will be revised and resubmitted to the members.
- Revised member bios will be sent to members.
- Revised Integrated Plan goals and objectives will be sent to members for feedback.

Adjourn

