HIV and Hepatitis Community Planning Group
Meeting Minutes
August 9, 2018

HIV & HEPATITIS COMMUNITY PLANNING GROUP MEMBERS *in attendance								
Julie	Baker	x	Corey	Hoefer		Jordan	Selha	x
Donald	Baxter		Steven	Kleppe	x	Michelle	Sexton	x
Sue	Boley	x	Douglas	LaBrecque		Carter	Smith	x
Colleen	Bornmueller	x	Roger	Lacoy	x	Samantha	Smith	x
Megan	Campbell	x	Jacob	Linduski		Sonia Reyes	Snyder	
Tim	Campbell	x	Daniel	Hoffman-Zinnel	x	Conner	Spinks	x
De'Shea	Coney	x	Jeffrey	Moore				
Kathryn	Edel		Luis	Morteo		Roma	Taylor	x
Linnea	Fletcher	x	Sara	Peterson	x	Pamela	Terrill	x
Kevin	Gabbert		Marty	Reichert	x	Mark	Turnage	
Greg	Gross	x	Claudia	Robinson	x	Kathy	Weiss	
Holly	Hanson	x	Theresa	Schall		Samantha	Willey	x
LeeVon	Harris	x	Shane	Scharer	x	Sarah	Ziegenhorn	x
Tami	Haught	x	Aaron	Shaw	x			
***Health Department Staff:**, Kathy Dooley, Kate Hoskins, , Tobias Gurl, Casey Ward, Nicole Kolm-Valdivia, Cody Shafer, Jessica Morris, Randy Mayer, Nicole Repp, Richard Nesselroad, Joe Caldwell, Bobby Barcelo, Jamesetta Mator*								
***Guest(s):** Kurt Berke, Rina Chaudhary, Ashlee Folsom, Jacob McNatt, Tara Jones, Tomika Abram, Kim Jochim, Andrea Meirick, Michael Ohl, Joe Lockard-Nobile, Patty Martin, Angie Hoth*								

Call to Order
Colleen Bornmueller called the meeting to order at 9:00 AM.

Roll Call
Colleen Bornmueller facilitated roll call. Holly Hanson is substituting for Biz McChesney, as she is traveling. Holly gave updates regarding absent members.

Test Agenda
No changes were made to the agenda. Colleen mentioned that a portion of the agenda will not be completed today (part of the group activity, “How are we going to get there?”)

Ground Rules and Agenda Review

Holly Hanson reviewed the group agreements, the agenda, and the goals of the meeting.

Goal 1: Identify HIV and HCV trends
Goal 2: Become updated on select goals and objectives in the Comprehensive HIV Plan
Goal 3: Become updated on select goals and objectives in the Hepatitis Action Plan
Goal 4: Discuss legislative and policy initiatives
Goal 5: Discuss community engagement and participate in small-group discussions
Goal 6: Receive an update on ad hoc committee work

Holly also reviewed the contents of member packets.

1. Molecular HIV Surveillance: Detecting, Defining, and Preventing HIV Transmission Clusters and Outbreaks presentation slides
2. 2017-2021 Iowa Comprehensive Plan presentation slides
3. Strategic Planning Update: Pre-exposure Prophylaxis (PrEP) & TelePrEP presentation slides
4. Iowa HIV Strategic Plan 2017-2021 document
5. CPG Meeting check-out form
6. CPG Contact List
7. Strategic Planning Update: Risk and Harm Reduction Supplies presentation slides

Approval of April Minutes

Colleen Bornmueller facilitated the approval of the April 12, 2018, minutes. No corrections or additions were made. Motion carried, seconded, and minutes were approved.

It was mentioned that no slide decks were provided with the minutes. Colleen said she will follow-up to make sure the slides are available to all members.

There was a unanimous vote to approve minutes.

Review of April Check-outs

Colleen Bornmueller facilitated the approval of the April 12, 2018, check-outs.

Generally, participants recognize the progress made and feel the data represents a positive impact on HIV, STD and hepatitis epidemics in Iowa. Feedback was very positive on the presentations about data across the prevention and surveillance programs.

Participants noted that the topics of cannabis, hepatitis C, legislative activities, and CTR site progress were very helpful and informative. Many appreciated the small group discussion and openness of presenters to engage in question/answer sessions and discussion.

Case studies, success stories, and real examples of how the state is meeting the strategic goals and objectives were requested. Real-time surveys were recommended during presentations to keep members engaged. Cannabis, IME/MCO, youth outreach, and health equity/racism were requested for upcoming meeting presentations, as well as discussion about how CPG members can be better advocates.

No corrections or additions were made.

Updates & Unfinished Business

Follow-up and feedback on HIV, STD, and Hepatitis Conference, Advances and Opportunities

This session was facilitated by Holly Hanson. Evaluations have been compiled. Jenna Sheldon has a handout of feedback and will be provided. Holly spoke about conference timeline and suggested every 3 years but because of the next state planning process will be underway at that time, the department is suggesting that the next conference be held in 2 years. Holly asked for members to comment on timeline on the check-out form.

Comments made regarding the conference by members included:

- The presentation after lunch that was data heavy.
- The trauma-informed care presentation was awesome and requested for the presenter to come back. Holly mentioned IDPH is continuing to work with the presenter to stay engaged.
- A positive comment was made regarding the health equity presentation.
- The IDPH was commended on the inclusion of PLWHIV.
- The owners of the venue are anti-LGBTQ.

Department Update

Randy Mayer provided a departmental update.

The HIV and Hepatitis Prevention Program Manager position will be filled and is pending interviews. Three potential candidates have been selected for interview.

There are some legalities about NuCara employees (contractor of IDPH Bureau of HIV, STD, and Hepatitis) and how they represent and conduct the work of the bureau. NuCara has hired a project manager to manage 13 staff that do work for the bureau. Dustin Wagner was selected to fill this position. Randy provided some background information about Dustin, who will be starting on September 17, 2018. The bureau will work with Dustin on project management, but Dustin will be responsible for supervision of staff.

CDC awarded IDPH $500,000/year for four years for a demonstration project entitled, *Public Health-Partnered Tele-Medical Pre-Exposure Prophylaxis (PrEP) Delivery in a Rural State (TelePrEP)*. Work will be done in partnership with the University of Iowa.

Discussion around syringe services programs is starting to ramp up again. The position of Legislative Liaison for the department is currently vacant, and the department is working to get that position filled.

Office of Medical Cannabidiol update

Presented by Randy Mayer

Randy presented an update on House File 524 – Iowa Code chapter 124E, the *Iowa Medical Cannabidiol Act*. The legislature passed the Act a year ago and assigned the program to IDPH. There are two staff in place and three more to be hired to support the program, which is overseen by Randy. Randy provided an overview of the law; board responsibilities; qualifying

debilitating medical conditions; the primary caregiver application process; health care practitioner responsibilities; forms, quantities, and strengths of cannabidiol; effectiveness data; resources; and obtaining medical cannabidiol in Iowa. Five dispensaries have been licensed and will begin dispensing December 1, 2018. HIV is one of the qualifying conditions. There are two licensed manufacturers. See presentation slides for more details.

A member asked about the difference between vaping and nebulizing. Randy answered that while both deliver an inhaled version of the product, vaping actually heats the substance and enhances delivery. This is primarily relevant to THC (tetrahydrocannabinol), the psychoactive component of *Cannabis*, but there are also vaping devices for CBD (cannabidiol). Currently, the administrative rules do not allow for vaporization; only nebulizable inhaled forms are allowed.

A question was raised about use of opioids with cannabidiol. Randy answered that use of *Cannabis* products could be used to reduce use of opioids for pain but that a patient may not be able to eliminate opioid use. MedPharm will formulate the product and will make recommendations on use (e.g., which condition) and dose. Staff at the dispensaries will individualize those recommendations based on severity of symptoms and weight, for example.

It was asked if THC will show up on a drug screen. Randy answered yes for the higher doses, but doesn't know at what level it will test positive. Employers can still require drug screens for employment, so products with THC might be problematic for those who are required to be drug free. Tests for THC do not quantify the amount of THC; they are positive or negative.

It was asked how the location of dispensaries was chosen. Randy answered there were twenty-one applications, which were separated by location and scored. The department used both score and location to make decisions.

Molecular surveillance and cluster analysis

Presented by Jessica Morris and Nicole Kolm-Valdivia

Jessica and Nicole presented an overview of molecular surveillance, including its purpose, how it will help with disease investigations, and the security and confidentiality of data. See presentation slides for more details.

A member asked if sequence changes over time and if additional testing is recommended in that case. Randy Mayer said that those issues are decided by medical providers so that they may provide appropriate treatment. He added that IDPH is not making any recommendations about molecular testing; we are only using sequences that are available to us to help us understand the epidemiology of HIV in Iowa.

A comment was made that PLWHIV are watching this very closely. It was suggested there is less trust with IDPH and said that language matters, and not to use stigmatizing words like "target" as this decreases trust. Some states are aggressively doing outreach based on this surveillance. This could impact or cause a barrier to testing.

Randy Mayer commented that states with higher morbidity have already been using molecular surveillance. These states are reporting that molecular surveillance is useful to help them determine where to focus their efforts. In Iowa, it may help us to understand patterns of transmission and networks among MSM of color, for example. Recently, we've seen diagnoses

among this population in Waterloo, Burlington, and Des Moines. Molecular surveillance could tell us if they are linked or just coincidental.

A member asked how sequencing PWHIV will help to identify people who are undiagnosed. Jessica answered that this is where partner services comes in to follow-up with partners. Randy suggested that if a network is identified, then we would look for "associates" or other people who may be in the network and might benefit from an HIV test. This will help DIS to understand when to spend more time on a network and when to move on.

Linnea Fletcher asked if this method can help to direct resources. Randy answered that other states have increased testing in response to this type of surveillance. San Antonio was able to identify a network of bars in a specific part of the city and redirect resources, marketing, testing, and care to that area.

It was suggested that involving LGBTQ in the process would help to minimize distrust among community members. The member also asked what the timeline is. Jessica answered that a base plan is currently under development and should be ready to review in a month, but the project as a whole will span 5 years.

Synergy for Integrated Planning Leadership Application – Vote

Presented by Colleen Bornmueller

Colleen provided an overview of a NASTAD opportunity for CPG to receive additional technical assistance toward making sure there is synergy between the community and the department. The objective is for the department and community co-chair to attend 2 meetings to develop an action plan. IDPH is currently working on an application and will be submitted next week.

Because of the timing of the technical assistance, we'll need to make some adjustments in voting in a new community co-chair to allow that person to attend the meetings. If nominations take place today, then a call will be conducted with CPG members at the end of August to vote in a new co-chair. This way three people (Biz, Colleen, and the new community co-chair) will go in October and March. Applicants will be notified by August 27, 2018, as to whether they were selected for the training.

Colleen asked for a motion on moving the voting should our application be selected. A vote is needed because moving the nomination and vote would deviate from bylaws.

Motion and second were made.

A member commented that membership needs to adhere to bylaws stating that those nominated need to share why they would like to be co-chair.

Vote:
Yes – 27
No – 0
Motion passed

Colleen will be calling for nominations at the end of the day. Any CPG member is eligible, with the exception of Shane Scharer, Jordan Selha, and Holly Hanson (who are all considered to be department members).

2017-2021 Iowa Comprehensive Plan presentation slides

Presented by Holly Hanson

Holly provided an overview of the strategic plan development and process. There was a meeting of 70 people who convened to talk about the HIV prevention and care landscape. Information was gathered and a plan was drafted in 2016. Things have changed since the plan was developed, including increased resources. See presentations slides for more details.

A member asked if IDPH has heard from NASTAD about how long Ryan White Part B supplemental funds will be available. Holly answered that she hasn't heard anything about this recently, but she suggested that 3 to 5 years is still a good bet. The third year will be starting this September 30. IDPH has asked for $16 million in Ryan White Part B supplemental funds, and she has no reason to believe IDPH will not get it. Holly commented that there are obstacles other than funding, and to stay focused on that.

New Business

Interim HIV Strategic Planning Activity

Members were asked to breakout into small groups and, after hearing a status report about PrEP, harm reduction supplies, HIV and Hep C testing, linkage, and re-engagement, discuss the following questions.

1. Where are we now?
2. What are the gaps and barriers?
3. Where do we want to go?

PrEP

Presented by Cody Shafer

Cody provided an overview of the TelePrEP program and IA PrEP Study, the current state of the PrEP program, gaps and barriers to PrEP uptake, and future plans. See presentation slides for more details.

A question and answer session was held:

Q: Say more about the daily regimen of PrEP over PEP.

A: PEP, in some settings, addresses immediate need (after an exposure) but referrals need to be made for PrEP (to prevent future exposures) so providers need to be educated to make sure this happens.

Q: Are there data on PrEP uptake statewide?

A: The only data available reflect clients we provide linkage to. A more holistic picture is a gap at this time.

Q: Are there other populations being prioritized?

A: IDPH is currently working to include PWID into educational materials.

Q: Are there current navigation services data?

A: There have been 673 linkages, primarily MSM.

Q: What level of assistance is provided?

A: Benefits navigation helps people understand what insurance pays for, then facilitates a linkage to resources that help offset costs. Gilead provides support, but this is changing. Private insurance co-pays are high and Gilead is not covering all out-of-pocket expenses, so helping to establish a financial plan is important. There has been some loss of access because co-pay cards are not being applied to insurance deductibles. When the co-pay card runs out, the person can't afford the out-of-pocket costs. Also, support for labs is being addressed.

Feedback Topics	**Notes**
What wasn't captured in 'where are we now'?	▪ Our public health systems do a good job of getting people from appointment to PrEP within closed or referral systems. There aren't any data to capture what is happening outside of our systems. ▪ Evaluation management website is fairly weak in terms of offering referrals for education and recording whether those

	referrals are made or not. Cost effectiveness of PrEP vs HIV medication over a lifetime.
	▪ Why is PrEP not available regularly at low-rent motels, strip clubs, shooting galleries?
	▪ The epidemic is disproportionate
	  o Need more strategies for disproportionate communities
	  o Need more info for private health providers and other community agencies
	  o Engage with those who aren't actively being seen at their places of regular visitation
	▪ Collaborative agreement through Genesis which allows for
	  o better linkage to care and immediate care
	  o mental health counseling is available
	  o assistance with co-pays and labs
	▪ FQHC training on PrEP
	▪ updating providers on website – not timely
	▪ prioritizing populations that could benefit from PrEP but are not on PrEP – many disparities
	▪ need an easier way to add providers to website (those providers who are providing PrEP)
	▪ More mass marketing – lack of knowledge about PrEP among providers and public - billboards may be a good media
	▪ Need inclusive, targeted ads for people who could benefit from PrEP
	▪ Need to help youth access PrEP (15-18)
	▪ Stay on "cutting edge" episodic PrEP – long active PrEP
	▪ Need LGBTQ friendly/specific providers
	▪ PrEP info/hotline in other languages?

What is working / isn't working?	▪ Knowledge of PrEP in ER settings is lacking – there are policy roadblocks in ER settings in getting people linked to community based services that are low/no cost and would increase access (we can't turn you away policies). ▪ Difficulties recording client questions and comments about the program. ▪ No statewide database or requirements for primary care providers to record this information; requires direct intervention from Cody for education and listing the provider on the website as a provider. ▪ Community backlash from seeing PrEP as a sort of anti-condom campaign (misconception). ▪ One bad encounter can often result in people avoiding a particular avenue for care.

	▪ Coverage of the medication isn't uniform by insurance providers, so Gilead cards are being maxed out by June. ▪ Struggle with engagement by primary care providers. ▪ Recruiting providers at each Primary Health Care site: o rural outreach may be area of improvement with recruiting providers. ▪ There is push back due to time commitment.
How do you feel about 'where are we going'?	▪ We need more formal and accessible provider training. ▪ Need to focus programs on increasing the diversity of PrEP patients. ▪ The Rural Outreach Liaisons need better more formal training – mixed messages can be damaging to provider understanding and willingness to participate in PrEP. ▪ Need better comprehensive PrEP marketing materials. ▪ Expansion of provider data collection and availability of data to providers and advocates. ▪ Working with people who use drugs. ▪ Differentiation between providers who give PrEP to their own patients vs providers who give PrEP AND are currently accepting new patients. ▪ Incorporating Trauma Informed Care/Sensitivity Training into regiment for those who provide PrEP. ▪ Perhaps a shift in narrative: PrEP as part of a holistic health practice, not as a singular program. ▪ More PrEP out of the hands of IDPH and into community spaces, both medical and non-medical o Asking people to enter a complex system that isn't set up to work for them makes linkage to PrEP difficult. o Having one point of contact at IDPH to enroll is a barrier. o Why can't PrEP enrollment be offered by community leaders from and embedded in communities of color, sex workers, and people who use drugs? ▪ Bigger campaign o Using people of the community o Be posted everywhere ▪ For those who test negative, provide more info but be careful with info. ▪ Get the info so people know before they test. ▪ Educate providers (not sound like pharmacy reps). ▪ Enhance marketing efforts. ▪ Formalize a path for clients with STIs to obtain PrEP. ▪ Promote HIV Prevention Simply Speaking website mailto:https://hivprevention.simplyspeakingcme.com/

Risk and Harm Reduction Supplies Presented by Cody Shafer Cody covered what groups distribute condoms and how inventory is managed. Gaps and barriers include coordinated efforts for condom distribution, marketing of condoms, monitoring procedures, inconsistent availability of harm reduction supplies, and the paraphernalia law. Future plans are to implement a statewide condom distribution system, with tracking and monitoring tools, ordering, and virtual supply locater.	
What wasn't captured in 'where are we now'?	▪ Kits for substance users are not available in all locations – and/or aren't made easily available. There is judgment attached to distribution of these materials. ▪ Pharmacies have differing policies on selling needles/syringes to people without prescriptions. ▪ Underground syringe exchange networks exist in some major Iowa cities. Bulk access to wound-care kits to clients, including sharps containers, fit-packs, bleach kits (primarily used as a platform for conversation). Johnson County purchases condoms, cookers, and sharps containers (only county).
What is working / isn't working?	▪ Harm reduction supplies can be seen as 'enabling' vs 'informed-decision making' --- greater education needs to be provided. ▪ Should require distribution of harm reduction kits in contracts. ▪ Efficacy of bleach is questionable when it comes to HCV. Needles are not the only paraphernalia prohibited under Iowa law (department is working with Attorney General's office on this). Not enough publicity surrounding harm reduction kits like bleach kits and wound care kits. High stigmatization of those who inject by primary providers, resulting in negative views of the system by people who inject drugs. ▪ Location matters. ▪ How to approach people currently under the influence/actively using. ▪ Approaching legislature, lobbying. ▪ Communities are not yet engaged. ▪ Supply distribution is regular.
How do you feel about 'where are we going'?	▪ Providing condoms that the community actually wants. ▪ Providing condoms at local businesses, jails, and courthouses is working. ▪ Black Hawk Co. seems to be pulling back from harm reduction. ▪ Walgreens might not be selling syringes anymore.

	▪ No one but IHRC is providing harm reduction kits. Creating communication about where to access condoms. ▪ Engage pharmacies that are more open to selling or providing syringes. ▪ Using unconventional methods of distribution. ▪ Health departments on board with harm reduction kits. ▪ Requirement to provide harm reduction kits. ▪ Assess needs for counties not engaging in harm reduction ▪ Explaining the difference between enabling and informed consent/education. ▪ Having condoms everywhere. ▪ Information about where kits can be accessed. There is no use of formal 'peer-to-peer' distribution models. ▪ Need a better variety of products available. ▪ Further development of cultural competency training to health departments. ▪ Attempt to increase buy in from sub-recipients and coalitions as a way of promoting positive public health change. ▪ Eliminate gateways to supplies, such as bringing them out from behind the pharmacy counter. ▪ Expand networks for people who inject drugs to communicate with one another, as well as providers they feel comfortable interacting with. ▪ Create guidelines for communication, education, and treatment for primary providers. ▪ Mail out harm reduction kits, similar in style to PrEP. Jails and Corrections supplying condoms. ▪ Promoting peer-2-peer supply distribution. ▪ Learning and providing supplies that play into the clients' personal preferences in order to promote regular usage. ▪ Spreading the word of which pharmacies will sell syringes.
HIV Testing Presented by Nicole Kolm-Valdivia Nicole provided an overview of HIV testing across Iowa, identified gaps and barriers, including false positive tests, service area gaps, lack of capacity building for funded test sites, and a lack of a program manual for testing sites. Future goals are to formalize demonstration projects, routinize HIV testing in emergency rooms, have urban outreach liaisons, improve communications, and develop capacity building.	
What wasn't captured in 'where are we now'?	▪ No feedback

What is working / isn't working?	▪ The availability of testing services in metro areas is good. ▪ Great spaces for gay and bisexual men in urban areas. ▪ Rural spaces lack accepting services. ▪ Stigma remains a barrier. ▪ How to reach out to other test sites who want to test. ▪ ROLs doing testing? Would take more time? ▪ More staff to do booths and health fairs. ▪ Opt-out testing.
How do you feel about 'where are we going'?	▪ Should require workforce training with a focus on providing counseling and services to individuals in 'non-traditional' relationship types. ▪ Get more data o Assess priority gaps. o Connect with small rural communities through county departments and hospitals. o Address confirmatory procedures at plasma centers: ▪ Create more partnerships. ▪ Inform and educate about reportable diseases. o FQHC testing and referrals: ▪ Inconsistent in some places. ▪ Other places with opt-out testing (QC) have better turn out and referral systems. o Memorandum of understanding ▪ State have direct contact with agencies for tracking data. ▪ Procedure for setting up demo project sites to allow communications, relationship, and testing goals to go uninterrupted. o Create and track a Prevention continuum ▪ Include referral networks o Assistance in reaching priority populations. ▪ Develop HIV testing in ER protocols. ▪ Need multi-service outreach (mobile unit). ▪ Need materials in other languages. ▪ Need rural outreach testers (example – Ashlee/NAP). ▪ More information about pharmacy testing projects – group has concerns about confirmatory testing, linkage to care, and confidentiality. ▪ Provide staff as opposed to pharmacy staff conducting testing (example – Ashlee/NAP).

Linkage to Care

Presented by Nicole Kolm-Valdivia

Nicole provided information about the number of people who tested positive for HIV that were linked to care within 30 days. Disease Intervention Specialists (DIS) can facilitate linkage and can provide referral and follow-up. Some gaps include mistrust of medical system, patient denial, and uncertainty of linkage process. Goals are to potentially hire more DIS staff, enhance DIS linkage procedures, develop continua of care for priority populations, develop marketing initiatives, rebranding, and develop protocol for people who are newly diagnosed.

What wasn't captured in 'where are we now'?	▪ A challenge: in an age of "information questioning," how do we push out information in a way that will be accepted by those who need to hear it? ▪ Staff, ROLs, and DIS are doing a good job. ▪ Testing at ITS sites will refer to medical care and case management. ▪ Connection to special populations – link to best fit agencies.
What is working / isn't working?	▪ Language ▪ More hepatitis (testing, follow up). ▪ Delays in reporting to IDPH. ▪ Traumatic experiences (sensitivity training, inconsistencies of DIS to deliver results). ▪ Not having insurance. ▪ Immigrants have no insurance and may not trust systems. ▪ Need a standardized process for linkage to care. ▪ Marketing services – rebranding case management (health coach, resource coordinator). ▪ What about people who don't need many services – tiered case management. ▪ We have many questions about same-day ART and need a lot of clarification.
How do you feel about 'where are we going'?	▪ Should consider a peer advocate model for linkage support when diagnosis occurs in primary care and/or ER settings (think of Rape Victim Advocacy Program model) ▪ Work with providers to gain buy-in for same day starts. ▪ Need provider education. ▪ Look at linkage to see if everyone is referred the same way. ▪ Seeing people that look like you. ▪ How starting ART look like without a provider on staff. ▪ Case management re-branding (wellness coach, wellness navigator). ▪ Youth finding people that look like them (gatekeepers). ▪ Need a good support system (peer to peer).

	▪ Release of information from new positive so group could call them – people that look like them. ▪ Peer advocates.
Re-engagement Presented by Holly Hanson Holly addressed the current status of re-engagement practices (staff, data collection, processes, current projects, and internal investigations). Goals are to potentially hire 1 FTE for re-engagement, finalize data management and forms procedures, implement more frequent not-in-care reporting, support pilot sites and have performance measures, incorporate CQM into re-engagement practice, and implement revamped program.	
What wasn't captured in 'where are we now'?	▪ Primary Health Care - care coordination; biweekly meeting to discuss viral loads and possible avenues of reengagement with clients. ▪ Expand to preventative measures and evaluate antecedents of break away in the first place.
What is working / isn't working?	▪ No formal method to evaluate reason for loss of contact; anecdotally, the causes are often quite severe. ▪ Easy to misplace contact information if the burden of contacting a provider is placed on the client. ▪ Coordinating with surveillance is helpful for tracking and re-engaging clients. ▪ Case managers and primary care providers know their clients best; make sure IDPH and other agencies coordinate their efforts for best results. ▪ Meeting people in a non-professional environment like a coffee shop or library can help people feel more comfortable and open to discussion. ▪ Community-based engagement exists around the state and appears to help with building relationships with clients. ▪ A lack of representation within the care community can cause some to break away. ▪ What are case managers thinking of clients and how does that transfer to the client? ▪ Candid conversations with clients. ▪ Why do they want to re-engage? ▪ The suggestions do not include solutions.
How do you feel about 'where are we going'?	▪ Are we asking clients why they want to come back into care? ▪ We need to collect data from clients who left the system and return. ▪ We have to understand the root ~~causes .~~causes.

	▪ What does it mean to be re-engaged?
	  o Responses from individuals who left care and come back. Why? What is causing people to leave care?
	  o Stages of how case managers interact with clients
	  o How can we predict a patient dropping out of care?
	▪ Engagement in care for clients
	  o How can we get case managers to be more engaged in their positions? Examine other models of case management.
	▪ Create hand-off procedure for clients who are moving or shifting providers.
	▪ Greater collaboration with pharmacies to maintain contact with clients.
	▪ Standardize training for treatment and communication between providers and clients, but promote some discretion on the part of the provider.
	▪ Connect those who feel stigmatized with programs like CLEAR and behavioral health in order to promote treatment compliance. Allow clients to set their own terms of engagement so they don't feel coerced into care.
	▪ Offer incentives for people to return to care.
	▪ Create an easy-to-find Ryan White database for people looking to engage in care.
	▪ Look at reworking the language: terms like "case management" can come across as distant or cold.
	▪ Create a third-party that acts as a moderator for clients and primary care providers.
	▪ Workforce reflecting the client population to keep clients engaged.
	▪ Create a guideline for hiring practice for hiring people who look like the clients.
	  o Systemic barriers that prevent populations from qualifying for positions (i.e., degrees).
	  o Weigh lived experience as much as education.
	▪ Provide adequate trainings to staff to increase client engagement.
	▪ Engage HR and other non-client facing staff.
	▪ Class-based training provided to staff.
	  o We need to get back to community-based case management.

	▪ Consumer advisory boards within each agency is a way for agencies to collect feedback and consumers can come with concerns.

Committee Reports

Gay Men's Health Committee

Cody Shafer reported that the committee had a productive meeting. The group is continuing to work on the website and received direction on adding LGTBQ resources and oral health providers to website. A 1/2 – full day interim meeting will be held to establish priorities for next couple of years.

Quality Management

Theresa Schall not present. Katie Herting on maternity leave. Will update next session.

Disrupting Racism

Disrupting racism training out of NC is no longer being provided. The creator of the training is still in contact and does consulting. IDPH is working with trainer to provide similar training for Iowa. This will not be a one-time training, but instead will develop a curriculum to enhance competency. It was recommended to have a contribution of health equity info in weekly emails to sub-recipients and others. There will be monthly conference calls to discuss resources sent out over the month, for clarification and to share additional information. As part of this call, Jamesetta came up with 12 different topics, one for each month. There will be 3-6 minute videos with information for discussion. Members can submit topic ideas to Jamesetta. Others can lead a call to discuss a specific topic. Members can also recommend guest speaker for a call. NPR is a good resource for topics.

Holly provided information about Monday Messages and Tuesday Tidbits. CPG and other members of the bureau are requesting to get messages.

Linnea Fletcher mentioned that Planned Parenthood is offering a Cultural Fluency Training March 25&26 in Omaha on the campus of UNO.

Public Relations

Tami Haught mentioned that CHAIN has not been as active as previous years. There is no day on this hill this year. The group is working on harm reduction and syringe exchange. The group went to presidential meet and greet and is bird-dogging to get training.

Trauma informed care

Holly Hanson said that the IDPH trauma informed care position is not currently filled. Holly mentioned that IDPH is looking into hiring a behavioral health coordinator to cover mental health and substance abuse (and other topics) through a trauma lens and provide reflective supervision. This position would be a resource to ITS contractors and case management.

Cross sector and regional trauma informed leadership come together to lift all work around trauma-informed care.

Drug user health

Joe Caldwell reported that there were two meetings. The group established a goal to have 50% of membership who are current/former PWID. Members can remain anonymous and the group can provide incentives to get feedback or life experiences. The group will develop a strategic plan and will include drug user health across the care spectrum. IDPH is using the workgroup to inform SSP in the comprehensive plan. Calls are every 6 weeks. Members can be on mailing list as well.

Other Business

Holly asked for co-chair nominations and mentioned that the nominee does not need to live in Des Moines. Nominations for the community co-chair was opened by Colleen Bornmueller. Nominations are listed below:

- Roger Lacoy nominated Greg Gross and Greg accepted.
- Carter Smith nominated Sonya Reyes Snyder, who is not present so this nomination is pending acceptance. Sonya will be contacted to accept or decline nomination.

Colleen closed nominations. Colleen will work on a plan for how to carry out early election procedures if they become necessary. She asked nominees to be ready with a 3-5 minute statement on why they would like to be the community co-chair.

Check-out Completion

Colleen Bornmueller asked members to complete and turn in their check-out forms.

Call to the Public

No comments from the public.

Announcements

Colleen announced that De'Shea Coney will be leaving CPG and moving back to South Carolina in September. De'Shea thanked the membership for his experience and said he has learned a great deal. He will bring his experience back home. He hopes to go to grad school and change the world!

Sarah Ziegenhorn invited everyone to attend the IHRC summit this September. There are a week's worth of events. The event is sponsored by the University of Iowa. There will be 2 panels covering Hepatitis C access and legislation. The summit is free to anyone living with HIV, hepatitis, or has a history of drug use.

Colleen spoke about Title X funds. HHS announced that the Family Planning Council of Iowa and IDPH were awarded grants. Colleen hasn't received notice on how the funds will be applied or how long the funding cycle will be. Current sub-recipients will be funded as well.

Next Meeting is November 8, 2018

Information will go out ASAP to vote on chair elect. The 2019 meeting schedule will be coming out soon.

Adjourn

Moved to adjourn motioned and seconded and approved.

Respectfully submitted,

Cristie Duric