

Washington State HIV Prevention Planning Group Meeting

Date: Thursday, March 15, 2012

Time: 9:00am - 4:00pm

REPORT

Location: Washington State Department of Health
101 Israel Road SE, Tumwater, WA 98501
Town Center 1, Room 163

Parking: Park in visitor designated parking or in the parking garage.

Meeting Attendance

Members Present Richard Aleshire, Steven Carzasty, Claudia Catastini, Maria Courogen, Lauren Fanning, , Heather Hill, Malika Lamont, Marcos Martinez, Jeff Natter, Michael Ninburg, Katie Querna, Daniel Schollaert, David Strong, Ed Wilhoite.

Members Absent Karen Hartfield, Mark Aubin, Ryan Oelrich.

DOH Staff Ann Bustamante, Paul Brown, Jason Carr, Amber Casey, Justin Hahn, Frank Hayes, David Heal, Dave Kern, Sally Perkins
and (facilitator), Jessica Peterson, Jon Stockton, Beth Watkins.

Facilitator

Visitors Brenda Newell (Snohomish Health District), Erick Seelbach (HHS HIV/AIDS Regional Resource Coordinator), Cherie Speelman (AIDS Outreach Project).

I Meeting Highlights

- 1) The HPPG created outcome pathways linking HIV Testing, STD Screening, Post-Exposure Prophylaxis and Pre- Exposure Prophylaxis to HPPG outcomes.
- 2) The HPPG began to investigate opportunities between HIV Prevention and Adult Viral Hepatitis service program collaboration and service integration.
- 3) The HPPG debated and clarified the implications of the focusing HIV prevention efforts geographically.

II Agenda Topic Presenter Estimated Duration

II	Agenda Topic	Presenter	Estimated Duration
1	Welcome/Opening Comments and Introductions	Ed Wilhoite , Community Co-Chair Maria Courogen , Health Department Co-Chair	9:00am - 9:10am
REPORT	Maria welcomed everyone to the meeting. Visitors introduced themselves.		
2	Review/Approve March Meeting Agenda, February Meeting Report	Ed Wilhoite , Community Co-Chair Maria Courogen , Department of Health	9:10am - 9:20am
REPORT	Maria asked HPPG members to review and request any changes to the March 15 HPPG agenda. The agenda was approved with no changes. Maria also asked HPPG members to review and request any changes to the February meeting report. There were no requests for changes or comments. The February meeting report was approved.		

II	Agenda Topic	Presenter	Estimated Duration
3	Two-Day HPPG Meeting Framework	Sally Perkins, Facilitator Dave Kern, DOH	9:20am - 9:50am
REPORT	<p>Dave recapped the February HPPG meeting evaluations, HPPG accomplishments to date and described how HPPG decisions will be translated into action. Dave's comments included:</p> <ul style="list-style-type: none"> + DOH appreciates the HPPG's patience with the thoughtful and deliberative process that was meant to help the HPPG members and DOH clearly explain HPPG process and decisions (especially to stakeholders not part of the formal planning process). + DOH acknowledges the important role HPPG feedback (via evaluations and comments, etc.) has had on developing the planning process and meeting format even if this has made the whole process seem slow. + The HPPG has made important decisions including a focus on the burden of HIV disease in urban areas including: committing to an outcomes-based approach, identifying outcomes, reviewing surveillance data within geographic areas and creating and strengthening outcome pathways that link interventions and strategies to outcomes. + DOH appreciates the HPPG's commitment to the innovative outcomes-based, statewide approach that is meant to achieve the overall impact of reducing the most HIV infections with available resources. + The HPPG will be making formal decisions today based on HPPG planning focus during the last twelve months that will influence the future allocation of resources (fiscal and other). + In the coming months the HPPG will investigate how best to match specific population needs with specific interventions and strategies. <p>See, "Sally's March 15 and 16 Meeting Notes" for more detailed information.</p>		

II	Agenda Topic	Presenter	Estimated Duration
4	Interventions/Strategies: Outcome Pathways (HIV Testing, STD Screening, Post Exposure Prophylaxis and Pre- Exposure Prophylaxis)	Sally Perkins, Facilitator	9:50am - 12:00pm
REPORT	<p>Sally used the HIV Interventions/Strategies: Outcome Pathways document as a guide to place pieces of paper representing HIV Testing, STD Screening, Post Exposure Prophylaxis and Pre-Exposure Prophylaxis pathways on the wall. Sally asked the HPPG three questions:</p> <ol style="list-style-type: none"> 1) How should this pathway work? Why? 2) How does this pathway work currently? 3) Are there missing pieces, missed connections, and/or missing partners or policies? <p>Sally then rearranged and added to the outcome pathways according to HPPG suggestions.</p> <p>See, "Sally's March 15 Meeting Notes" for more detailed information.</p>		
BREAK and LUNCH			
5	Maximizing Opportunities: Adult Viral Hepatitis Prevention	Dave Kern, DOH Sally Perkins, Facilitator	12:30pm - 1:15pm
REPORT	<p>Ed observed that the morning outcome pathway conversations were completed more quickly than expected. Ed suggested to the HPPG that the Adult Viral Hepatitis (AVH) conversation be moved from Friday to now. The HPPG agreed to the agenda amendment.</p> <p>Sally framed the agenda item as an opportunity to identify synergistic connections between AVH and HIV Prevention. Dave said that some populations adversely affected by HIV are also affected by Hepatitis B and C and that there is an opportunity to integrate services at the client level when appropriate. All current DOH contractors are mandated to provide some level of AVH services within their HIV prevention programming including: educating their staff on AVH, providing AVH client referrals, testing for Hepatitis B and C, vaccinating for Hepatitis A and B, and providing primary care and treatment for Hepatitis A and B. Dave said that beginning with this conversation the HPPG will help shape the next iteration of funding opportunities for the integration of hepatitis and HIV prevention in and out of the current healthcare delivery system.</p> <p>See, "Sally's March 15 and 16 Meeting Notes" for more information.</p>		

II	Agenda Topic	Presenter	Estimated Duration
BREAK			
6	The "Who" and the "Where": Implications and Decisions	Ed Wilhoite , Community Co-Chair Claudia Catastini ,	1:25pm - 3:45pm
REPORT	<p>Ed introduced the agenda item as an opportunity for the HPPG to formally decide on the populations (who) and geographic areas (where) where focus HIV prevention effort will be focused. Dave first reviewed the HIV prevention funding framework then Ed reviewed the HPPG's planning process and working decisions over the last year. Ed outlined three decisions that the HPPG is being asked to make today:</p> <ol style="list-style-type: none"> 1) Approve geographic focus on three areas with the greatest disease burden (Puget Sound, Vancouver, and Spokane). 2) Approve a statewide focus on persons living with HIV. 3) Approve populations groups within the three areas (choose all populations or draw a line). <p>The HPPG analyzed and discussed the presentation and questions to see if they were ready make the outlined decisions. Sally asked the HPPG to break up into small groups to discuss the implications of the proposed decisions in terms of opportunities, concerns, and considerations. The full HPPG then discussed the small group observations that can be found in the document, "March 15 2012 Who and Where Notes."</p> <p>Dave said that the HPPG is being asked to approve broad decisions today. The details of the decisions, such as matching the interventions and strategies with specific populations within the three geographic areas or defining the scope of work for PLWH across the state, comprise the bulk of HIV prevention planning work moving forward. Additionally, in the future, the HPPG may choose to investigate populations of special concern that may or may not be in the areas of greatest disease burden. The HPPG will also continue to review the integration opportunities for Adult Viral Hepatitis and HIV Prevention.</p>		

II	Agenda Topic	Presenter	Estimated Duration
6	The "Who" and the "Where": Implications and Decisions	Ed Wilhoite, Community Co-Chair Claudia Catastini,	1:25pm - 3:45pm
REPORT	<p>Sally polled the group and asked HPPG if they had any concerns that would impede them from making the three proposed decisions today. Many HPPG members had questions about what it will mean to have a statewide focus on PLWH, especially in areas outside the three identified areas with the greatest disease burden. Dave said that there will be a statewide priority to get PLWH into care, initiate treatment, and move individuals toward viral suppression. Dave added that DOH will continue to use surveillance to monitor new HIV diagnoses throughout the state and, with the help of the HPPG, adjust HIV prevention efforts based on current epidemiology. There was consensus from the group to table the decisions until Friday. Ed reviewed the decisions that the HPPG will consider tomorrow (see outlined above). Sally said she would email the HPPG a summary of the small group comments, and Dave said that he would email the "The People Affected: Who and Where Coming to Consensus" presentation.</p> <p>See the "The People Affected: Who and Where Coming to Consensus" presentation, the "March 15 2012 Who and Where Notes," and "Sally's March 15 and 16 Meeting Notes" for more detailed information.</p>		

II		Agenda Topic	Presenter	Estimated Duration
7	DOH Update		Dave Kern , Department of Health	3:45pm - 3:55pm
REPORT	Dave said that there was no new information on the state budget. Dave encouraged HPPG members to visit the Conference on Retroviruses and Opportunistic Infections (CROI) website for additional information on biomedical interventions including information on PrEP and PEP.			
8	Public Comment and Evaluations		Claudia Catastini , Community Co-Chair Elect	3:55pm - 4:00pm
REPORT	Ed announced that the evaluations will be tabled until tomorrow. Erick Seelbach said that the White House has announced that new director of National HIV/AIDS Policy is Dr. Grant Colfax from the San Francisco Department of Public Health. The meeting was adjourned.			

III Close Meeting

Next meeting: April 19, 2012

Washington State HIV Prevention Planning Group Meeting

Date: Friday, March 16, 2012

Time: 9:00am - 1:10pm

REPORT

Location: Washington State Department of Health
101 Israel Road SE, Tumwater, WA 98501
Town Center 1, Room 163

Parking: Park in visitor designated parking or in the parking garage.

Meeting Attendance

Members Richard Aleshire, Steven Carzasty, Claudia Catastini, Maria Courogen, Lauren Fanning, , Heather Hill, Malika Lamont, Marcos

Present Martinez, Jeff Natter, Michael Ninburg, Katie Querna, Daniel Schollaert, David Strong, Ed Wilhoite.

Members Karen Hartfield, Mark Aubin, Ryan Oelrich.

Absent

DOH Staff Ann Bustamante, Anne Brenner, Jason Carr, Amber Casey, Justin Hahn, Frank Hayes, David Heal, Dave Kern, Sally Perkins
and (facilitator), Jessica Peterson, Beth Watkins.

Facilitator

Visitors Erick Seelbach (HHS HIV/AIDS Regional Resource Coordinator)

I Meeting Highlights

- 1) The HPPG voted and approved the three HIV prevention planning decisions outlined at the Thursday meeting.
- 2) The HPPG voted and approved the Membership Committee recruitment frames and criteria with caveats.

II	Agenda Topic	Presenter	Estimated Duration
1	Welcome/Opening Comments and Introductions	Ed Wilhoite , Community Co-Chair Maria Courogen , Department of Health	9:00am - 9:10am

II	Agenda Topic	Presenter	Estimated Duration
REPORT	Ed opened the meeting and suggested some changes to the agenda due to the robust conversations yesterday: Add more time to the Membership Committee (agenda item 4), delete HPPG HIV Prevention Decision Check-in (agenda item 2) and continue the decision making process from yesterday, and table the World Cafe (agenda item 3) until the April meeting. The HPPG accepted the proposed changes and the agenda was approved.		
2	The "Who" and the "Where": Implications and Decisions (Continued from Thursday)	Ed Wilhoite, Community Co-Chair Claudia Catastini, Community Co-Chair Elect Dave Kern, DOH	9:10am - 11:50am
REPORT	<p>Sally polled each HPPG member on their concerns and readiness to make the proposed decisions discussed during the Thursday HPPG meeting:</p> <ol style="list-style-type: none"> 1) Approve geographic focus on three areas with greatest disease burden (Puget Sound, Vancouver, and Spokane). 2) Approve a statewide focus on persons living with HIV. 3) Approve populations groups within the three area (choose all populations or draw a line). <p>(See "Sally's March 15 Meeting Notes" for more detailed information and discussion remarks.)</p> <p>Jeff Natter made a motion to approve the geographic focus on the three areas with greatest disease burden (Puget Sound, Vancouver, and Spokane). Steven Carzasty seconded. After discussion the motion was put to a vote and passed by 12 for to 2 against of 14 members present.</p> <p>Steven motioned to approve a statewide focus on persons living with HIV. Lauren Fanning seconded. David Strong made an amendment to the motion to emphasize linking PLWH to care and treatment in order to reduce viral load. Both Steven and Lauren accepted the amendment. After discussion the motion was put to a vote and passed by 14 for to 0 against of 14 members present.</p>		

II	Agenda Topic	Presenter	Estimated Duration
2	The "Who" and the "Where": Implications and Decisions (Continued from Thursday)	Ed Wilhoite, Community Co-Chair Claudia Catastini, Community Co-Chair Elect Dave Kern, DOH	9:10am - 11:50am
REPORT	<p>The HPPG discussed the inclusion of population groups within the Puget Sound, Vancouver, and Spokane (choose all populations or draw a line):</p> <p>Puget Sound Marcos Martinez made the motion to accept all populations identified in the presentation slide for continued consideration. Steven seconded the motion. After discussion the motion was put to a vote and passed by 14 for to 0 against of 14 members present.</p> <p>Vancouver Jeff made a motion to draw a line under White MSM in Vancouver. Richard Aleshire seconded. After discussion the motion was put to a vote and failed by 7 for to 7 against of 14 members present. Marcos motioned to accept the full list of populations identified in the presentation slide for Vancouver for further consideration. Steven seconded. After discussion the motion was put to a vote and passed by 8 for to 6 against of 14 members present.</p> <p>Spokane Jeff made a motion to accept all populations identified in the presentation for Spokane for further consideration. Lauren seconded. After discussion the motion was put to a vote and passed by 8 for to 6 against of 14 members present.</p> <p>Maria reviewed the decisions made by the HPPG today and next steps. Sally asked HPPG members to list the questions they were most concerned about answering effectively with regards to the HPPG decisions made today. There was not enough time to review and discuss the questions at this meeting.</p> <p>See the "The people Affected: Who and Where Coming to Consensus" presentation and "Sally's March 15 and 16 Meeting Notes" for more detailed information.</p>		
BREAK and WORKING BRUNCH			

II	Agenda Topic	Presenter	Estimated Duration
3	Membership Profile Presentation, Discussion and Decision	Katie Querna and Daniel Schollaert, Membership Committee	12:00pm - 1:00pm
REPORT	<p>Katie Querna and Daniel Schollaert introduced the Membership Committee (MC) (Claudia Catastini, Heather Hill, Lauren Fanning, Daniel Schollaert and Katie Querna). The presenters described the MC's work for 2012. Katie described the focus of the MC's presentation and discussion was to vote to accept HPPG membership recruitment criteria. After today the MC will also be developing a recruitment timeline, a recruitment strategy, an evaluation process, and a new HPPG member orientation. The MC reminded the group that HPPG member qualities will be used to guide the selection of new HPPG members per the HPPG Charter and Policy and Procedures Manual.</p> <p>The presenters outlined the membership roles and responsibilities of the MC and the HPPG. While the MC will facilitate the recruitment and evaluation process there is a collective responsibility of the HPPG to target and recruit quality HPPG member candidates based on recruitment criteria. The presenters reviewed a draft MC timeline, the HPPG membership profile and membership criteria frames, and recruitment opportunities. The presenters also mentioned that the HPPG will need to have a separate conversation about gaining additional HIV prevention planning perspective and input in alternative ways to HPPG membership.</p> <p>HPPG membership criteria concerns included:</p> <ul style="list-style-type: none"> + How will HPPG qualities and other criteria be weighed when evaluating HPPG member candidates? + How will HPPG member candidates be asked to respond to membership qualities and other criteria (self report, etc.)? + Make the application process simple. + Change recruitment of "PLWH" to "HIV consumer". <p>Daniel made a motion that the HPPG accept the frames and criteria (with HPPG qualities being foundational), as shown in the presentation, with the caveat that HPPG concerns will be addressed at a future HPPG meeting. Jeff seconded the motion. After discussion the motion was put to a vote and passed by 13 for to 1 against of 14 members present. The discussion about gaining additional HIV prevention planning perspective and input in alternative ways to HPPG membership was tabled until a later date.</p>		

II	Agenda Topic	Presenter	Estimated Duration
4	Public Comment and Evaluations	Claudia Catastini, Community Co-Chair Elect	1:00pm - 1:10pm
REPORT	There was no public comment.		

III Close Meeting

Next meeting: April 19, 2012

HPPG MARCH 15 AND 16, 2012 FLIP CHART NOTES

THURSDAY, MARCH 15, 2012

HPPG COMMENTS ON THE RECAP COMMENTS:

- Where does stakeholder input fit into this work? We talked about it during the transition. *We hope to cover this tomorrow and it is part of the focus ahead.*

HPPG COMMENTS ON THE HIV TESTING AND STD TESTING OUTCOME PATHWAYS (see also diagrams of the actual pathways as “marked up” by the HPPG)

- What are the links to Hep C? *We will begin this conversation tomorrow as well.*
- Can we eventually integrate HIV, STD and Hep C?
- Should an HIV test be offered for all folks seeking STD tests?
- Barriers to routine testing need to be reduced/eliminated
- Should we approach this as “sexual health,” all in one package?

HPPG COMMENTS ON THE nPEP OUTCOME PATHWAY:

- Is this available now? Who pays? How does it work currently?
- There is a lot of controversy on this
- What are other states doing?
- I want to look at the science on this—how/whether it works
- Does it work or do people drop out? Is occupational risk understood/perceived differently?
- I don't feel that I know enough about this to have an effective conversation
- The HPPG needs a level playing field of information
- What is it, what is algorithm?
- What is the attrition rate of patients on nPEP?
- Are there long term health effects (liver, kidney, other)?
- Will multiple drug resistance start to happen?
- If the HPPG has a presentation, I would rather not have a debate of opinions but a dispassionate presentation of the science
- Articles to read
- Would this have a positive or negative impact on drugs available to HIV+ folks?
- If we can't get meds for folks who ARE infected, how would we get meds for folks who AREN'T? Won't this increase the disparities for folks who ARE infected?
- If the focus is sero-discordant couples, then that is gay men, I fear that this will be focused only on gay men
- These are gender-non-specific interventions
- Acceptability of this to our customers? But can we really assess this? Our customers could change their minds about acceptability (ex: condoms)
- How are they taking it; how do they want to take it?

HPPG COMMENTS ON THE PrEP OUTCOME PATHWAY:

- PrEP can be taken orally, topically or intermittently. Depending on the science, there are different pathways.
- If there is a waiting list for ADAP, then why publicly fund this?
- How do we use information about HIV meds and impact to understand this?
- What is the issue re: political will?
- Additional scientific information comes on line all the time, we need to continue to review and track it for impact on Outcome Pathways
- This pathway needs to be linked with health education, risk reduction, and other supports.
- Need to look at qualitative research on folks' attitudes, beliefs and knowledge about PrEP.
- Adherence with meds? Stigma?
- Assume that this would be happening with high risk folks? How would we sort out high-risk groups? Or are we looking at risk in general?
- Acceptability—is this really an issue or can we change the conversation?
- Try for a “both/and” outlook, rather than an “either/or”

ADULT VIRAL HEPATITIS AND HIV PREVENTION—WHAT ARE THE OPPORTUNITIES TO COORDINATE?

- *There is an opportunity to integrate services at the client level*
- *Some focus is required currently in DOH contracts—staff training, prevention, testing, etc for hepatitis.*
- Viral hepatitis includes Hep A, B and C
- *Looking for the intersection between HIV and Viral Hepatitis*
- What does good integration look like? How do we increase capacity among providers?
- What is currently being done?
- One challenge is to get vaccines into programs, if staff do not have credentials to administer immunizations
- Also STD's
- “Tactical” integration? For groups whose risk profile matches the risk of viral hepatitis and HIV?
- Feds will not fund what they consider to be duplicative services...and people will fall through the cracks.
- We accomplish this significantly with partners—there either needs to be an STD clinic, or partners.
- One barrier is that there is nowhere to send people for care
- One opportunity for impact is in the defining of benefit packages and essential services under the Affordable Care Act. We need to get to the Health Care Authority (WA State), and the timing is urgent.
- A rapid Hep C test is now available

- If we maximize integration, what does that get us for HIV prevention? It won't improve outcomes for HIV prevention; it will improve outcomes for STD's.
- HIV+ people do less well if they are co-infected with Hep C?
- Shift paradigm to sexual health or needle health, and then this integration strengthens the whole effort
- Good Hep C prevention does mean good HIV prevention
- Good HIV prevention may not impact Hep C
- Grouping can normalize services in the community
- Cannot ignore the fact that there are fewer resources for treatment for Hepatitis, and we don't have places to send people for confirmatory tests and care.

FRIDAY, MARCH 16, 2012.

HPPG POLL THE GROUP INDIVIDUAL COMMENTS ON THE PENDING DECISION ABOUT THE WHO AND WHERE (Friday morning; note that most of these comments related to the first decision about the three circles):

- We are leaving people behind, which gives me pause. 23% outside the circles...what is our responsibility to the 23% areas? Some level of service?
- Are we prioritizing populations within circles? Need to have this conversation. Review our intention and philosophy. Hard to do. Why would we choose this decision? The infection is driven in the urban core, is there also an impact outside? What this means for quality, focus, etc. of the work.
- I am ready to decide, but worry that there will be new infections in vain. I don't have faith about what happens to the 23%, we don't have certainty about what WILL work.
- Uncomfortable—what is our moral obligation to the communities we serve/capacity to help groups that might lose...are we writing off part of the population?
- I would like to know what the implications really are—we should answer before deciding (in an ideal world)
- Data-wise, what would it look like to draw a circle/oval for the Yakima-Tri-Cities-Walla Walla corridor? What will be lost in this area if it is not included?
- We have done the work to decide, but understand the emotional barriers...we need to review the philosophy again, other partners may be addressing some of these areas, too. I am not fatalistic.
- I am comfortable; we agreed on the philosophy a long time ago, to be data-driven.
- I am ready, we need to be careful going forward, and trust DOH to be responsive to our concerns. Some concerns may not be answerable ahead of time. So we need to speak up if we see this not happening. It is a great obligation that we have to the people not being served, we need to monitor, monitor, monitor.
- Agree with Jeff, the framework has been decided. But when the \$\$ moves, will the recipient deliver what needs to be delivered? The money needs to be better spent, to achieve outcomes. I worry that the inertia of the system will slow this down or prevent it. DOH needs to hold people to practical outcomes and what happens if they don't meet them?
- I am comfortable but have a concern about the amount of time it has taken us to make a decision when people are getting infected as we move slowly. A strategy to serve HIV+ people in the 23% will help address those who are seen as losing services.
- I am ready to decide, but I have a concern about folks' access to health care when that access comes (now) through the HIV programming in the rest of the state. What is the operational difference going to be? We will recreate what HIV prevention should look like in the three areas.
- I am comfortable, and appreciate the thoughtfulness of the HPPG, and the focus. I have concerns about DOH's intentions for the initial framework...excellent work in Olympia may be more important than crappy work in Renton. How will this be carried out in service delivery? DOH needs some courage.
- I need to know intellectually that this is the right decision, even if my gut hurts.

Decision #1 (regarding the three epicenters/circles):

The HPPG reviewed the **philosophical framework** for the decision:

Vision: Reduce as many HIV infections as possible given the resources available.

Data-Driven: Look at the data, look for concentrations of cases. These are found in urban areas. We looked at new infections because they represent the greatest chance of transmission.

Three “circles:” The circles represent the three areas with the greatest concentrations of new cases.

Additional comments and discussion by HPPG members:

- Is what we are doing now in prevention working? Either in the 23% or within the three circles?
- What will be different and better for HIV+ people around the state?
- If we impact the core, I believe we will impact outside the core.

Comments related to the decision about the three circles:

- We need a better HOW for Puget Sound service delivery
- Challenge DOH to rethink who is effective in doing this work. Look for new organizations?

Decision #2 (regarding services for all HIV+ persons statewide):

Comments and discussion by HPPG members:

- It is hard to vote on this without knowing what this would entail in the way of services.
- DOH explained that this would include linkage to care and partner services, and there may be other considerations as well.
- If the goal is linkage to care (leading to suppression of viral load) then let's add this to the decision. Also partner services. Descriptive, not restrictive.
- DOH is already doing this? Maybe it's time to launch the “bow tie” between Prevention and Care?
- I am concerned that Part A is not available to Pierce County so that this decision would unfairly impact Pierce County. *There are other sources of funds to cover Pierce County for this issue.*
- Will this focus first on the communities with the largest number of HIV+ people with the funds we have, consistent with our philosophy? *No, we intend to reach everyone.*

Decision #3, regarding prioritizing populations within epicenters:

- For the **Puget Sound** circle, should we prioritize now, or move the whole list forward and prioritize later?

- Link to geography? I don't want to lose the geographic flavor within the Puget Sound epicenter.
- The decision was to move all of the groups forward for deeper study and possible prioritization in the future.
- For the **Vancouver** circle:
 - All but the largest group has one new infection a year—how can we argue to focus on this group?
 - Especially compared to other areas that are not in the three circles but have higher case counts?
 - Funding cannot be group-based, but can funding be flexed to serve the occasional person not in the group? *Yes.*
 - Focus on white MSM—does this include IDU or not?
 - Will a focus that does not include IDU mean that syringe exchange will not be funded? [*Sally's note: there were comments pro and con about the effectiveness of syringe exchange in HIV prevention*]
 - Concern re: excluding Hispanics
 - This is way too detailed—ONE case a year?
 - Should HIV prevention funds support syringe exchange?
 - We haven't had the conversation about what we do (implementation-wise) with the groups prioritized.
 - The proposal to draw a line under white MSM failed in a tie vote.
 - All groups contribute to the disease burden so why exclude some?
 - All groups were passed through for further discussion about prioritization in the future.
- For the **Spokane** circle:
 - All groups were passed through but focus is still important.

Next Steps:

- DOH:
 - Get the Assistant Secretary and Mary Selecky on board and gain their support.
 - Coordinate this with other DOH initiatives.
- HPPG:
 - Look at the populations within the three circles, to see whether/how to prioritize
 - Have a sound bite answer to the question, "why is this the decision?"
 - The presentation slides include much of the information for a summary of what we decided and why
 - We can say that the details will be fleshed out in the future
 - How we present this matters
 - We need to commit to continue the hepatitis conversation—how does it relate to our Vision? How does it fit? Are we talking about IDU health, where a portion of the issue is in HIV prevention but also in AVH?

- When do we revisit our scope?

Questions we worry about being asked. Once this decision is made public, HPPG members will be expected to answer questions about it. To surface the most “worrisome” questions, HPPG members listed out the questions that they are most concerned about being able to answer effectively. These were written and turned in; there was not time for a discussion at this meeting.

- What guided you to your decision about HIV prevention?
- What will happen to people outside the three areas?
- What prevention services will there be outside of the three areas?
- Why don't Latinos matter (migrant workers, especially rural)?
- Why don't African-American women matter, especially with health disparities?
- Why don't African-American MSM matter, especially with huge MSM/HIV disparity in new rates? [African-American women and MSM especially in Vancouver and outside of oval]
- How are you going to be able to really reduce new infections—isn't it just going to be funding who already gets the money—status quo, doing everything as usual with just more money?
- How do I respond to the Yakima Valley (Yakima/Kennewick) communities when asked, “Why Vancouver and not us?”
- How we could defend our decision to apply a different logic model to our populations in Vancouver/Spokane than we did to Puget Sound.
- Why are you recommending operational funding (or its possibility) for, say, white hetero females in Spokane and now with MSM in, say, Olympia or Bellingham, or Latino men in the Yakima Valley [the logic inconsistency]
- Why does King County get all of the services?
- Why do people with HIV get some much money to provide services?
- Why doesn't DOH care about Eastern Washington?
- I don't go to cocktail parties. I will be at the syringe exchange. People at the syringe exchange will ask: Why don't I matter? What am I going to do? Where do I go?
- If HIV doesn't only affect gay men then why aren't we focusing on other groups like women?
- How will increased resources to the focus areas improve outcomes?
- What has been proven successful re: HIV prevention in WA State already?
- Why not just do more of that?
- Why can't services be centralized in the three areas to deliver more effective services?
- What is going to happen to those accessing services (care in areas that will no longer be prioritized)?