Philadelphia HIV Prevention Planning Group (HPG)
Meeting Minutes of
Wednesday, June 29, 2016
2:30-4:30p.m.
Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia, PA 19107

Present: Jennifer Chapman, Tiffany Dominique, Gus Grannan

Excused: Sophia Bessias, Caitlin Conyngham, Lorett Matus, Clint Steib, Nick Wood

Absent: Fred Graham, Daniel Harris, Mark Anthony Wilson, Jr., Paul Yabor

Guests: Joseph Roderick, Mark Coleman, Leroy Way, Katelyn Baron, Derrick Wilson

Staff: Mari Ross-Russell, Debbie Law, Nicole Johns, Briana Morgan, Antonio Boone, Jennifer Hayes

Call to Order: J. Chapman called the meeting to order at 2:38p.m.

Welcome/Moment of Silence/Introductions: J. Chapman welcomed HPG members and guests. A moment of silence followed. Those present then introduced themselves.

Approval of Agenda: J. Chapman presented the agenda for approval. **Motion**: T. Dominique moved, J. Chapman seconded to approve the agenda. **Motion passed**: All in favor.

Approval of Minutes (*April 27, 2016*): J. Chapman presented the minutes for approval. **Motion**: T. Dominique moved, J. Chapman seconded to approve the April 27, 2016 minutes. **Motion passed**: All in favor.

Report of Co-Chair: J. Chapman stated that she'd recently attended a UCHAPS meeting. She reported that the topics were HPG 2.0 and meaningful community engagement, along with the HIV continuum for people who were HIV-negative. She said she'd present a few slides at the next HPG meeting.

Report of Staff: None.

Discussion Item:

- **Review Integrated Plan Section I**

N. Johns directed the group to the draft of Section I of the Integrated HIV Prevention and Care Plan in their packets. She stated that the Comprehensive Planning Committee had reviewed Section I last Thursday. She added that the Planning Council would also look over Section I next month.

N. Johns explained that Section I of the plan set the stage for the goals, objectives, and activities outlined in Section II. She stated that Section III discussed monitoring standards for these programs. She asked the group to look through Section I and share any feedback or questions they had.

N. Johns stated that the integrated plan followed HRSA's guidance. She noted that some of the information included in the plan might be redundant as a result.

N. Johns explained that the beginning of the plan included an epidemiological overview. She stated that it mapped out demographic characteristics of the general population in the EMA (the entire 9-county region), though most prevention information was specific to Philadelphia. She said the demographics included race/ethnicity, poverty and income, education, employment, insurance, mental health, substance use, sexual behaviors, teen pregnancies, prenatal care, sexually transmitted infections, incarceration, and housing.

N. Johns directed the group to the map on pg. 4. B. Morgan noted that the legend of the draft version may be difficult to read, although this would be updated in the next version of the plan. She stated that orange dots represented White people at or below the poverty line, blue represented Black, red was used for Asian, and green for Hispanic. She stated that census tract level data was used to create the maps. She noted that maps of poverty by race and ethnicity closely mirrored the populations at risk for HIV in the regions.

N. Johns stated that the plan included a long discussion of substance use in the EMA. She said substance use, poverty, mental health, and housing were explored in depth throughout the document.

B. Morgan explained that the data used in the epidemiological overview was based on the full epidemiological profile, released in 2015. She stated that she'd updated data where possible. She noted that the availability of current data varied.

N. Johns stated that the next segment of the epidemiological overview included information specific to PLWHA in the Philadelphia EMA. She said there was data on HIV prevalence, HIV incidence, deaths, emerging populations (new cases versus prevalence), and special populations (including MSM, Black women and men, Latino men and women, people who inject drugs, youth aged 13-24, transgender women, and pregnant women).

N. Johns informed the group that underlined urls in the document were hyperlinks, which would be clickable on the pdf version of the plan.

T. Dominique asked if national or governmental sources were required by HRSA's guidance. N. Johns replied that not all sources had to be governmental. She stated that the plan used data from many sources. T. Dominique said she knew of a paper from 2014 that dealt with the HIV epidemic in Philadelphia specifically, along with Baltimore. She said that the study was released by the CDC. N. Johns stated that she believed the study had been used in a later section of the plan. T. Dominique stated that the same author had written a report using insurance claims data, which was released in 2008 or 2009.

J. Chapman asked if the categories in the epidemiological overview were all required by the guidance. B. Morgan stated that the epidemiologic overview section was based on the OHP's separate epidemiological profile, which had its own guidance from HRSA and the CDC. She said the draft of the plan met the guidance, but expanded on some areas. G. Grannan asked how much the guidance for the epidemiological profile and integrated plan differed. B. Morgan responded that the two were not inconsistent. However, she said the epidemiological profile guidance was more specific. M. Ross-Russell stated that the process for writing the plan needed to be consistent with the National HIV/AIDS Strategy (NHAS). B. Morgan said that the needs, gaps, and barriers section of Section I (to follow) included some additional statistics.

T. Dominique asked if the prevention section of the plan was confined to Philadelphia only. M. Ross-Russell explained that the EMA had been given various options for writing the plan. She

said these included writing a statewide plan, in which the EMA would write plans in conjunction with Pennsylvania and NJ. She added that another option was an EMA-wide plan, following up with PA and NJ states where needed to ensure goals and objectives were consistent between the three. Further, the EMA had the opportunity to write separate care and prevention plans, as they had done in past years. She explained that the EMA had chosen to write one integrated care and prevention plan, and had asked the states for information as needed.

N. Johns moved forward to part B of Section I. She stated that much of part B came from the Ryan White grant application. She noted that it started with a care continuum for the Philadelphia EMA. She stated that definitions for spots along the care continuum followed, along with an explanation of how they were measured in the EMA. Next, it included a summary of efforts to improve outcomes on the continuum. It also covered disparities along the continuum. Finally, pg. 26 discussed how the Planning Council developed a care continuum tool that was used for Ryan White Part A priority setting.

T. Dominique stated that she'd attended a Planning Council meeting in April. She noted that someone at the meeting had mentioned adding a category of "always suppressed" on the care continuum. She acknowledged that always suppressed was an ambitious goal. N. Johns stated that always suppressed was not part of the care continuum according to the guidance. M. Ross-Russell said the individual in the meeting was talking about another region that included "always suppressed" on their continuum of care. She noted that the category was not included in the NHAS. She stated that it was likely not possible to add the category for this year's plan, though it may be added in a future update.

G. Grannan noted that the plan discussed different funding sources for syringe exchange on pg. 19, at the end of the first paragraph. He asked why private funding was not included. B. Morgan said that the section was talking about the Philadelphia Department of Public Health's efforts to expand syringe access using city funding.

J. Chapman noted that a new website, "Do You Philly," was also mentioned on pg. 19. She suggested that the website "Take Control Philly" be added as a hyperlink in the section of the plan discussing condom distribution.

T. Dominique asked if the CDC's 15-1509 grant was specifically for African-American men who have sex with men (MSM). D. Wilson said that it targeted MSM of color, of any age.

J. Chapman pointed out that the PDPH piloted an HIV testing tool, as mentioned on pg. 20. She asked if the program had been successful. N. Johns replied that it had. J. Chapman suggested noting that the program was successful in the document.

N. Johns directed the group to part C of Section I. M. Ross-Russell explained that part C was a Financial and Human Resources Inventory, which included both private and publicly funded services available to PLWHA in the EMA. She said it included number of staff, workforce capacity gaps, and any funding that supports those services. She said the information had been gathered from various sources. M. Ross-Russell stated that this information had previously been collected through CareWARE, but was no longer part of the software.

M. Ross-Russell explained that she'd updated a table included in the Part A application attachments, with checkmarks in the boxes that represented funding sources by service category. She stated that the chart also included a dollar amount for funding from each source. She noted that the chart was divided into core and supportive services.

M. Ross-Russell stated that pg. 30 of the plan listed services that affected each level of the care continuum. She said the chart included funded services only and was taken from the grant application.

T. Dominique noted that M. Ross-Russell had said the OHP was trying to keep the plan below 100 pages. She asked if that included the appendices. M. Ross-Russell stated that it did not. She noted that the appendix included a full list of resources for PLWHA in the EMA. She said that service providers funded by AACO were listed in bold and italics. She added that demographic maps would also be included in the appendix.

M. Ross-Russell explained that data on workforce capacity was taken from the Bureau of Labor Statistics. She said that the data was used to identify deficiencies in workforce capacity in any region of the EMA. She stated that values of 1 and above for location quotient signified that the area was at or above the national average for the occupation title. On the other hand, values below 1 signified a deficiency for that occupation. She noted that Salem County was part of another statistical area for the Bureau of Labor Statistics, and thus had not been included.

J. Chapman noted that there were no epidemiologists available in certain counties. M. Ross-Russell explained that the Bureau of Labor Statistics sent out a survey to gather their workforce capacity data. She stated that for every occupation that was not listed, she had looked for data from other sources. M. Ross-Russell pointed out that "case manager" was not listed as an occupation title. She stated that it was not included as a category by the Bureau of Labor Statistics.

M. Ross-Russell directed the group to pg. 41 of the plan. She noted that HRSA published a list of health professional shortage areas. She stated that the statistics looked at shortages in primary care, dental care, and mental health care providers. She noted that New Jersey and Pennsylvania were shortage areas.

N. Johns said that part D of Section I concerned needs, gaps, and barriers. She stated that the first few pages described the needs assessment process and data sources, including OHP needs assessment activities and activity from the PDPH and national data sources. She stated that the Medical Monitoring Project (MMP), OHP Consumer Survey, AACO client intake data, and other sources were used to gauge unmet need. She explained that the next segment listed identified service needs and gaps for PLWHA and those at most risk of HIV. She said that these needs included high quality HIV and primary care, medical and non-medical case management, transportation, dental care, mental health and substance use services, and resources to address housing insecurity/homelessness. N. Johns noted that she'd added information she received from dental providers into the plan over the last few days.

N. Johns stated that the plan proceeded to identify barriers to HIV prevention and care services. She said these included social and structural barriers, legislative and policy barriers, health department barriers, program barriers, service provider barriers, and client barriers.

G. Grannan pointed to pg. 49, in the overdose section. He stated medications, including medications for HIV, could increase the likelihood of overdose. He added that some foods like grapefruit juice could also increase the chance of overdose. He pointed out that periods of abstinence (including incarceration and successful abstinence-based treatment) could contribute to overdose. J. Chapman said the integrated plan mentioned high-purity batches of heroin. She pointed out that Philadelphia and Camden had some of the highest-purity heroin in the country.

N. Johns stated that she'd originally included this in the plan, but had removed it. G. Grannan pointed out that information on heroin potency was not always reliable.

B. Morgan said that part E on data access, sources, and systems began on pg. 56. She explained that this part described the major data sources used for writing the plan. She added that the section explored challenges to data gathering, in addition to barriers to it. She noted there were inconsistencies in definitions between different data sources. She noted that PA did not have full reporting for CD4 counts or viral loads. She said that there were limitations to estimating population characteristics for various HIV risk groups (e.g. trans populations). Further, insurance data could not be estimated by sexual orientation, and the numbers of people who used drugs could never be estimated in a reliable way. She noted that the section listed data limitations for the epidemiological overview as well as the needs gaps and barriers section. N. Johns pointed out that some data that might be helpful was not currently collected.

N. Johns stated that the plan was due at the end of September. She noted that community feedback would be welcomed over the next few weeks. She said that sections 2 and 3 would be shared by email before the next meeting. She stated that a draft of the final plan would be available at the August planning body meetings. She asked that any comments be emailed to her at nicole@hivphilly.org.

Old Business: None.

New Business: J. Chapman suggested combining the July Planning Council and HPG meetings. N. Johns noted that the Comprehensive Planning Committee meeting was scheduled for July 21st. She noted that the CPC also intended to review the integrated plan. J. Chapman stated that the July HPG meeting would be combined with the Comprehensive Planning meeting on July 21st.

Research Updates: T. Dominique stated that there would be an announcement coming out July 23rd on an important study being conducted in South Africa. T. Dominique stated that Philadelphia was the number one site in the US for the Antibody Mediated Profusion (AMP) study. She said the goal was to have 90 people enrolled in the study in Philadelphia. She noted that the study had been so successful that the measurements for future studies were going to be changed to increase inclusiveness. J. Chapman asked for more information about the AMP study. T. Dominique stated that the AMP study used a profusion of antibody clones to encourage immune responses that may prevent people from getting HIV in the future. A. Boone asked how many studies were going on in the US. T. Dominique stated that there were 20 sites in the US. She added that there were also some sites in South America and South Africa.

Announcements: M. Coleman stated that June was LGBT Month.

J. Chapman stated that D. Wilson would be joining the HPG as their temporary governmental co-chair.

Adjournment: The meeting was adjourned by general consensus at 3:47p.m.

Respectfully submitted by,

Jennifer Hayes, OHP

Handouts distributed at the meeting:

- Meeting Agenda

- April 27, 2016 Meeting Minutes
- Integrated Care and Prevention Plan Section I (Not scanned)
- OHP Calendar

HIV Prevention Planning Group (HPG)

Meeting Agenda

Wednesday, June 29, 2016
2:30 p.m. – 4:30 p.m.

Call to Order

Welcome/Moment of Silence/Introductions

Approval of Agenda

Approval of Minutes (*April 27, 2016*)

Report of Co-Chairs

Report of Staff

Discussion Item:

- Review Integrated Plan Section I

Old Business

New Business

Research Update

Announcements

Adjournment

Please contact the office at least 5 days in advance if you require special assistance.

The next HIV Prevention Planning Group (HPG) meeting will be held on
Wednesday, July 27, 2016 from 2:30-4:30p.m. at
the Office of HIV Planning, 340 N. 12TH Street, Suite 320, Philadelphia, PA 19107
(215) 574-6760 • FAX (215) 574-6761 • www.hivphilly.org

Philadelphia HIV Prevention Planning Group (HPG)
Meeting Minutes of
Wednesday, April 27, 2016
2:30-4:30p.m.
Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia, PA 19107

Present: Sophia Bessias, Jen Chapman, Tiffany Dominique, Gus Grannan, Lorett Matus, Clint Steib, Nick Wood

Excused: Caitlin Conyngham, Paul Yabor

Absent: Fred Graham, Daniel Harris, Mark Anthony Wilson, Jr.

Guests: Ralph Bradley, Deanne Wingate, Willie Jenkins, Tyler Berl, Christine Quimby, John Collins, Keith Carter, Mark Coleman, David Gana, Candace Irabli, Tessa Fox, Adam Thompson, Kathleen Brady (AACO), Steven Saunders, Judith Peters, Katelyn Baron, Christopher Rivera, Alan Edelstein, J. Maurice Pearsall (AACO)

Staff: Mari Ross-Russell, Nicole Johns, Briana Morgan, Antonio Boone, Jennifer Hayes

Call to Order: J. Chapman called the meeting to order at 2:40p.m.

Welcome/Moment of Silence/Introductions: J. Chapman welcomed HPG members and guests. A moment of silence followed. Those present then introduced themselves.

Approval of Agenda: J. Chapman presented the agenda for approval. **Motion**: C. Quimby moved, D. Gana seconded to approve the agenda. **Motion passed**: All in favor.

Approval of Minutes (*March 23, 2016*): J. Chapman presented the minutes for approval. **Motion**: N. Wood moved, D. Wingate seconded to approve the March 23, 2016 minutes. **Motion passed**: All in favor.

Report of Co-Chair: J. Chapman reported that B. Shannon, former HPG interim governmental Co-Chair, no longer worked at AACO. She said there would be a replacement Co-Chair at the next HPG meeting.

Report of Staff: None.

Special Presentation:

- **Annual Epidemiologic Presentation** – *Kathleen Brady, PDPH*

K. Brady stated that she'd provide EMA-wide data in her presentation, unless it was unavailable. She introduced the group to the HIV Care Continuum, which traced people living with HIV/AIDS (PLWHA) on a continuum from "not in HIV care" to "fully engaged in HIV care." She said the steps of the continuum included unaware of HIV infection, aware of HIV infection and not in care, receiving some medical care but not HIV care, entered HIV care but lost to follow-up, cyclical or intermittent user of HIV care, and fully engaged in HIV care.

K. Brady explained that data for the prevalence-based (including people who are aware and unaware of their HIV infection) continuum in her presentation was gathered from the National HIV Surveillance System and the Medical Monitoring Project. She displayed a bar graph titled "Persons Living with Diagnosed or Undiagnosed HIV Infection, HIV Care Continuum Outcomes,

2012 – US and Puerto Rico." She said that 87.2% of PLWH in the United States were diagnosed, 39.1% received medical care, 36.2% were prescribed ART, and 30.2% were virally suppressed. She noted that the rate of viral suppression was not very high.

K. Brady stated that the diagnosis-based continuum was based on the National HIV Surveillance System and the Medical Monitoring Project (the former was the denominator and the latter was the numerator). She reported that, according to this data, 53.9% of PLWHA received HIV medical care, 50% were prescribed ART, and 41.7% were virally suppressed.

K. Brady reviewed a bar graph of HIV Linkage to Care by year, from 2010 to 2014. She said that the blue bar stood for linkage to care in 30 days whereas red stood for linkage in 90 days. She noted that the new National HIV/AIDS strategy required that people be linked to care within 30 days. She said that, in 2014, 77% of people were linked to care in 30 days, and 82% were linked in 90 days. She noted that the NHAS goal was 85% linkage in 30 days.

K. Brady continued with a bar graph of Care Continuum measures of HIV diagnosis, retention, and suppression. She pointed out that, in 2014, out of HIV diagnosed individuals, 52% were retained in care and 53% were virally suppressed. She pointed out that viral suppression had significantly increased over time, from 44% in 2011 to 53% in 2014. G. Grannan asked why, according to the graph, more people were virally suppressed than retained in care. K. Brady explained that some patients only went to doctors' appointments once a year or so, particularly patients who had been virally suppressed for many years. She stated that not everyone who was virally suppressed was retained in care and vice versa. However, retention in care was a reliable predictor of viral suppression.

A. Thompson asked if AACO had data about PLWHA who were in and out of care over time. K. Brady stated that the data was available, but she didn't include it in her presentation. She stated that she'd presented a poster at Conference on Retroviruses and Opportunistic Infections (CROI) on a 4 year study that used surveillance and Ryan White data to trace predictors of long term retention in care and long term viral suppression. She stated that utilization of the Ryan White system was a predictor of viral suppression. A. Thompson noted that Puerto Rico had added an "Always Suppressed" bar to their care continuum. He recommended looking into a similar measure in the Philadelphia EMA.

K. Brady said the next slide summarized data from Philadelphia to national numbers on Care Continuum measures. She pointed out that US data was from 2012, whereas Philadelphia data was from 2014. She stated that 82% of PLWHA were linked to HIV care in Philadelphia, versus 80% of PLWHA in the US; 52% of PLWHA in Philadelphia were retained in care versus 54% nationwide; and 53% in Philadelphia were virally suppressed versus 42% nationwide. She noted that numbers for the number of people on antiretroviral therapy in Philadelphia were not available.

K. Brady moved forward to a section of her presentation on new HIV diagnoses. She showed a map that laid out the rate of diagnoses of HIV from state to state across the US. She continued with a map of newly diagnosed HIV by census tract in Philadelphia in 2014. She noted that the all red section in the top right of the graph (representing a high HIV diagnosis rate) included the Philadelphia prisons. She stated that there were higher concentration of HIV diagnoses in North Philadelphia, down Broad Street, and over toward West Philadelphia. She reviewed a chart of newly diagnosed HIV (non-AIDS) for 2012-2014 by demographic traits. She pointed out that a majority of new HIV cases were in Philadelphia, among people who were Black. She noted that there were differences in the racial and ethnic makeup of the HIV epidemic in different areas of

the EMA. She reported that 76.2% of new diagnoses of HIV (not AIDS) were among males, with similar proportions across the EMA, with a slightly higher rate among females in NJ. A. Edelstein asked if there was a category for transgender people. K. Brady stated that transgender data was not included on the chart. She said she'd be reviewing a continuum of care for transgender people later in the presentation. She noted that there were some inconsistencies in the way gender data had been gathered in different surveys.

K. Brady continued to a chart laying out the percentages of newly diagnosed HIV (non-AIDS) for each area of the EMA in 2012-2014 by age. She noted that there was a high rate of new diagnoses for the age group of 20-29. M. Coleman asked if Hepatitis C was being treated in the Philadelphia Prison system. K. Brady stated that people were treated for HIV in jail in Philadelphia, but were not treated for Hepatitis C. She said free opt-out HIV testing was also offered.

K. Brady displayed a chart of newly-diagnosed HIV (non-AIDS) cases by mode of transmission. She noted that MSM (men who have sex with men) was the most common mode of transmission, followed by heterosexual contact. She said that injection drug use was the third most common mode of transmission. W. Jenkins asked for clarification about the category "risk not reported or identified." K. Brady replied that people who did not attest to MSM, injection drug use (IDU), or heterosexual contact went into this category. She noted that some men who were reported as heterosexual also may have had sexual contact with men or people who used drugs. D. Wingate asked if transwomen were considered MSM for the sake of data collection. K. Brady replied that the PDPH collected separate data on transgender people. She noted that transwomen who had sex with men were considered a risk category, but transwomen who had sex with women were not. She stated that she'd have more transgender data in next year's presentation.

K. Brady said the next graph depicted newly-diagnosed HIV cases, death, and living HIV cases by year in Philadelphia from 2008-2014. K. Brady noted that there was a declining death rate from 2008 to 2014. She pointed out that 2014 data was incomplete. She added that the number of HIV diagnoses had been declining as well. She noted that the stability in the rates of number of PLWHA in Philadelphia was partially due to people moving to and from Philadelphia.

K. Brady continued to a pie chart of people newly diagnosed with HIV/AIDS in 2014. She stated that there were 624 newly diagnosed cases. Among these, 78.8% were male at birth. 67.6% were Black, 14.5% Hispanic, and 14.4% White. She added that 23.2% of these were among 13-24 year olds.

K. Brady reviewed line graphs of HIV/AIDS cases by dates of diagnosis, newly diagnosed HIV disease by sex at birth (regardless of AIDS status), newly diagnosed HIV disease by race/ethnicity, newly diagnosed HIV disease by mode of transmission, and age at diagnosis. She pointed out that rates of newly diagnosed HIV disease among heterosexuals and people who inject drugs were falling.

K. Brady noted that the next few slides contained prevalence information as opposed to diagnosis information. She reviewed a bar graph of HIV prevalence by race/ethnicity. She stated that 2.9% of Black males were living with HIV/AIDS in the EMA, compared to 2.2% of Hispanic males, 1.1% of Black females, 1.1% of White males, 0.8% of Hispanic females, and 0.2% of White females. She stated that the overall prevalence of HIV in Philadelphia was 1.3%. A. Edelstein noted that the graph left out people who were unaware of their HIV status. K. Brady noted that epidemic level was 1% prevalence, which Philadelphia exceeded.

K. Brady stated that there were 27,121 PLWHA in the EMA who were aware of their status. She said nearly 72% were male at birth. Of PLWHA aware of their status, 57.9% were Black, 14.9% were Hispanic, and 23.2% were White. Additionally, 48% were 50+. She noted that the pie chart on the slide broke down the epidemic by mode of transmission. She pointed out that the population of PLWHA in the EMA was aging as fewer people were dying from AIDS. G. Grannan noted that the prevalence of HIV among IDU was falling due to needle exchange programs in Philadelphia.

K. Brady reviewed local estimates of HIV infection from 2013. She noted that the PDPH conducted incidence surveillance among people who got HIV blood tests. She said additional testing was done on the HIV-positive blood samples to estimate how recently the HIV infection was contracted. She stated that there were estimated to be 508 new local HIV infections in 2013 in adults and adolescents. She said the line graph on the next slide demonstrated HIV incidence trends broken down into demographic groups. She stated that the total incidence of HIV in the EMA had been declining since 2009. She noted that incidence among young people and MSM was falling but still was higher than 2009.

K. Brady showed the group a chart of estimated incidence rates in 2013. She said that heterosexuals, for the sake of the chart, were defined as persons 13 or older who were living in poverty. She noted that the case rate of HIV incidence per 100,000 people was by far the highest among MSM. She said that an estimated 11.5% of men and 7.5% of women with HIV in Philadelphia were unaware of their status. She noted that the total rate of people unaware of their status was estimated at 10.4%, which was lower than the national average. She stated that groups with lower percentages of people unaware of their status were more likely to have been tested.

A. Edelstein asked how the percentages of people unaware of their HIV status were estimated. K. Brady reiterated that blood tests estimated how long ago people were infected with HIV, and, based on that information, incidence estimates could be made for a whole area.

K. Brady stated that another way to gauge the number of people who were unaware of their status was to compare non-concurrent and concurrent HIV/AIDS rates in 2014. She said that 24.8% of people diagnosed with HIV in 2014 were diagnosed with AIDS at the same time. She noted that most of these people were late testers. She pointed out that the rate of women with concurrent HIV/AIDS infection was higher, which may indicate they were less likely to be tested.

K. Brady reported that older people were more likely to have concurrent HIV/AIDS. She explained that older people were often not perceived as sexually active. Therefore, doctors may not ask them about sexual risk factors. She added that heterosexuals had a greater likelihood of being diagnosed with concurrent HIV/AIDS (due to low perception of risk and later testing). She noted that the PA counties had a higher rate of concurrent HIV/AIDS than Philadelphia or the NJ counties.

K. Brady noted that there was an increase in concurrent HIV and AIDS a few years ago. She stated that the PDPH responded by conducting a survey on access to medical care. She said most of the respondents had contact with a care provider prior to their diagnosis. Thus, there were many missed opportunities for HIV testing with these individuals. She stated that the data suggested that routine HIV testing would help to prevent concurrent HIV/AIDS diagnosis. J. Chapman asked if the survey collected information on specific providers that patients had visited prior to their diagnoses in order to target these providers for PrEP. K. Brady replied that respondents had not been asked which providers they visited.

K. Brady stated that the next several slides concerned special populations. She said that the blue bars in the first graph represented areas that were not geographic hotspots, whereas the red bars represented hotspots. She said there was a pair of bars for each level on the continuum from diagnosed to virally suppressed. She noted that multiple factors may affect HIV/AIDS care from region to region. For instance, people who did not live near a pharmacy may have trouble getting their medications. G. Grannan asked if any of the numbers had been linked with social class. He pointed out that some people living in poverty may sell their HIV drugs. K. Brady speculated that not many people were selling their HIV medications in Philadelphia. She said that poverty, geography, and the HIV care continuum were correlated in very complex ways in Philadelphia.

K. Brady said the next graph measured the percent of people retained in HIV care, using ART, and virally suppressed with and without mental illness (using data from the Medical Monitoring Project). T. Dominique asked if data was available on whether or not people with mental illness were taking medications. K. Brady replied that people were often asked what medications they took, but these were not necessarily indexed to what conditions the medications treated. A. Thompson asked if mental illness was self-reported or diagnosed. K. Brady responded that they had been diagnosed by a doctor.

K. Brady said the next graph compared transgender people and overall PLWHA along the care continuum in 2014. She stated that transgender people were linked to care at similar rates to overall and retained in care/virally suppressed at higher rates. She added that more data on transgender individuals would be forthcoming.

K. Brady stated that the next graph broke down the Philadelphia HIV Care Continuum by all PLWHA, MSM of color, Black MSM, Hispanic MSM, other MSM of color (non-White MSM), and White MSM. She said that the measures included estimates for people who were unaware of their status. She stated that the highest rate of HIV diagnosis occurred among White MSM. However, White MSM had the lowest rates of engagement in care and ART prescription. Rates of viral suppression were similar among all races. She summarized that there weren't many disparities along the care continuum by race or ethnicity.

K. Brady noted that the National HIV Behavioral Surveillance (NHBS) survey had been done since 2004. She noted that collection of data for the most recent NHBS started in July 2015, concerning IDU. She reviewed the eligibility requirements and screening process for the survey and said the goal was to conduct 500 interviews. She said there were 645 people who participated in the study. She noted that most participants were male, White, over 40, and lived in Kensington. She noted that 32 participants in the study were HIV positive, with 19 self-reporting they were HIV positive. She stated that 81% of people interviewed had Hepatitis C, including 169 newly diagnosed infections. She reviewed limitations of the study. For instance, they did not perform the confirmatory HCV test. Further, the survey sample may not have been representative of the overall IDU population in Philadelphia (including youth, female, and Hispanic).

G. Grannan noted that Hepatitis C could be transmitted in a variety of ways. He said that, in high Hepatitis C prevalence communities, people may get Hepatitis C even if they did not inject drugs.

K. Brady stated that survey participants were asked if they had used oral opiates as well as injection drugs. She said that about half of participants said they had an addiction to oral opiates before they began injecting. J. Chapman asked if the study included individuals who shared needles in order to inject hormones. K. Brady said that it could, though participants weren't asked what drugs they were injected. She speculated that not many people were sharing needles for injecting hormones.

J. Chapman asked if Philadelphia had a larger youth epidemic than other areas. K. Brady said the CDC gave a report to Philadelphia about the number of youth in the city who were HIV positive as opposed to other areas. She said these numbers were similar to other areas in the country. However, she stated that Philadelphia was very successful in getting information from youth who injected drugs.

G. Grannan pointed out that the drug being injected did not matter in terms of HIV risk. K. Brady concurred that it mattered a lot more where people got their needles. She said most people who injected drugs got needles from different sources, including dealers, exchange sites, friends, etc.

Old Business: None.

New Business: None.

Research Updates: T. Dominique stated that the AMP study was open. She said the study looked at a PrEP-like transfusion. She stated that Philadelphia was recruiting for the study. She explained that similar studies were being conducted with MSM, transgender people, and women across the world.

Announcements: M. Coleman stated that Philadelphia Gay Black Pride started tomorrow and ran until Sunday. He added that April was STD awareness month.

B. Morgan noted that the OHP's website[1] was now back up, though the office did not have full internet access. She stated that internet access would likely be restored before phones were back up.

J. Chapman encouraged attendees to carefully look at their calendars, as several meeting dates in May had changed.

Adjournment: The meeting was adjourned by general consensus at 4:10p.m.

Respectfully submitted by,

Jennifer Hayes, OHP

Handouts distributed at the meeting:

- Meeting Agenda
- March 23, 2016 Meeting Minutes
- HIV in Philadelphia (Slides)
- OHP Calendar

[1] hivphilly.org