Philadelphia HIV Integrated Planning Council
Prevention Committee
Meeting Minutes of
Wednesday, July 26, 2017
2:30-4:30p.m.
Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia PA 19107

Present: Mark Coleman, Tiffany Dominique, Gus Grannan, Lorett Matus (Co-Chair), Joseph Roderick, Clint Steib (Co-Chair), Leroy Way

Excused: Jennifer Chapman

Guests: Meg Carter (AACO), Caitlin Conyngham (AACO)

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

Call to Order: C. Steib called the meeting to order at 2:35 p.m.

Welcome/Moment of Silence/Introductions: C. Steib welcomed Prevention Committee members and guests. A moment of silence followed. Those present then introduced themselves.

Approval of Agenda: C. Steib presented the agenda for approval. **Motion**: L. Way moved, G. Grannan seconded to approve the agenda. **Motion passed**: All in favor.

Approval of Minutes (*June 21, 2017*): C. Steib presented the minutes for approval. **Motion**: L. Way moved, G. Grannan seconded to approve the June 21, 2017 minutes. **Motion passed**: All in favor.

Report of Co-Chair: C. Steib stated that he had attended the Pennsylvania HIV Planning Group (PA HPG) meeting for the first time, and that the PA HPG and Philadelphia's Prevention Committee were working on similar activities. N. Johns added that the PA Department of Health was working on a new program targeting pre-exposure prophylaxis (PrEP) to individuals who had their third or fourth sexually transmitted infection (STI) in a specific period of time. She noted that this program had not yet been implemented, but would be soon. C. Steib stated that Pennsylvania was the only state using lifetime number of STIs, as well as STIs in the past two years, in targeting PrEP. He went on to say that there was a model that demonstrated that this program would reduce HIV transmission.

Report of Staff: None.

Presentation:

- **CDC Notice of Funding Opportunity** – *Caitlin Conyngham, AIDS Activities Coordinating Office, Philadelphia Department of Public Health*

C. Conyngham stated Notice of Funding Opportunity (NOFO) 18-1802 was the flagship Centers for Disease Control and Prevention (CDC) HIV prevention grant, and that this

program would now combine surveillance and prevention activities *(see – attached handout)*. She stated that there was a focus on treatment as prevention, intensive data-to-care initiatives, and interventional surveillance. She went on to say that priority activities included HIV testing, linkage to care, engagement in care, retention in care, PrEP, prevention at a community level, and HIV cluster interventions. She then stated that desired outcomes included increased surveillance and evaluation, an increase in the number of people aware of their HIV status, improved participation in partner services, and improved response to HIV clusters, increased viral suppression, increased PrEP referrals, reduced perinatal transmission, and increased availability of condoms. She went on to say that AACO's approach was to integrate programs, align resources with the geographic burden of HIV, and improve data collection.

C. Conyngham stated that the CDC's funding algorithm for 18-1802 was based on 2014 prevalence data in each jurisdiction. She continued on to say that Philadelphia received Category B funding under 12-1201, which covered opt-out testing in clinical settings. She explained that the Category B funds had been reabsorbed into the main funding pool for FY2018. She went on to say that the CDC had released floors and ceilings for funding levels to each jurisdiction, noting that low-prevalence jurisdictions would be funded at a high enough level to allow them to sustain operations. She then stated that special demonstration projects could result in extra funding beyond the operational funding. She stated that Philadelphia would receive a 17 – 25% reduction in funding, which would take effect on January 1, 2018. She noted that programs would be affected. C. Conyngham continued to on say that AACO would assess the program requirements and submit an application, and that they would then conduct a request for proposals (RFP) process to align with CDC funding priorities. She added that past performance would be considered.

C. Conyngham stated that AACO's application for funding would be due on September 13. She stated that an RFP timeline would then be developed, which would assume the receipt of the CDC award in December for new contracts beginning on January 1, 2018.

C. Conyngham then reviewed the required strategies and activities in the NOFO *(see – attached handout).* C. Steib asked for more information about the funding for opt-out testing in healthcare settings. C. Conyngham replied that this funding had been placed back into the bigger funding pool. She explained that the CDC had been pushing for HIV testing to be routine, opt-out, and covered by third-party payers.

T. Dominique asked how this would affect current programs, such as 15-1509. C. Conyngham replied that this would be an independent RFP. L. Matus asked for clarification on how this would change the way the prevention system worked. C. Conyngham replied that 18-1802 had a heavier emphasis on initiatives such as "data to care", in which lab reporting and other surveillance data were used to identify people who had fallen out of care.

Discussion Items:

- **Continue Discussion of Integrated Plan Goals and Objectives**

C. Steib stated that the Prevention Committee had gotten to Objective 1.2.4 during their last meeting. He noted that they had moved on to Objective 1.2.5, on eliminating perinatal transmission throughout the EMA *(see – attached handout)*. L. Matus stated that they were currently assuming that expectant mothers were being tested and treated if necessary, and that the committee could look at that. N. Johns replied that she had been part of the Fetal and Infant Mortality Review (FIMR) committee for several years. She stated that Philadelphia has a best practices review of positive women having children, although they did not review every case for positive women. She went on to explain that they looked at cases where there was a system failure, or where specific procedures did not happen as they were supposed to. She explained that this work was already happening, and that Philadelphia had an excellent history of reviewing birth outcomes as well as maternal and child health. She added that Philadelphia's small number of delivery hospitals helped to ensure that all providers got the information they needed.

M. Ross Russell stated that the 18-1802 logic model reflected that perinatal prevention and surveillance included prenatal testing, case surveillance, perinatal HIV exposure reporting, and perinatal HIV service coordination. She went on to say that their objective was to reduce perinatally-acquired HIV, increase awareness of status for pregnant women, and improve perinatal HIV surveillance data. She noted that these activities were already occurring, and would be required moving forward. She went on to say that the combination of these areas in the NOFO meant that they would be doing more work with less funding. She added that the first item under Objective 1.2.5 was already in progress. N. Johns stated that there were generally two or fewer perinatal transmissions in any one year, but that there were usually zero. She noted that there was one transmission in 2016, and there were many factors and failures that resulted in an incredibly unusual set of circumstances. Referencing the data points for the current objective, M. Ross Russell asked about the number of cases that were reviewed as a part of the FIMR process. N. Johns replied that she could ask Kathleen Brady (AACO) about this, since there were specific criteria involved. C. Steib stated that there had also been some conversation about HIV transmission through breastfeeding.

T. Dominique asked how they would assess improved health outcomes for HIV-positive women. She went on to say that HIV-positive women who had more than one child were less likely to be engaged in HIV care.

C. Steib asked if they would ask AACO for number of FIMR cases reviewed, and N. Johns agreed. N. Johns added that Health Federation provided logistical support for the FIMR process, so she could contact Health Federation for more information about the process and the recommendations that came out of it. G. Grannan asked if they could get information as granular as birth order. N. Johns replied that every case included the number of pregnancies a woman had had, as well as what the endpoints of those pregnancies were.

The group moved on to discuss Objective 1.2.6 on identifying persons with acute HIV infection and immediately linking them to care. L. Matus clarified that acute infections were among people who had recently been infected. C. Steib stated that a person in acute

infection was much more likely to transmit HIV. G. Grannan stated that this objective would contribute significantly to reducing community viral load. C. Steib stated that this could also address HIV clusters. M. Ross Russell stated that they could also use this data to target services.

G. Grannan stated that a church in Kensington that was home to a community of drug users had recently been shut down, and that this could cause a spike in infections among injectors. He explained that this could happen in any community that had been taking care of itself, but was disrupted.

L. Matus asked if this objective would be a good place to address the difference between using third- and fourth-generation HIV testing. C. Steib stated that there was now a fourth-generation rapid test, and that AACO was funding the use of this test in some areas. He noted that this test was the Alere Determine. He went on to say that this test was highly effective in his clinic, and would be implemented in the emergency department in August. He noted that the rapid test was not quite as sensitive as the laboratory test, but that it could identify the HIV1 p24 protein in 10 – 14 days. L. Matus added that results took twenty minutes. C. Steib noted that the INSTI rapid HIV test only took 60 seconds, so the new test impacted patient flow. L. Matus stated that twenty minutes could be a long time in community-based testing. G. Grannan noted that the original wait time for the third-generation test had taken twenty minutes, and that counselors and testers had a precedent for using that time. T. Dominique noted that they had been moving away from counseling in recent years.

L. Matus stated that Objective 1.2.6 would be a continued discussion under the new 18-1802 grant. T. Dominique asked how they could increase implementation of fourth-generation testing in emergency departments. C. Steib replied that he was not sure what the effect of lost funding would be. He went on to say that AACO might also lose the data from the hospitals if they were no longer paying for the HIV tests, which would impact their ability to collect the measure on the number of four-generation tests performed in clinical settings. M. Ross Russell noted that AACO was aware that they could not reasonably expect a provider to put forward staff time to answer questions if they were not funding that provider. She went on to say that the Integrated HIV Prevention and Care Plan had been written with the assumption that they would have access to that data through funded providers, but that 18-1802 would change this. She next stated that this might change what data they had access to while monitoring the Plan. She noted that they could then state that an activity could not be completed due to funding changes in 18-1802. G. Grannan noted that data requests were often made from non-funded providers. C. Steib stated that testing could also decrease in the absence of a funded testing coordinator in a clinical setting.

M. Ross Russell stated that some of the objectives in the plan would likely have to be revised as they moved forward with 18-1802. T. Dominique stated that, in absence of funding, they would need community will to move forward. She went on to say that providers could decide that compliance was not worth the effort for the funding available, and therefore they would need the community to push them forward.

The group moved on to discuss Objective 1.2.7, on reducing the percentage of youth, including gay and bisexual men who engage in HIV-risk behaviors. L. Matus noted that the Love Your Brotha campaign had recently been launched. She asked if there were any surveys or other types of feedback about Love Your Brotha, so the Prevention Committee could evaluate its effectiveness. M. Ross Russell replied that data would likely include the number of HIV tests requested, the number of STI tests requested, and the number of hits on the Love Your Brotha website. She added that they may be able to measure the number of STIs at a population level from year to year.

C. Steib asked how they could get more information about condom distribution in Philadelphia schools. M. Ross Russell replied that the schools were given condom dispensers, and that it was their responsibility to contact PDPH if they needed more condoms. She noted that Take Control Philly would likely have information. She added that charter schools were separate and had different processes. C. Steib noted that condoms would still be given out at Health Resource Centers (HRCs), and that communication with charter schools was variable depending upon the school leadership.

T. Dominique asked if the committee intended to influence sex education in schools, noting that time allotted to sex education in schools was limited. C. Steib asked if 15-1509 covered any activities in the schools. B. Morgan replied that she sat on the Philadelphia School District's CDC Materials Review Panel, and that there was nothing like this in the schools. N. Johns noted that many of the young men that OHP had previously conducted focus groups with reported that the sex education they got did not meet their needs. She explained that these programs often focused on pregnancy prevention. M. Ross Russell stated that the CDC produced School Health Education Profiles (SHEP) regarding which subjects were taught in public schools. She noted that these profiles were available at the state level, and in some cases, at the city level. B. Morgan noted that the state of New Jersey required comprehensive sexuality education. N. Johns noted that Pennsylvania only required that HIV prevention be taught at some point, and that there was no sexuality education requirement. M. Ross Russell noted that there may be an increased emphasis on abstinence education for youth moving forward. C. Steib stated that it would benefit youth healthcare providers to include routine HIV testing in children's physicals, but that they did not have control over private physicians. G. Grannan asked if high school students who needed medical clearance in order to play sports had to get HIV tests, and whether data was available on this. M. Ross Russell replied that any medical clearance information would be reported to the school nurse, but unlikely anywhere else. G. Grannan asked if there were group sports medical assessments, and if those might provide an opportunity to offer HIV testing to those students. N. Johns replied that this might be a challenge, since parents already had difficulty accepting STI testing in schools.

- **Prevention Continua**

A. Boone stated that he would share examples of prevention continua *(see – attached slides)*. He began with a review of the comprehensive HIV prevention continuum from the International AIDS Society. He explained that unique service models could allow

HIV-negative people to stay engaged at a specific site. He went on to review benefits of prevention continua, as described by Horn, Sherwood et al. He then displayed another example of a prevention continuum, which included testing, linkage, retention, and adherence to HIV prevention services. He explained that each person's prevention needs were different, and could vary based on location or other factors in a person's life. He stated that there were a number of challenges, including uneven engagement in prevention services. He went on to say that this continuum could help illustrate the connections between prevention and care services, as well as address gaps in data that impact the service system.

A. Boone went on to say that HIV testing and re-testing were a common entry point into the HIV prevention cycle, and that all high-risk negatives should retest annually. He noted that HIV testing should not be seen as a one-time event, and that additional needs should be identified and addressed as a part of prevention services. He then stated that risk assessments and needs assessments could include self-assessments, and could provide opportunities to increase linkage and decrease burden on providers. He reviewed potential elements of a risk assessment, such as knowledge of risk reduction strategies, eligibility for PrEP, and navigation needs. He went on to say that these individuals could then be referred for STI screening, mental health and substance abuse assessments, screening for interpersonal violence and trauma, and assessment of health insurance and benefits.

A. Boone next stated that linkage for prevention services could include linkages to interventions and community-based organizations. He went on to say that engagement, retention, and adherence could apply to PrEP, post-exposure prophylaxis (PEP), sexual health services, syringe services programs, behavioral interventions, case management, and patient navigation services.

A. Boone next identified missed opportunities and gaps, including lack of knowledge about transmission, lack of awareness about preventive services, structural barriers to insurance, and inadequate medical care. He went on to say that they could also identify gaps by identifying what prevention services a person was accessing when they became positive, and what opportunities there were there. M. Ross Russell stated that including STI testing in HIV testing could help in identifying people who were engaging in activities that resulted in STI acquisition. She noted that this could also be a way of identifying missed opportunities. G. Grannan stated that these models were heavily centered on HIV testing. He went on to say that some populations were heavily incentivized not to test for HIV, but would test for STIs. L. Matus stated that she would also suggest including Hepatitis C testing. She went on to say that there was liability and cost associated with STI and Hepatitis C testing the field. M. Ross Russell stated that prevention providers could still give referrals to preventions services, in the event of a negative HIV test result. C. Steib asked how a provider might fund wraparound services for people who were HIV-negative. M. Ross Russell replied that a memorandum of agreement (MOA) or a memorandum of understanding (MOU) with a prevention provider could address this, since many prevention providers were required to serve a certain number of clients as a part of their contracts. G. Grannan stated that they could

also get feedback on whether providers were providing culturally competent services. M. Ross Russell noted that testing providers could still refer clients to specific sites if they had MOUs.

A. Boone stated that they could use HIV surveillance data in prevention continua, and that they could track linkages and treat each infection as an opportunity to assess gaps in the prevention system. He went on to say that rates of health insurance coverage, linkage to service providers, use of evidence-based interventions, collection of current and prior HIV testing data, and referrals to specific HIV prevention services were all examples of essential data. He noted that the CDC had combined national datasets to identify 1,232,000 individuals as potential candidates for PrEP, and that this could be used as a lower-bound threshold for a national prevention system continuum. He then reviewed examples of datasets that could be used to assess a prevention continuum.

A. Boone stated that prevention continua could offer new methods to measure HIV prevention program performance. He concluded with a review of necessary analyses in implementing a prevention continuum, noting that surveillance data was particularly important.

Old Business: None.

New Business: L. Matus stated that Conrail would be clearing out a section of railroad tracks commonly known as a center for drug use on the coming Monday. She went on to say that several organizations were coming together to provide testing and health screenings, as well as help with placement, housing, and food. She stated this event would be held for three consecutive days.

Research Updates:
T. Dominique stated that the International AIDS Society was currently meeting in Paris.

T. Dominique stated that, on June 20, the Pennsylvania Supreme Court decided that, in the case of research on experimental products or off-label FDA-approved drugs, a principal investigator who is also a physician would be required to conduct all informed consents face-to-face for all participants for research studies in the state. She explained that this had the potential to slow down enrollment for studies, which could subsequently slow down the flow of research grants. G. Grannan asked if it was possible for these face-to-face informed consents to be conducted by a physician's assistant or a nurse practitioner. T. Dominique replied that they had to be conducted by the physician principal investigator. She went on to say that the case had not been about research, but rather a case in which a woman having a brain tumor removed had signed a consent form provided by a physician's assistant following a discussion with a physician. She went on to say that the suit asserted that the physician's assistant did not sufficiently convey information about the risks associated with the surgery. She then stated that the physician had originally won the case, but that the case had gone to the Pennsylvania Supreme Court upon the appeal. She concluded that, as a result, informed consent now had to be conducted by the physician principal investigator. She noted that anyone who did not

follow this procedure was violating protocol, and would have to alert the FDA. She added that this would affect HIV cure research, as Philadelphia was one of the only sites in the United States that was doing cure research in humans.

Announcements: None.

Adjournment: The meeting was adjourned by general consensus at 4:25 p.m.

Respectfully submitted by,

Briana Morgan, OHP Staff

Handouts distributed at the meeting:

- Meeting Agenda
- Meeting Minutes from June 21, 2017
- Integrated Plan Objective 1.2 Spreadsheet
- Notice of Funding Opportunity: PS18-1802
- Meeting Calendar
- OHP Calendar