Department of Public Health
CITY OF PHILADELPHIA

EHE Advisory Group Kickoff Meeting

Division of HIV Health

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AGENDA

What we'll present today

- Introductions
- Meeting Overview
- EHE Community Plan
  - Background
  - Recommended activities
  - Implemented activities
  - Continued activities for 2025-2030
  - Ongoing challenges
- Discussion

WHAT IS THE EHE ADVISORY GROUP?

- Previously established in 2020 and comprised of members of the HIV Integrated Planning Council (HIPC)
- Purpose is to serve as a platform for ongoing feedback and development of EHE programming in Philadelphia
- Who is encouraged to attend:
  - Community stakeholders
  - EHE funded providers
  - HIV prevention & care providers

EHE COMMUNITY PLAN

BACKGROUND

- CDC cooperative agreement PS19-1906
  - Fund eligible health departments to conduct a rapid planning process that engages the community, HIV planning bodies, HIV prevention and care providers, and other partners
- First EHE Community Plan was published in English and Spanish on December 1, 2020 and is available at https://ehe.hivphilly.org/
- Overall goal: To decrease new HIV infections by 75% by 2025 and by 90% by 2030
- Plan is organized around the Federal EHE initiative's four pillars and one local pillar: Pillar Zero, Diagnose, Treat, Prevent, and Respond

PHILADELPHIA EHE COMMUNITY PLAN UPDATE PROCESS

2020-present	• Posted EHE Community Plan final in December 2020 • Updated and released the Integrated HIV Prevention and Care Plan 2022-2026 • Program monitoring and evaluation • Community and provider consultations on EHE activities • Focus groups • Consulted program teams to update the EHE Community Plan based on activities from 2020-present
November 2024	• Present Draft EHE Community Plan Update to EHE Advisory Group
December 2024	• Announce update and post draft on hivphilly.org for public comment
By March 2025	• Post EHE Community Plan Update on hivphilly.org and PDPH website

PILLAR 0

THE PILLAR THAT SUPPORTS ALL OTHER EFFORTS

Pillar zero was added locally to the Philadelphia EHE Community Plan to prioritize the promotion of health equity through systems and social structures that have historically operated as barriers for people.

The success of our subsequent planning depends on being successful at:

- Provide radical customer service at all levels
- Reduce HIV stigma through education, awareness, and anti-bias program
- Provide safe and secure housing
- “Flip the Public Health Script” to address health systems rather than individual behavior

PILLAR I

DIAGNOSE – FROM 2020 EHE PLAN

GOAL: BY 2025, 95% OF PEOPLE LIVING WITH HIV WILL KNOW THEIR HIV STATUS

GOAL: BY 2030, 98% OF PEOPLE LIVING WITH HIV WILL KNOW THEIR HIV STATUS

STRATEGY 1.1: Increase access to HIV testing through bio-social screening in medical settings, including primary and urgent care settings, emergency departments, and at prison intake

STRATEGY 1.2: Increase access to HIV testing through community-based programs

STRATEGY 1.3: Increase the frequency of HIV testing among key populations

STRATEGY 1.4: Implement a status-neutral approach to linkage with realignment and expansion of key personnel. This includes linkage to HIV medical care or prep

Strategy 1.1: Increase access to HIV testing through bio-social screening in medical settings, including primary and urgent care settings, emergency departments, and at prison intake

PLANNED

- Expand support for opt-out HIV testing in medical settings and at prison intake
- Focus funding opportunities on structural practice improvements
- Require that clinical leadership be significantly involved with implementing routine HIV testing
- Strengthen partnerships among Prison Health Services and local clinics
- Provide technical assistance to clinics on routine HIV testing

IMPLEMENTED

- Established opt-out HIV testing in 3 major emergency departments, 2 pediatric hospitals, and the Philadelphia Department of Prisons
- Hired a Prevention Clinical Associate to provide technical assistance and provider outreach
- Health Equity Assessments among funded providers

Strategy 1.2: Increase access to HIV testing through community-based programs.

PLANNED

- Develop low-threshold sexual wellness clinics with HIV/STI/HCV testing, PrEP, PEP, and linkage to care
- Use geospatial analysis to align community-based (CBO) testing with population needs
- Implement pharmacy-based HIV testing
- Partner with HIV self-test providers
- Expand community engagement efforts to promote HIV testing, PrEP, and treatment

IMPLEMENTED

- 3 Low-threshold sexual health sites
- Implemented pharmacy-based HIV testing at 2 CBO pharmacies
- HIV self-test program partnerships with 10 CBOs
- Non-clinical testing through 4 funded CBOs
- Ongoing outreach at community events
- Digital marketing focused on HIV testing, PEP, & PrEP
- PKOL Social Media Ambassadors

Strategy 1.3: Increase the frequency of HIV testing among key populations.

PLANNED

- Expand capacity for low-barrier HIV testing in strategic locations serving key populations
- Conduct health promotion activities to encourage more frequent HIV testing based on health assessment
- Explore school-based HIV testing through partnerships with community stakeholders and parent groups

IMPLEMENTED

- Low-threshold sexual health sites
- Social marketing and digital media efforts

Strategy 1.4: Implement a status-neutral approach to linkage with realignment and expansion of key personnel.

PLANNED

- Support a centralized Client Services Unit to facilitate HIV medical appointments
- Establish a Field Services Program for linkage support to care services for people diagnosed with HIV at locations with limited capacity
- Incentivize timely linkage to PrEP and HIV care of new patients as a condition of funding
- Provide partners services for partner notification after possible HIV/STD/STI exposure and link people to care

IMPLEMENTED

- Continued support for DHH Client Service Unit
- DHH Field Services Program established in 2020
- Continued collaboration with STD Control Program for Partner Services
- Quality Improvement Projects with CBO testing agencies on linkage to HIV care
- Biannual secret shopper test calls with all Ryan White Outpatient/Ambulatory-funded providers

PILLAR I

*CONTINUED ACTIVITIES FOR **2025-2030***

- Ongoing provider education/technical assistance for routine HIV testing, opt-out HIV testing, and bio-social screening
- Support the network of low-threshold sexual health sites with integration of viral hepatitis testing
- Support current partnerships with community-based pharmacies
- Expand current HIV self-test program through improved accessibility for online ordering via PKOL
- Distribute marketing and promotional materials through social media platforms, other marketing channels, and provider technical assistance
- Support partner services staff
- Expand the Field Services Program

PILLAR 2

TREAT – FROM 2020 EHE PLAN

GOAL: BY 2025, 92% OF PEOPLE LIVING WITH HIV WILL BE VIRALLY SUPPRESSED
GOAL: BY 2030, 98% OF PEOPLE LIVING WITH HIV WILL BE VIRALLY SUPPRESSED

Strategy 2.1: Improve rapid access to HIV medications and medical appointments

Strategy 2.2: Improve the capacity of the HIV medical system to retain patients in care

Strategy 2.3: Address social and structural influencers of health to improve healthcare outcomes among PLWH through behavioral health care, housing, and supportive service

Strategy 2.4: Empower people living with HIV to improve their health

Strategy 2.1: Improve rapid access to HIV medications and medical appointments.

PLANNED

- Increase access to immediate ART initiation (within 96 hours)
- Support new low-threshold HIV treatment sites and explore low-threshold implementation models of HIV care
- Build capacity in high-volume substance abuse treatment programs
- Reduce barriers to Special Pharmaceutical Benefits Program (SPBP) and emergency pharmaceutical assistance

IMPLEMENTED

- Support 6 diagnosing and 13 Philadelphia-based HIV treatment providers to develop iART protocols
- CAREWare-based performance measure to evaluate iART provision at Ryan-White Outpatient/Ambulatory-funded providers
- Support low-threshold HIV treatment sites
- Represent Philadelphia on the Pennsylvania State SPBP Steering Committee
- Ongoing technical assistance and support to substance use treatment providers

Strategy 2.2: Improve the capacity of the HIV medical system to retain patients in care.

PLANNED

- Expand the existing PDPH Data-to-Care Program to all existing HIV treatment sites
- Support provider-initiated approaches, based on provider need and capacity, to re-engage PWH in medical care
- Use data, including barrier to care data, to identify the unique needs of provider's patients and offer resources that promote retention and viral suppression
- PDPH will fund a range of options for facilities to implement to improve retention

IMPLEMENTED

- Operationalized planned programs as the EHE Engagement and Reengagement Program at 8 funded agencies, including subrecipient sites that include harm reduction and adolescent programs.
  - Each subrecipient selected evidence-informed strategies based on barrier to care data provided to the treatment sites by DHH
  - All subrecipients required to: participate in Data-to-Care, reengage of out of care patients last seen at the subrecipient, provide iART, expand service hours, participate in EHE Learning Collaborative, participate in health equity assessments and health equity plan activities
- Expanded Data-to-Care program to all but one Philadelphia-based RW funded treatment site

Strategy 2.3: Address social and structural influences of health to improve healthcare outcomes among PLWH through behavioral health care, housing, and supportive service.

PLANNED

- Expand service access through partnership with DBHIDS
- Increase the coordination of mental health and HIV care for PLWH
- Implement a Rapid Rehousing Program to assist PLWH
- Direct emergency financial assistance for rent and utilities
- Expand access to transitional and long-term housing
- Address social and structural barriers such as: transportation barriers, trauma, linguistic needs, food insecurity, and financial stressors

IMPLEMENTED

- Health Equity Officer role in leadership to ensure health equity approaches in all practices
- Expanded the Behavioral Health Consultant program to increase coordination of mental health and HIV care
- DHH transitional housing program for PLWH
- Continue to administer RWPA and State Rebate funded support services while integrating a trauma-informed approach to service delivery

Strategy 2.4: Empower people living with HIV to improve their health**.**

PLANNED

- Strengthen visibility and knowledge of Ryan White funded service delivery system
- Develop and distribute rights-based consumer medical education for PLWH
- Reduce stigma by including health equity and cultural humility approaches
- Increase the capacity of PDPH-funded HIV care providers through technical assistance
- Establish public online dashboard and ensure ongoing data dissemination to key community partners and stakeholders

IMPLEMENTED

- Health Information Helpline and Resource Finder for PLWH on PhillyKeepOnLoving.com
- Health Equity Framework implemented in all practices/across all DHH-administered services
- EHE Leaning Collaborative for providers
- Launched the EHE Dashboard

Strategy 2.5: Assess the needs of people aging with HIV in the jurisdiction, including long-term survivors and more recently diagnosed people with HIV over 50, then identify and implement strategies to support identified needs**.**

PLANNED

- Review literature on social and health challenges for people aging with HIV, and evidenced-based strategies to improve their health outcomes
- Consult with stakeholders and community members regarding proposed strategies to support people aging with HIV
- Identify service delivery providers through RFP(s) based on needs identified from the review of the literature, consultations, and available funding

IMPLEMENTED

- Annual Aging & Thriving summit
- Aging and long-term survivor-related training for MCM providers
- Interlocking Aging with HIV service guides for providers and community members
- Focus groups to identify the needs of adults over 50 impacted by HIV
- Development of an aging readiness checklist for Philadelphia-based RW funded outpatient ambulatory care sites.
- February 2025 provider meeting for HIV care and support services providers

PILLAR 2

*CONTINUED ACTIVITIES FOR **2025-2030***

- Ongoing support to increase access to immediate ART initiation
- Continue supporting new low-threshold HIV treatment sites and explore low-threshold implementation models for HIV care
- Continue building capacity in high-volume substance abuse treatment programs to increase rapid linkage to immediate ART, and link PLWH to HIV medical care
- Increase update of iART among eligible persons newly diagnosed with HIV to 95%
- Continue addressing social and structural influencers of health through behavioral health care, housing, and supportive services
- Continue supporting MCM services within the EMA
- Ongoing support and efforts towards assessing the needs of older adults aging with HIV

PILLAR 3

PREVENT – FROM 2020 EHE PLAN

GOAL: BY 2025, 50% OF PEOPLE WITH A PREP INDICATION WILL BE PRESCRIBED PREP, AND 100% OF PEOPLE SEEKING NPEP WILL BE PRESCRIBED TREATMENT

STRATEGY 3.1: Increase access to low-threshold pre- and post-exposure prophylaxis (PrEP/nPEP) for priority populations

STRATEGY 3.2: Ensure access harm reduction services and linkage to substance use disorder treatment

STRATEGY 3.3: Provide HIV prevention activities for communities at risk

STRATEGY 3.4: Provide perinatal HIV prevention activities

Strategy 3.1: Increase access to low-threshold pre- and post-exposure prophylaxis (PrEP/nPEP) for priority populations.

PLANNED

- Develop low-threshold sexual wellness clinics
- Expand PrEP clinical-community partnerships
- Expand PrEP access and provider capacity
- Establish PrEP partnerships with grassroots organizations
- Expand financial support for PrEP lab work
- Increase awareness and establish a centralized mechanism to distribute PEP
- Expand PEP availability through starter packs
- Continue clinical PrEP technical assistance
- Expand capacity to evaluate PrEP uptake

IMPLEMENTED

- Low-Threshold Sexual Health Sites
- Hired the PrEP & PEP Coordinator
- Philadelphia TelePrEP Program
- Expand support to funded providers for coverage of PrEP labs and ancillary costs
- nPEP Center of Excellence
- PrEP & PEP educational campaigns
- Hired the Prevention Clinical Associate

Strategy 3.2: Ensure access to harm reduction services and linkage to substance use disorder treatment

PLANNED

- Expand capacity for programs to distribute harm reduction supplies
- Provide organizational development and capacity building to expand local partnerships and establish new organizations providing harm reduction services and new locations of service based on need and HIV public health data
- Expand the promotion and distribution of community-specific sexual wellness and harm reduction information/supplies through innovative approaches

IMPLEMENTED

- Public Health Vending Machines

Strategy 3.3: Provide HIV prevention activities for communities at risk.

PLANNED

- Continue City-wide distribution of free condoms including high schools, locations accessed by youth, and at harm reduction programs
- Re-establish community-based partnerships for age-appropriate, comprehensive sex education and HIV education through existing health education programs including work with Philadelphia Schools
- Expand capacity for HIV prevention workforce to provide primary HIV-related education

IMPLEMENTED

- Continued partnership with STD Control Program for condom distribution
- Partnership with Health Federation for HIV related educational trainings
- Trainings by the PrEP/PEP Coordinator and Prevention Clinical Associate with providers and clinical staff
- Provider Action Toolkit

Strategy 3.4: Provide perinatal HIV prevention activities.

PLANNED

- Continue sentinel case review and system improvement activities
- Provide specialized case management for pregnant persons living with HIV
- Develop PrEP navigation support for pregnant HIV-negative women at risk of HIV acquisition

IMPLEMENTED

- Continued perinatal HIV prevention and surveillance activities such as:
  - Perinatal HIV Exposure Reporting
  - Fetal Infant Mortality Review
  - Perinatal case management
- Coordinate with Health Federation to assess and improve perinatal HIV systems

PILLAR 3

*CONTINUED ACTIVITIES **FOR 2025-2030***

- Support the Philadelphia TelePrEP Program
- Support the nPEP Center of Excellence
- Launch the Public Health Vending Machines
- Integrate existing referral networks using a whole-person approach to connect individuals to support services
- Develop partnerships with non-traditional public health partners
- Support and promote social marketing campaigns to increase HIV awareness, reduce stigma, and promote testing, prevention, and treatment
- Integrate congenital syphilis assessments into FIMR-HIV activities

PILLAR 4

RESPOND – FROM 2020 EHE PLAN

GOAL: IDENTIFY AND INVESTIGATE ACTIVE HIV TRANSMISSION CLUSTERS AND RESPOND TO HIV OUTBREAKS

Strategy 4.1: Maintain a robust core HIV public health data system to identify outbreaks of HIV

Strategy 4.2: Review incidences of HIV acquisition through Philadelphia's DExIS Project (Demonstrating Expanded Interventional Surveillance)

Strategy 4.1: Maintain a robust care HIV public health data system to identify outbreaks of HIV.

PLANNED

- Increase the capacity for HIV-related lab reporting
- Maintain capacity for new diagnoses follow-up
- Maintain capacity for molecular HIV surveillance activities and cluster review
- Quickly implement outbreak response plan as necessary to respond rapidly
- Streamline systems of data management to avoid duplication, enhance data-linkage and ascertain death factors

IMPLEMENTED

- Maintained all HIV lab reporting, surveillance, and follow-up capacity.
- Developed and maintained updated outbreak response plans.
- Rapidly implemented outbreak response plan activities including organizing internal meetings, generating communication materials including health advisories, and carried out targeted programmatic activities to respond to outbreaks.

Strategy 4.2: Review incidences of HIV acquisition through Philadelphia's DExIS Project (Demonstrating Expanded Interventional Surveillance).

PLANNED

- Conduct systematic cohort reviews of sentinel new HIV diagnoses to identify missed HIV prevention opportunities and to deepen understanding of care-seeking among people at risk of infection
- Develop plans for sustaining the DExIS activities after demonstration project ends
- Establish interventions for implementing system-wide changes based on findings of the review teams

IMPLEMENTED

- Secured competitive CDC C-CORE funding starting in August 2024 to support expanded outbreak activities including implementation of systematic cohort reviews of sentinel cluster cases to identify missed HIV prevention opportunities (Expanded Interventional Surveillance, ExIS)

PILLAR 4

*CONTINUED ACTIVITIES **FOR 2025-2030***

- Ongoing outbreak response activities
- Enhanced CDR engagement to review data and design multi-level intervention
- Design and pilot use of an adaptable cluster response evaluation plan
- Pilot a response project adaptable to other jurisdictions
- Enhance community response planning and implementation engagement
- Identify CDR promising practices & develop translation and adaptation tools

ONGOING CHALLENGES

- Less funding for CDC PS24-0047
- Establishing partnerships with Philadelphia schools
- Low PrEP Uptake among Black and Latinx MSM, cisgender women, and PWID
- Structural and systemic issues that hinder iART and Re-engagement protocols to be successfully implemented
- Need to identify more agencies to partner with, especially in hard-to-reach communities
- Ongoing programming dependent upon Federal appropriations

THANK YOU