Meeting Agenda

HYBRID:
Wednesday, October 28th, 2026
2:30 p.m. – 4:30 p.m.

- Call to Order
- Welcome/Introductions
- Approval of Agenda
- Approval of Minutes (September 23rd, 2026)
- Report of Co-Chairs
- Report of Staff
- Presentation Item
  - PrEP Use & Breakthrough Infections (Dr. Kwakwa)
- Action Item
  - Co-Chair Election
- Other Business
- Announcements
- Adjournment

Please contact the office at least 5 days in advance if you require special assistance.
The next Prevention Committee Meeting will be combined with the CPC on November 19th, 2026.

Office of HIV Planning, 340 N. 12TH Street, Suite 320, Philadelphia, PA 19107 (215) 574-6760 • FAX (215) 574-6761 • www.hivphilly.org

Prevention Committee

HYBRID: Prevention Committee
Meeting Minutes of
Wednesday, September 23rd, 2026
2:30 p.m. - 4:30 p.m.
Office of HIV Planning, 340 N. 12th St., Suite 320, Philadelphia, PA 19107

Present: K. Carter, S. DiBianca, H. Docmanov, J. Ealy (Co-Chair), S. Jacinto, C. Johnson, N. Johnson

Guests: Jada Starrett (DHH), Tanner Nassau (DHH), S. Kane

Staff: Tiffany Dominique, Elizabeth Fischer, Debbie Law, Sofia Moletteri, Kevin Trinh, Kristin Wilson

Call to Order/Introduction: J. Ealy called the meeting to order at 2:32 p.m. and asked for introductions. People introduced themselves in the room and through Zoom.

Approval of Agenda:

J. Ealy referred to the September 2026 Prevention Committee agenda and asked for a motion to approve. **Motion**: S. Jacinto motioned; C. Johnson seconded to approve the September 2026 Prevention Committee agenda. Members voted vocally in the room and through Zoom. **Motion passed:** All in Favor. The September 2026 Prevention Committee agenda was approved.

Approval of Minutes (*August 26th, 2026*):
J. Ealy referred to the August 2026 Prevention Committee Meeting minutes. **Motion**: S. Jacinto motioned; J. Ealy seconded to approve the August 2026 Prevention Committee meeting minutes. Members voted vocally in the room and through Zoom. **Motion Passed:** 4 in Favor, 1 abstained. The August 2026 Prevention meeting minutes were approved.

Report of Co-chairs:
None.

Report of Staff:
K. Trinh reported the Narcan Training on September 30th from 10:00 AM - 12:00 PM.

Presentation Items:
~ExIS & C-Core ~
T. Nassau presented an overview of cluster detection and response. T. Nassau said C-Core stood for HIV Centers for Cluster and Outbreak Response Enhancement. He asked members why collecting public health surveillance data was important. J. Ealy said it was to improve public health worldwide. S. DiBianca said it was to learn more about the clients that we serve. S. Kane said it used statistics and data to gather accurate information.

T. Nassau defined it as the "Systematic and ongoing assessment of the health of a community including timely collection, analysis, interpretation, and dissemination of information for public health purposes." It was used for communicable and non-communicable conditions such as HIV, tuberculosis, syphilis, cancer, and lead poisoning.

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T. Nassau continued that they must consider diagnosis, prevention access, treatment & viral suppression, and outbreak response for Ending the HIV Epidemic. In response efforts, it was essential to increase access to testing, treatment, and prevention. He noted that there were people within networks that were at increased risk for acquiring HIV because there's someone in their network who was living with HIV. So they want to ensure they direct resources and educational materials to get them into prevention services.

T. Nassau said they frequently have providers, community-based organizations, and partner services report any increases in diagnoses within a specific population. They also use HIV diagnosis trends and HIV cluster analyses. He continued that molecular HIV surveillance was a CDC-required HIV surveillance and prevention activity that uses molecular HIV data to identify rapid HIV transmission in communities. It can help identify gaps in HIV prevention and treatment, ensuring communities have equitable access to care. It can also lead to beneficial results like a reduction in new HIV transmissions and increased PrEP and harm reduction service uptake. T. Nassau explained how molecular data was collected. When a person was diagnosed with HIV, their provider ordered HIV drug resistance testing to determine the appropriate treatment regimen. Labs then generate the HIV sequences and resistance report. The health department received the HIV sequence information with other HIV-related testing, then analyzed the data to identify potential clusters and initiate a response.

K. Carter asked how many similar genotypes have been identified in the city. T. Nassau said within the past year, there have been 10-12 priority clusters. He noted that each year, 60% of people with HIV (PWH) had a genotype identified by the health department, meaning 40% weren't getting the resistance testing completed. T. Dominique asked if the health department could tell if it was an acute infection or new to them. He said they can tell if the specific virus was related to another case. K. Carter asked how many other tests used genotypes to determine the virus. T. Nassau said they used the method for many conditions, such as foodborne outbreaks. K. Carter shared concern about how genotype could be traced back to someone for criminalization purposes. T. Nassau said the only information that would be shared required a court order, and the only thing they could report was the HIV status of a person. He noted that they cannot determine directionality within a cluster. K. Carter asked how often DHH had been asked to give information to the courts. T. Nassau said there had been no instances in the past 7 years. J. Ealy asked if the goal of collecting the data was to ensure people were in care or aware of prevention techniques. T. Nassau said that was the goal, and he would explain why later in the presentation.

T. Nassau said the CDC preliminary data estimates that individuals identified within a cluster represent only about 25% of PWH in the underlying transmission network, with more than a third of people estimated to be undiagnosed. Others may not be identified due to missing resistance testing or virus mutations over time. Molecular HIV surveillance cannot determine directionality or specific encounters that may have led to transmission.

K. Carter asked what happened with the biosample after the testing was complete. T. Nassau answered that they dispose of the sample after testing.

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T. Nassau described an example scenario. He noted that they would consider what the level of concern was for the cluster. He asked the members what additional information they would need to better assess how concerning it was. T. Dominique suggested finding out how long it had been since being last tested. She clarified that she meant sexual health more broadly, not just HIV testing. She mentioned the potential missed opportunity around doxy PEP, PrEP, or linkage to care. J. Ealy added that many providers don't talk to their patients about their sexual history. T. Nassau agreed that it's important to consider the missed opportunities at the provider level.

T. Dominique asked what the threshold for high or emergency level of concern is. J. Ealy asked if they had ever reached that threshold. T. Nassau said they escalated to emergency response for PWID (People Who Inject Drugs) in 2018. He noted that they had to work with the Substance Use Prevention Harm Division, the Division of Disease Control, and the Office of Homeless Services to streamline the deployment and data sharing across separate divisions and departments within the city. He said they used a prioritization scheme based on case volume, but it varied by population. K. Carter asked about outliers within those populations. T. Nassau responded that it would require one-on-one conversations with people in the networks to get a better understanding of the missed opportunities.

T. Nassau continued that HIV C-Core aims to advance HIV cluster detection and response (CDR), address the needs of and improve health outcomes for people in clusters of rapid HIV transmission, prevent onward transmission, address service gaps that were contributing to rapid transmission, and reduce differences in HIV health outcomes across populations. The Philadelphia Department of Public Health (PDPH) was one of five nationwide recipients of the C-Core grant.

C-Core was split into two tiers, both of which Philadelphia was funded to carry out. The first tier included Strategy 1: Strengthen internal Health Department engagement in designing multilevel responses; Strategy 4: Enhance CDR community engagement and communications; and Strategy 5: Support cross-jurisdictional sharing and translation of promising CDR practices. Tier 2 involved Strategy 2: Design & implement an evaluation plan of multi-level response outcomes and impact and Strategy 3: Develop, implement, and evaluate CDR innovations to inform CDR implementation.

T. Nassau explained that J. Starrett was involved in the outreach, interviews, and coordination of the Expanded Interventional Surveillance (ExIS) project. ExIS was a framework that collected comprehensive data for cluster detection and response, improved cross-department coordination, increased community engagement, identified missed opportunities, identified organizational-, system-, and community-level interventions, and slowed or stopped HIV cluster growth. ExIS methodology was based on the PDPH's successful Infant Mortality Review. The goal was for the framework to identify missed opportunities for HIV prevention, conduct robust evaluation of the system failures and strengths, and develop meaningful response activities.

For case selection, individuals must be adults with HIV or named partners who meet one of the following 3 criteria: were connected to a molecular cluster at the .5% threshold that had grown by 3 or more cases since January 2023; had a diagnosis date of January 2024 or later and were in

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a time-space or molecular cluster at any threshold; or showed evidence of acute HIV infection at diagnosis and a diagnosis date of January 2023 or later.

After identifying those individuals, staff would conduct outreach to find people interested in completing an interview with the team. The interviews would take about 45 minutes to 1 hour, and participants would receive a $50 VISA gift card. The interview included topics such as sexual orientation and gender identity, housing and financial status, insurance status, primary care access & attitudes, PrEP awareness and utilization, substance use behaviors, access to treatment, and criminal justice interactions. The interview was qualitative with open-ended questions. K. Trinh asked if these questions were publicly available and if they could share them with the HIPC. T. Nassau said it was not public, but he could send a copy to HIPC.

T. Nassau continued by explaining the difference between ExIS and Partner Services. Partner Services focused on transmission sources, looked for discrepancies, assessed medication adherence, and aimed to stop disease spread through partners, testing, and treatment. ExIS focused on services received, perceived barriers, and experiences with healthcare providers, aiming to understand participants' experiences. K. Carter said it could be difficult asking sexual partners questions about their sexual experiences. He was concerned that it could lead to violent situations. J. Starrett said it was presented as a way to better understand the healthcare system and that the partner was identified as someone who might want to give feedback or help.

T. Nassau continued that the chart abstraction looks at HIV and STI surveillance data, Partner Services data, HIV testing data from community-based organizations, outpatient medical records, and emergency department and inpatient records. Comparing interview and chart data provided broader context for patients' perspectives, informed probing interview questions, and helped address potential barriers to care, including stigma, access, and health literacy. They use the interview and chart abstraction to create a case summary report. They meet monthly to review the cases and identify missed opportunities for HIV prevention or care, categorize themes and key patterns, and make preliminary recommendations. He noted that the case review team consisted of internal health department staff. J. Ealy asked if they included behavioral health specialists in the review team. T. Nassau said they did not have a behavioral health specialist, but it was a goal for the future. He added that they also hoped to include a representative from the Office of Homeless Services.

T. Nassau noted that the Community Action Team (CAT) met on a quarterly basis and included members who have the ability, influence, and resources to affect systems-level changes. They meet to review aggregate data, CRT findings, and preliminary recommendations. They develop action plans and initiate system changes.

ExIS reviewed interview findings across different levels. At a community level, they look at social/family support, system support during crisis, support for injectable/long acting PrEP or ART, and more. They also gather information within clinics, such as stigma/norms, patient-provider relationships, biases, capacity, provider turnover, and investment. They also gather client-level information, such as stigma, non-disclosure, mistrust, and limited health literacy.

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T. Nassau said they base response activities on the pillars of Ending the HIV Epidemic (EHE). They investigate how HIV testing impacts either individual clusters or system-level HIV care activities related to ensuring people were engaging in care quickly after diagnosis and becoming virally suppressed as soon as possible. They relate prevention activities to expanding access to PrEP and PEP and leveraging social media campaigns to increase awareness of knowledge related to HIV transmission. They also do structural and syndemic interventions on things like housing and access to harm reduction supplies.

T. Nassau opened the floor for discussion. He noted that he wanted to partner with HIPC in the future to help refine interventions and materials. J. Ealy asked how services affect locations outside of Philadelphia. T. Nassau said they operate primarily in Philadelphia. He added that if necessary, the CDC would inform both locations' health departments and they would take the necessary steps. Part of that process would be to provide HIV self-test kits to anyone and have them report back their test results for an incentive. If they were in Philadelphia, they would link them to care or prevention services.

J. Ealy asked how the staff evaluated their own performance. T. Nassau said they have concrete metrics to track trends within the clusters and look at linkage to care and viral suppression. He added that there were softer metrics such as informing providers how to collect effective sexual histories.

K. Carter asked if they've ever done a public service announcement to learn if providers ask about their sexual history. He believed people were not aware that their provider should be asking about sexual history. T. Nassau said they ask people about their general health and experience with providers during the interviews. He noted that they motivated clinics by highlighting the financial benefits and increased revenue associated with prescribing PrEP.

T. Dominique said she found a lot of value in cluster detection and response. She said she rarely heard it discussed. She added that people were hesitant to discuss it because they feared directionality and criminalization. She asked how HIPC could help eliminate stigma. T. Nassau said they previously did not have a good response because they didn't have dedicated funds and were worried about pushback. He said they would want to bring plain language materials for cluster detection and their goals. He asked if HIPC would review the materials for plain language.

J. Ealy noted that these past few years made it hard for people to feel comfortable sharing their experiences. K. Trinh suggested meeting again in the future for HIPC to provide feedback.

Discussion Items:

~Co-Chair Nomination~

T. Dominique reported that there was an open Chair position for the Prevention Committee. This person would facilitate meetings and set agenda topics. Candidates were required to be members in good standing of both HIPC and the committee. The committee established a one-month waiting period to allow interested members to express interest before electing a Chair. H. Docmanov nominated himself, and K. Carter seconded the nomination. T. Dominique

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encouraged interested members to email K. Trinh with any questions about the role before October 28, 2026.

Other Business:
S. Kane said they had a conversation with Horsham Clinic about becoming more progressive, and they would be open to exploring this topic. She said she would send a survey for the group to anonymously suggest improvements for the hospital. J. Ealy said the Horsham clinic had received training and further discussions about it.

Announcements:
T. Dominique said the New Jersey DOH would hold the HR1 Medicaid Non-Citizens training on September 25th at 12 pm. It would discuss who was and wasn't qualified for Medicaid based on immigration status.

T. Dominique announced the Narcan Training taking place on September 30th from 10:00 AM - 12:00 PM.

Adjournment
J. Ealy called for a motion to adjourn. Motion: J. Ealy motioned, K. Carter seconded to adjourn the September 2026 Prevention Committee meeting. Members voted vocally in the room and through Zoom. Motion passed: All in favor. The meeting adjourned at 4:06 p.m.

Respectfully submitted,
Elizabeth Fischer

Handouts distributed at the meeting:

- September 2026 Prevention Committee Agenda
- August 2026 Prevention Committee Meeting Minutes

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