HIV Integrated Planning Council
Prevention Committee
August 28, 2019
2:30 PM – 4:30 PM
Office of HIV Planning 340 N. 12th Street, Suite 320, Philadelphia, PA 19107

Present: Keith Carter, Mark Coleman, Dave Gana, Gus Grannan, Lorett Matus (Co-Chair), Nhakia Outland, Erica Rand, Clint Steib (Co-Chair)

Absent: Joseph Roderick

Excused: Katelyn Baron, Janice Horan

Guests: Brian Langly, Robert Woodhouse, Jeanette Murdock, Sarah Nash

Staff: Briana Morgan, Sofia Moletteri

Call to Order:
L. Matus called the meeting to order at 2:33 PM.

Welcome/Introductions:
L. Matus asked everyone to state their name and asked everyone to describe themselves in one word.

Approval of Agenda:
C. Steib called for a motion to approve the August 28, 2019 Agenda. **Motion:** D. Gana moved, G. Grannan seconded to approve the August agenda. **Motion passed:** general consensus.

Approval of Minutes *(July 24, 2019):*
C. Steib made a motion to approve the meeting minutes from July 24, 2019. **Motion:** E. Rand moved, K. Carter seconded to approve the July minutes. **Motion passed:** general consensus.

Report of Co-Chairs:

C. Steib reported on research his intern conducted regarding PrEP and the populations accessing it. It was revealed that the majority of patients at his organization seeking PrEP are young, African American women coming through the emergency department for sexual assault. In most cases, they were provided PEP and transferred to PrEP later. C. Steib suggested that the female African American population is regularly glossed over when considering PrEP usage. K. Carter asked if there were any men in the data that also started using PrEP after a sexual assault related emergency room visit. C. Steib responded that there were a few male patients, but a majority of the data consisted of female patients. C. Steib reported that some cases with repeated sexual assaults appeared to be linked to sex trafficking—he noted that authorities had been alerted.

N. Outland noted that women often go to the ER and report sexual assault, because they were having difficulties acquiring PEP or PrEP any other way. She also mentioned the increasing amount of heterosexual men receiving HIV testing at the Mazzoni Center. She expressed the need for more inclusive prevention outreach—testing is important for everyone, and no populations should be excluded.

G. Grannan asked about the definition of sex trafficking in this specific scenario. C. Steib explained that he only knows if patients are considered ROSES (rape or sexual assault patients) so they can be managed with PEP and offered PrEP. K. Carter asked if the mentioned demographic was representative of transgender women, cisgender women, or both. C. Steib said the demographic identified was typically cis, heterosexual women ages 14-27 with the average patient being 18. He said that there were 72 patients total in the study, and 59.7% were female.

Report of Staff:

No report.

Discussion Items:

—Strategies for Engaging Youth—

B. Morgan mentioned that last meeting, the committee discussed reviewing some information to put in EPI Profile regarding youth. She directed the group's attention to the 2016 School Health Profiles and the Philadelphia school responses which consisted of 260 respondents (130 lead heath education teachers and 130 principals). When referring to Table 2.17 on the back side, she mentioned that all numbers listed represented percentages. There would be an update on the data from J. Peters in a future meeting. B. Morgan mentioned that recently learned about a new Philadelphia Board of Education member who is a huge advocate of health education, so the health educational system may eventually see some improvements.

N. Outland asked about the "19 health topics" listed on Table 2.17. B. Morgan responded that the 19 sexual health topics are considered very basic in terms of health education. N. Outland was shocked to see high percentages for teaching health education. She often talked to students who were ridiculed for going to the nurse's for condoms, and she did not often witness supportive health educational systems. B. Morgan said the percentages on paper may not represent the effectiveness of the health education. N. Outland voiced her concern around the faulty communication between health teachers and nurses. K. Carter asked why the survey was not given to students, and B. Morgan mentioned a different survey that solely interviewed students.

B. Morgan continued with the data, explaining that every school district has different requirements for health education. For example, NJ has required comprehensive sex education, explaining why it has 100% in some categories. K. Carter was interested to see if the NJ youth had lower STI rates than PA and Philly due to the better health education. G. Grannan suggested that it might be just as effective to compare schools in Philadelphia that either have no or effective comprehensive sex education programs.

K. Carter asked if the data included private/religious based schools as well. B. Morgan said the data is likely only public schools.

B. Morgan said that in addition to material in the meeting packet, there was CDC information about sex and violence reported from students. She warned the group that the content was very saddening. It was not included in the packet because she did not want to provide such triggering information without a forewarning. She pulled out the sheet with 2015 data and included narrative. She added that she had already updated the tables for 2017, noting that these tables had the "DRAFT" stamp at the bottom of the paper. The updated 2017 data was accurate, but it did not have accompanying narrative. She informed the group that new data is released every two years on odd years.

B. Morgan stated that the youth behavior surveillance is led by the J. Peters and works with high school students. She said it is one of the only surveys that talks to students directly. The survey includes everything from how often students consume fruit or wear bicycle helmets to topics about sexual activity and violence. She also mentioned that sexual identity was a newly added category to the survey.

Looking at the 2015 data, B. Morgan said that an interesting trend is that self-reported drug / alcohol / sexual activity has been on the decline. Students were much less likely to have had sex, be currently sexually active, or to have more than four partners. N. Outland asked how "sex" is identified in the survey. B. Morgan said that oral sex is explicitly mentioned, but the survey also ensures breadth in the definition by listing sex as "any sexual act." B. Morgan said there were some misleading or confusing questions in the survey that may have yielded inaccurate responses. For example, one question asked students if they "were never tested for HIV" instead of asking students if they have had HIV testing in the past.

There was confusion among the group about the "data not available" areas. B. Morgan informed the group that when the cell size is too small, data may come up as "data not available." She thought that the sexual identity portion was especially noteworthy since the "not sure" category often had a higher percentage for both the violence and the drug and alcohol portions. She explained that this portion is extremely ambiguous and could have a lot of different meanings. B. Morgan reviewed a bit of Experiences of Violence 2017 data.

M. Coleman asked how to assess whether someone needs to a HIV test or recommend PrEP. C. Steib mentioned the Sexual Health Risk Assessment as a method of discerning whether or not a patient needs a test or PrEP. L. Matus also said that many medical providers now include HIV testing as part of their routine check. K. Carter asked if people are questioned about their sexual activity in such instances. C. Steib said that in the case of routine check tests, there is a script to follow so no patient has to be singled out or questioned about their sexual activity. N. Outland agreed that routine testing was ideal but explained that many primary care doctors still do not perform routine tests. N. Outland asked about sex education in NJ and whether or not there was pushback from parents or guardians. B. Morgan said there is a law in NJ regarding sex education and schools have to teach it.

B. Morgan said that the information in the data sets is important for understanding youth populations as well as inviting students into the HIPC space. She also said it would be good to come up with specific

questions for J. Peters. B. Morgan suggested the committee review the content before actually reaching out to students and note how there may be stark differences in data depending on race/ethnicity and sexual identity. G. Grannan considered how it may be fruitful to also ask students if they were the perpetrators of sexual assault or violence (toward LGBTQ+ students or in general). C. Steib mentioned that the data his intern collected included some prior sexual assault victims who came in a few years later as perpetrators.

B. Morgan and K. Carter noted the data may even underrepresent the amount of children suffering with depression and/or suicidal thoughts. K. Carter commented on how numbers could be much higher since data was self-reported and some students may feel uncomfortable disclosing such private information.

B. Morgan directed attention to the sheet with figures 2.5 and 2.6 which included data up to 2017. She stated that the percentage of students reporting alcohol and marijuana use has gone down. B. Morgan also mentioned the somewhat new question about using prescription drugs without a doctor's prescription. She said that reports of usage had progressively gone up since the question was added in 2011 but dipped in 2017. N. Outland asked about the source of the data, and B. Morgan recognized the source as Philadelphia.

G. Grannan suggested that the decrease in illegal prescription drug usage may be due to smaller prescriptions. B. Morgan directed attention to table 2.14 which showed a more detailed breakdown of student drug and alcohol use. She said there was a decrease across the board—especially in alcohol use. B. Morgan mentioned a new question in the survey that asked students about vaping (nicotine) habits. The general response, she explained, was that most students *have* vaped, but they do not vape regularly. She surmised that this was because the kits are very expensive, and vapes are not as "shareable" as cigarettes.

K. Carter noted the high percentage of drug exchange on school property. B. Morgan said the numbers are not great, but the percentage has definitely gone down. C. Steib inquired about inhalants, and B. Morgan explained that inhalants category encompasses any inhalant used for getting high such as glue or house hold cleaners.

C. Steib suggested asking J. Peters to look into the effectiveness of schools that have HRCs (Health Resource Centers) vs schools that do not. He said that the HRCs have open door policies and generally have better communication about health with students. B. Morgan said this may be achievable since HRC representatives attend school review panels, so there is likely already some data collection. C. Steib commented that if HRCs are proven effective, it may be incentive to have them in more schools.

L. Matus considered the data from 2015 and 2017, saying that 9th graders in 2015 would conceptually be the 11th graders in the 2017 data set. B. Morgan said yes, conceptually, but it is most likely not the same sample. L. Matus said that, regardless, it offers an idea of how those numbers transferred and general patterns of behavior throughout the high school lifespan.

The group discussed community trauma and the intersection of mental and sexual health. K. Carter and N. Outland discussed initiation for sports teams and how sexual assault was common. They figured it may

still be common since parents may find it typical since they experienced this as well. In other words, the trauma perpetuates the sexual violence. N. Outland said that implementation of mental health centers and education in schools are good, but without proper sexual health (that looks outside of heterosexual activity as well), mental health cannot be properly addressed.

K. Carter asked what the Planning Council should do with the data. B. Morgan considered the data as helpful for youth outreach. Though HIPC may have no impact or pull regarding school districts, they can still strategize other approaches for interventions.

K. Carter asked about how they would target youths, and clarified that it would have to be outside of school. He also wondered what forum might be best for connecting with youth. B. Morgan identified the material review panel as the gatekeeper for outside content—this panel reviews content to see if it is age appropriate and current/inclusive, etc. Thus, there are outside groups that can present information within the schools, but only with approval from the panel. B. Morgan said there are opportunities to recommend interventions for schools, but it may not be the most appropriate since HIPC members are not high school educators.

K. Carter asked about clubs and sexual health centers that happen on the premises but are not completely under school jurisdiction in terms of education. C. Steib and N. Outland mentioned GSA (Gay Straight Alliance). N. Outland said that it is separate from education and is mostly about providing a safe space. E. Rand mentioned how Mazzoni has an expansive and ongoing collaboration with different school districts' GSAs. Those from the Mazzoni Center are allowed on school premises to present and do activities with the GSAs.

B. Morgan knew of many school districts that host LGBTQ+ proms, explaining that there were enough students to actually establish such events. D. Gana inquired about the HIV testing sites that are nearby schools and whether they provide sex education and support counseling. C. Steib said this was a good question and thought it should be introduced to J. Peters. C. Steib mentioned that even if places are not testing for HIV, they should be educating about HIV. He recalled a case wherein youth were misinformed and thought they had received HIV testing but only received a basic STI screening.

M. Coleman asked about advertising for HIV prevention and testing. D. Gana said that the Philly Keep on Loving adverts should still be around. Many individuals in the group said that they had not seen advertisements for the prevention initiative. B. Morgan said the campaign launched on Valentine's Day of 2019. C. Steib mentioned that Walgreen's/CDCs campaign for encouraging HIV testing was also largely advertised then died out. The group discussed how it was expensive to continue advertising for extended periods of time. G. Grannan wondered if there was a way to get discounted advertisements since HIV prevention is a federal effort.

B. Morgan said HIPC can definitely ask J. Peters about the HRCs as well as who to connect with to talk directly with Planning Council about the HRCs. If everything works out, HIPC could invite the HRC representative and J. Peters to speak.

—Ending the HIV Epidemic—

B. Morgan said there are a lot of NOFOs (Notice of Funding Opportunity) coming out of lately. She said that the first CDC EtE (Ending the HIV Epidemic) came out and was already submitted, reminding the group that C. Terrell had presented on the submission. B. Morgan then mentioned that the Part A NOFO was just released, and AACO was working on it.

B. Morgan mentioned that there were seven different interventions listed as options as NOFOs for the EtE. She reiterated that none of them are set in stone, but they are all different possible prevention positive interventions. J. Browne compiled and condensed information about the interventions to send to the Planning Council. B. Morgan said she would share the information, because even if does not end up being part of the EtE application for the jurisdiction, it could still be useful material.

B. Morgan mentioned that there are different levels of information available for each intervention. For example, some interventions do not appear to have tool kits for proper implementation. This is because some interventions are "homegrown" in some jurisdictions and may be more contextual and less fully developed. However, the Planning Council cannot recommend interventions that do not have tool kits. B. Morgan explained that some interventions have a lot of links that can provide information for a deeper understanding of each intervention.

G. Grannan noted that the interventions for PWID are only focused on stopping people from injecting. He explained that this can be an acceptable approach, but it is not representative of all available resources and routes for PWID.

G. Grannan went on to explain different types of interventions in the form of MAT (medically assisted treatment). First, he identified Methadone which fully occupies and activates receptors, different than Buprenorphine which partially activates and partially deactivates receptors. K. Carter asked if partial activation and deactivation of receptors is most effective. G. Grannan said it depends. He explained that PWID can take as much Methadone as needed to fill physiological needs. However, because of Buprenorphine's pharmaceutical characteristics, it has a ceiling and people stop getting effective blockage if their addiction is too strong. K. Carter questioned the helpfulness of using drugs to treat addictions to opioids—what is the point if there is still an addictive element? G. Grannan said that MAT takes away the chaotic elements of opioid usage, and Methadone and Suboxone only require once-a-day usage. MAT allows for individuals to still live active and responsible lives. B. Morgan explained that MAT is considered harm reduction, since it is a controlled, manufactured substance.

C. Steib asked if the interventions being discussed were NOFOs that the health department already applied for. B. Morgan responded that they are allowable fundable interventions part of Part A EtE. They have potential for inclusion within the application, but the application is not yet submitted. She mentioned that most information provided thus far is unofficial. However, she expressed that the information was still important to review, because it allowed the council to gauge HRSA's intention and anticipated direction. The Planning Council can also review the materials and look for portions that may work well for future recommendations.

B. Morgan explained that the first CDC EtE application for 1 year grant to create the EtE plan was already submitted. The Part A EtE is a 5 year grant focused on implementation of the work as detailed in the 1 year planning grant. G. Grannan asked if the EtE would either be replacing or supplementing RWHAP. B. Morgan replied that it would be supplementing. Later, she continued, there would be another CDC EtE NOFO that might address prevention portions from the 1 year application.

B. Morgan noted that implementation of the first planning grant is supposed to begin October 1st, so the Planning Council should be hearing more details soon. K. Carter asked about the effectiveness of tool kits and how that is measured. B. Morgan said that it depends on how one looks at effectiveness. She said that there are many ways to measure effectiveness, and it does not necessarily always look at retention. One way to measure effective may involve looking at current best care practices and updating people on research and science. For example, measuring effectiveness could also look like system trainings website for doctors. K. Carter asked if that exists currently. B. Morgan said she does not know the exact measures of effectiveness used for the interventions, but she knows there were certainly measures. All of the interventions are from projects that have already been implemented elsewhere and have proven effectiveness.

Old Business:

None.

New Business:

L. Matus addressed the HIPC calendar that listed the Prevention Committee meeting dates. She said that the October 2019 meeting was correct on the calendar, but the November 2019 meeting listed is right before Thanksgiving and the December 2019 meeting is set for Christmas. The dates needed to be fixed since the office would be closed. L. Matus suggested that Prevention Committee does not meet in December. By general consensus, the group agreed.

G. Grannan said that if they are cancelling December meeting, the group should plan to move the November meeting to mid-December to break nonmeeting times up evenly. C. Steib suggested either December 4th or 11th as possible meeting dates. L. Matus asked for December 11th, but G. Grannan reminded everyone that the December RWHAP meeting would be the December 12th.

Because it may be too much back-to-back, C. Steib suggested the group go with December 4th as the new meeting time. L. Matus and C. Steib proposed to have the November 2019 meeting pushed to December 4th and resume the regular schedule starting in January 2020. The room agreed to these changes by a general consensus.

Announcements:

M. Coleman announced that the Community Health Center would having a webinar about microbiology on the August 30th, 12 PM – 1:30 PM.

K. Carter announced that the Positive Committee would have a 6 PM – 8 PM evening meeting on Tuesday, September 10th. K. Moore will talk about Mental Health and there will also be discussion on U=U.

N. Outland announced that she would be presenting at the National AIDS Conference in D.C. on September 4th. She would present with the CDC regarding Navigation and PrEP. C. Steib asked if she would share with the group post-presentation. N. Outland said that she would be interested in doing that. C. Steib asked if she would be prepared to do that on the next September 25th meeting, and N. Outland agreed to the idea. B. Morgan said she would put it on the agenda.

L. Matus asked if it would be possible to have a holiday/snack party for the December 2019 meeting. The group agreed on the idea and it was unanimously decided to hammer out details later.

N. Outland announced that she was developing a professional CEU course on sex positive approaches to LGBTQ+ health. She said the event is $79 for Temple alumni and $99 for those who are not.

M. Coleman announced that Saturday, August 31st, there would be a conference at the University of Penn for the Black and Latinx, Poz Queer & Trans Community. He said there would be also be an afterparty.

Adjournment:

C. Steib called for a motion to adjourn. **Motion:** G. Grannan moved, D. Gana seconded to adjourn the August 28th, 2019 Prevention Committee meeting. **Motion passed:** general consensus. Meeting adjourned at 4:37 PM.

Respectfully Submitted,

Sofia M. Moletteri, staff

Handouts distributed at the meeting:

- August 28, 2019 Agenda
- July 24, 2019 Prevention Committee Meeting Minutes
- School Health Profiles, 2016
- Youth Risk Behavior Surveillance System, 2015
- Figure 2.5… YRBS Respondents Reporting Alcohol and Marijuana Use, 1991-2015
- Figure 2.6…Illegal Prescription Drug Use, Heroin Use, and Injection… 1995-2015
- 2.15 Sexual Behaviors by Sex, Grade, Race/Ethnicity, and Sexual Identity, YRBS…2015
- 2.16 Experiences of Violence by Sex, Grade, Race/Ethnicity, and Sexual Identity, YRBS…2015
- (DRAFT) 2.15 Sexual Behaviors by Sex, Grade, Race/Ethnicity, and Sexual Identity, YRBS…2017
- (DRAFT) 2.16 Experiences of Violence by Sex, Grade, Race/Ethnicity, and Sexual Identity, YRBS…2017
- (DRAFT) Student Drug and Alcohol Use by Sex, Grade, Race/Ethnicity, and Sexual Identity…2017
- (DRAFT) Figure 2.5 (Alcohol & Marijuana) & 2.6 (Prescription, Heroin, and Illegal Injection) 1996-2017
- Summary of Projects and Initiatives … Part A NOFO
- Populations of Focus and Applicable Resources Chart