HIV Integrated Planning Council
Prevention Committee
Wednesday, January 22, 2020
2:30 PM – 4:30 PM
Office of HIV Planning 340 N. 12th Street, Suite 320, Philadelphia, PA 19107

Present: Sade Benton, Keith Carter, Mark Coleman, Roberta Gallaway, Dave Gana, Kailah King-Collins, Dena Lewis-Salley, Tyrell Mann-Barnes, Lorett Matus (Co-Chair), Sarah Nash, Nhakia Outland, Erica Rand, Clint Steib (Co-Chair)

Absent: Katelyn Baron, Allison Byrd, Richard LaBoy, Joseph Roderick

Excused: Gus Grannan, Janice Horan

Guests: Caitlyn Conyngham (AACO), Javontae Williams (AACO), Blake Rowley, Ebony Gardner, Savannah Lozada, Ke'Ana Robinson, André Felipe Rodriguez, Beth Gotti, Desiree Surplus

Staff: Nicole Johns, Briana Morgan, Sofia Moletteri

Call to Order:
L. Matus called the meeting to order at 2:36 PM.

Welcome/Introductions: L. Matus asked everyone to introduce themselves with their name, area of representation, and whether they prefer cold or hot weather.

Approval of Agenda:
C. Steib called for a motion to approve the January 22, 2020 Prevention Committee Agenda. **Motion:** K. King-Collins motioned, D. Lewis-Salley seconded to approve the January 2020 agenda. **Motion passed:** general consensus.

Approval of Minutes ***(December 04, 2019):***
M. Coleman noted that on page 5 of the meeting minutes, it was stated that cisgender women on PrEP are often left out of studies due to fertility or pregnancy reasons. B. Rowley explained that cisgender women weren't included because FDA required the enrollment of 500,000 women over 8-10 years, so they wanted to go for the path of least resistance and enroll only men and transgender women. C. Steib made a motion to approve the December 2019 minutes. **Motion:** K. Carter motioned, K. King-Collins seconded to approve the December 2019 minutes. **Motion passed:** general consensus.

Report of Co-Chairs:
C. Steib reported that he was leaving a *Journal of Pediatrics* abstract about PrEP and adolescence in OHP office for people to read.

Report of Staff:
B. Morgan reported that she made copies of an August 2019 report of injection practices for PWID from 2015-2017. Such information was relevant to Prevention Committee topics, so she was leaving copies for everyone in the office.

She also reported that HIPC was having an evening meeting from 6 – 8 PM on March 12th, 2020.

N. Johns reported that all of the new guests at the current meeting should feel free to ask questions about the subcommittee and full council. Office staff would also be available after the meeting to answer any questions.

Discussion Items:
—EHE (Ending the HIV Epidemic) Pillar Three—

B. Morgan explained that they went through the data last Prevention Committee meeting for each of the EHE Pillars. Philadelphia and the Planning Council were participating in EHE—a plan for areas unusually impacted by HIV in the USA to end the epidemic. The Planning Council was helping to create the plan, and the official draft plan was submitted to the CDC on December 30th. AACO was incorporating community feedback to create the final plan for September 2020.

B. Morgan said the subcommittee would review Pillar Three of EHE for feedback and questions. There were two people from the Health Department to assist with the discussion: C. Conyngham (Prevention Coordinator) and J. Williams (EHE Project Coordinator). R. Gallaway asked for a brief synopsis of how EHE would look during implementation. J. Williams explained that EHE did not mean ending HIV completely. Disease exists, but an epidemic is when disease disproportionately affects subgroups and is concentrated in populations. In other words, HIV is an epidemic that does not have a "fair distribution."

J. Williams said that EHE meant seizing an opportunity – using PrEP for prevention and effective HIV medication to make it untransmittable. This meant ultimately implementing wraparound services for affected populations. Since there is no cure, they can work to end the epidemic and take the burden off of communities by leveraging all stakeholders for feedback and assistance. Therefore, they are asking what can be done in Philadelphia specifically—they can come up with their own solutions, pull from other cities and EMAs, and even set an example for other EMAs or counties within Philadelphia's EMA.

J. Williams asked for volunteers to read Pillar Three. The plan starts on page 18, but he suggested everyone go over the preceding pages in their free time. He noted that OHP made an annual EPI (epidemiological) profile of the HIV epidemic in the EMA that is more than 300 pages. For EHE, B. Morgan reduced the profile to 5 pages for a "snapshot" of the epidemic within the plan. He explained that some details and other important information is left out due to the fact that AACO was responding to specific CDC guidelines. If there were suggestions for additions to the plan, he encouraged the subcommittee to let him know. For example, during the last meeting at OHP, someone mentioned the need for more Spanish-speaking accessibility.

Regarding type of feedback, J. Williams said that feedback for implementation was not yet needed. For example, someone suggested a PLWH-specific Urgent Care so ER visits were not necessary for lesser issues. This type of broad feedback, he explained, was most helpful.

J. Williams asked everyone to turn to page 23. R. Gallaway read Pillar Three goal: Over the 5-year period, 50% of people with a PrEP indication will be prescribed PrEP, and 100% of people seeking nPEP will be prescribed treatment. E. Garlner then read the first strategy: Increase access to low-threshold pre- and post- exposure prophylaxis (PrEP/nPEP) for priority populations. She continued to review the activities as well which were signified by the bullets bellow Strategy 1. Please refer to page 23 of the draft plan for more information.

M. Coleman asked about the activity for establishing partnerships between grassroots and community-based organizations not currently involved in HIV services. J. Williams responded that it meant pairing with local pharmacies such as ACME or CVS to get PrEP. C. Conyngham said there were areas across the city where PrEP was inaccessible. J. Williams explained that they were in search of places and groups willing and ready for PrEP rollout. D. Lewis-Salley asked if this meant going to a pharmacy to write and fill prescriptions, and J. Williams said yes, though there may be some legislative roadblocks. D. Lewis-Salley suggested that they also want to add it to IOP (Intensive Outpatient Program) so people receiving treatment for Drug and Alcohol Use Disorder can also receive HIV medications. R. Gallaway asked who would do the testing in local pharmacies since HIV testing is mandatory before offering PrEP. J. Williams responded that such details were unknown.

J. Williams encouraged everyone to think outside of the box as well and thinking big in terms of dismantling the current system and building it back up. N. Outland suggested that after people get tested, they should immediately receive PrEP if interested, even on mobile testing sites.

K. Carter asked what a PEP starter pack looked like. C. Conyngham explained that PEP needs to be taken within 72 hours of high risk behavior, and therefore, it needs to be immediately accessible. K. Carter asked about the dose and length of treatment. C. Conyngham responded that it depends on the distributer and the patient: treatment can range from one week to a full month. N. Outland said that there is often confusion at the provider level regarding who they should administer PEP to. C. Steib said there are pharmacies that have private rooms for HIV testing without an MTU (mobile testing unit).

K. King-Collins mentioned the comment about HIV-specific Urgent Care center and how that may cause issues with anonymity. She suggested instead of a HIV-specific care center, there should be a specialized and competent department within Urgent Care. J. Williams said the Urgent Care suggestion came from a consumer who had had prior issues with privacy. He explained that the consumer voiced the need for emergent care when they could not get in contact with their doctor. They had not yet decided a way to implement the Urgent Care idea.

K. King-Collins read Strategy 2: Ensure access to syringe service programs, substance disorder treatment, and harm reduction services. K. Robinson read Strategy 2 activities listed underneath. Refer to page 24 of the plan for more information. J. Williams noted that there was only 1 syringe service program in Philadelphia. E. Rand commented on how substance disorder treatment through CBH (Community Behavior Health) under Medicaid has its capacity met by 8:30 AM. People spend their whole day to wait for their turn, and though they are mentally ready to accept treatment, they cannot receive the services. Patients will also seek treatment who have temporarily ceased using drugs but are denied due to their temporary cessation. K. Carter asked how the intake process worked. E. Rand responded that it is first come first serve, but the eighth person in line would have to wait all day in the waiting room.

B. Morgan said it is especially difficult to count PWID who are youth unless the individual is HIV positive. K. Carter asked about syringe distribution at the pharmacy and referring youth from Prevention Point to pharmacies where they can actually receive clean syringes. J. Williams summed up that this meant that they needed to expand capacity & resources and getting access to substance use treatment. L. Matus mentioned that maybe there should be a place where people could dispose of their used syringes within the community. A. Felipe Rodriguez mentioned that they need to implement harm reduction and education with CBOs.

E. Garlner read Strategy 3: Provide HIV prevention activities for communities at risk. She also read the corresponding activities. Refer to page 24 of the plan for more information. J. Williams explained that the Philadelphia School District receives funding from the CDC to do HIV Prevention. The program officer was having the school district work with AACO to do work together for EHE. There were already many activities and programs such as sexual wellness centers, teacher and parent education (including LGBTQ safety in the classroom), and parental engagement around HIV activities. AACO was planning on working more closely with the school district to figure out where EHE and already-established prevention initiatives within the school overlap. K. Carter asked why there was no testing in public schools if they were receiving CDC funds. J. Williams responded that the school systems may be overlooking something, and HIPC could ask school districts sit in on HIPC meetings for questions and concerns.

N. Outland asked about changing the language in Strategy 3 activities from "sex wellness" to "comprehensive sex education." She explained that comprehensive sex education is about consent, body autonomy, etc.., whereas sexual wellness can be limited. B. Rowley added that comprehensive sex education would also focus on HIV prevention and treatment.

R. Gallaway said there should be more specificity with "Philadelphia Schools" in the activities language. J. Williams responded that the goal is to teach comprehensive sex education "from young" to avoid delays in early education. However, he noted discussions for sex education would have to be "age appropriate," so adding that language may be helpful. R. Gallaway explained that parents may have different opinions of when they want to start their sexual education discussions. By middle school, it should be the school's responsibility, but before that, parents may want to handle such discussions.

T. Mann-Barnes agreed that "comprehensive sex education" was better language, especially because it insinuated a long-term and sustainable change in the system. J. Williams worried that some may not know all that comprehensive sex education entails. They must be specific in their descriptions for sex education so there is not too much pushback from children's guardians. He added that they were also looking for suggestions on how to make the education portion in the plan more HIV specific. A. Felipe Rodriguez suggested looking into models from other countries that may meeting school guidelines.

K. King-Collins read Strategy 4: Provide perinatal HIV prevention activities. M. Coleman read the corresponding activities. Refer to page 24 for more information. J. Williams said there had been 0 mother to child HIV transmissions in the last three years in Philadelphia. C. Steib suggested that providing HIV prevention activities in pediatric offices might be a helpful way to reach youth. K. King-Collins added that pregnant "women" should be changed to pregnant "persons."

K. Carter asked about weight indicators for PrEP, and B. Rowley responded that you have to be over 77 pounds for PrEP. B. Rowley said that before HIV diagnoses, people often have an STI at some point

first. He suggested adding language around STI diagnosis being an indicator for PrEP under Strategy 1 and 3 within Pillar 3.

E. Rand asked if SPBP (Special Pharmaceutical Benefits Program) would be covering PrEP. C. Conyngham responded that you cannot cover the drug on SPBP, but the state was currently using non Ryan White rebate funding for PrEP preferred providers outside of the city of Philadelphia. Therefore, people could go to sites in neighboring counties (cover visit fees and labs), but would have to use another access point to cover the medication itself. Within Strategy 1, she said they are looking to cover labs and medical visit fees. E. Rand suggested adding education regarding PrEP and webinars accessibility for practitioners within each of the four strategies under Pillar 3, Prevent. There is still a lot of outdated information within providers regarding side effects or general information. They needed to extend educational models to continue PrEP and HIV education training.

J. Williams asked the committee who in the community would need to know more about PrEP. K. King-Collins answered community health workers. K. Robinson answered case managers. R. Gallaway answered those in outreach. T. Mann-Barnes said educators and parents. J. Williams said that the training needed to be specific to each population. There also needed to be more PrEP awareness in general with more intensity and strategic advertisements.

They moved onto key partners, and J. Williams read them off. Refer to page 24 of the plan for a list of all the key partners. He asked the group if there were any organizations left out. T. Mann-Barnes asked if they could look at zip codes and find legislators. He suggested partnering with local colleges/universities. Within universities, those seeking HIV prevention and services are often exported outside of the university. There should be more access on campus. J. Williams said they were organizing a town hall with political stakeholders, and they could discuss that more as well. There were going to be six town halls in total.

L. Matus mentioned that there are agencies within the community that can translate to who should be at the table for the town halls. D. Gana said that they should consider going to barbershops to spread the word. Unconventional partnerships may gather the most support and intelligence. N. Outland said that key partners should include the key populations, e.g. the ballroom community. R. Gallaway asked for definition regarding community based providers—did he mean churches community action groups as well? J. Williams responded that such groups would include organizations that have the ability to write a prescription and aren't directly funded by AACO. B. Morgan said specifically mentioned FQHCs would be helpful. R. Gallaway suggested adding community "organizations" since they are different than community "providers." T. Mann-Barnes suggested Septa as a partner.

N. Outland noted that the PrEP Workgroup had a lot of similar discussions, so that might be worth looking at the PrEP Workgroup Report. J. Williams said a lot of that information from the PrEP Workgroup was used for the Club 1509 program for Black and Brown men. However, of the 7,000 men indicated, only 188 men got their prescriptions. He has access to the PrEP Plan, but it was important to try a different approach to identify new strategies that are deliverable. They are taking community engagement as a serious aspect which will make strategies more effective. Collective wisdom would be the way to change with the context and discover new ideas.

Old Business:
None.

New Business:
None.

Announcements:
K. Carter announced that the workshop submission form for the Prevention Summit was available online at PhillyFight.org. C. Steib added that there would be a second Youth Central at the Prevention Summit and they are looking for people to be on the committee. The next meetings would be February 18th and March 17th. He asked anyone who worked with youth to promote the event.

C. Conyngham said the AACO program analyst sent out flyer about focus groups done with UPENNs CFAR. It's a project that complements EHE and would work to do message development on HIV Treatment/U=U. The focus groups were enrolling with some eligibility requirements. She wanted to make sure people knew about it and got enrolled.

B. Gotti said she represented the FC2 Internal Condom. She announced that there was new pricing for the internal condoms and was directed to share with the community. The packs of 100 condoms were $100, and cases were $950 and have 10 packs of 100.

Adjournment: C. Steib called for a motion to adjourn. **Motion:** D. Lewis-Salley motioned, R. Gallaway seconded to adjourn the January 2020 Prevention Committee meeting. **Motion passed:** general consensus. Meeting adjourned at 4:21 PM.

Respectfully Submitted,

Sofia M. Moletteri, staff

Handouts distributed at the meeting:

- January 2020 Prevention Committee Agenda
- December 2019 Prevention Committee Minutes
- January/February 2020 Calendar
- EHE Community Draft (December 30, 2019)