Meeting Agenda

Wednesday, September 23, 2020
2:30 p.m.

- Call to Order
- Welcome and Introductions
- Approval of Agenda
- Report from Chair
- Report from Staff
- Report from AACO
  - EHE Update
- Public Comment
- Discussion Items
  - Committee Structure/Focus
  - Work plan for 2020-2021
    - Sex Education Bill
    - Linkage/Retention for Recently Incarcerated
    - Review of Integrated Plan Prevention Activities
- Old Business
- New Business
- Announcements
- Adjournment

PREVENTION COMMITTEE
MEETING AGENDA

Please contact the office at least 5 days in advance if you require special assistance.

The next Prevention Committee meeting is scheduled is **TBD**

HIV Integrated Planning Council
Prevention Committee
Wednesday, February 26, 2020
2:30 PM – 4:30 PM
Office of HIV Planning 340 N. 12th Street, Suite 320, Philadelphia, PA 19107

Present: Clint Steib, Dave Gana, Erica Rand, Gus Grannan, Kailah King-Collins, Keith Carter, Lorett Matus, Sarah Nash

Absent: Allison Byrd, Gail Thomas, Joseph Roderick, Mark Coleman, Nhakia Outland, Richard LaBoy, Roberta Gallaway, Sade Benton, Tyrell Mann-Barnes, Zsofia Szep,

Excused: Dena Lewis-Salley, Janice Horan

Guests: Blake Rowley, Desiree Surplus, Ebony Gardner, Ke'Ana Robinson

Staff: Briana Morgan, Mari Ross-Russell, Nicole Johns, Sofia Moletteri

Call to Order: C. Steib called the meeting to order at 2:42 PM.

Welcome/Introductions:
L. Matus asked everyone to introduce themselves with their names and area of representation.

Approval of Agenda:
C. Steib called for a motion to approve the February 26, 2020 Agenda. **Motion:** D. Gana motioned, G. Grannan seconded to approve the February 2020 agenda. **Motion passed:** general consensus.

Approval of Minutes *(January 22, 2020):*
M. Ross-Russell noted that there were changes made to the January 2020 Prevention Committee minutes on pages 4 and 5 to correct language around the use of rebate money. She noted that the only way to pay for PrEP would be through non-Ryan White money. The language was changed so there was no confusion or misinformation around Ryan White abilities. B. Rowley corrected his name in the minutes, noting that he did not work AACO. E. Gardner corrected the spelling of her last name in the meeting minutes, and K. Robinson corrected the spelling to her first name, Ke'Ana. **Motion:** E. Gardner motioned, K. Carter seconded to approve the January 2020 minutes with the discussed changes. **Motion passed:** general consensus.

Report of Co-Chairs:
None.

Report of Staff:
M. Ross-Russell reported that HIPC would have an evening meeting on March 12th from 6-8 PM. At the meeting, they would focus on gathering information and feedback for the EHE (Ending the HIV Epidemic) Plan. She recognized the importance of HIPC attendance as well as

attendance from those not normally involved in Planning Council meetings. There were flyers in the office and RSVP was mandatory.

N. Johns reported that Positive Committee was beginning to interview former and current members of the Positive Committee for the 20th Anniversary Project. There were flyers at the office for more information for interview dates. If anyone was interested in being interviewed, she asked that they schedule the interview ahead of time. They would also be offering to take portraits of committee members. People could choose to be interviewed anonymously with alias of choice.

Discussion Items:

—Ending the HIV Epidemic (Pillar One)—

B. Morgan reminded the committee that they last reviewed Pillar 3: Prevent of the EHE Plan and that they would next review Pillar 1: Diagnose. The Comprehensive Planning Committee already reviewed Pillar 1 and offered feedback, but Prevention Committee business also overlapped with the "diagnose" portion of the plan.

B. Morgan distributed the Pillar 1 worksheet with discussion questions. She explained that the worksheets were to be used as guidance for group discussions. B. Morgan asked everyone to split into groups and each discuss and offer feedback on one strategy of the plan. The committee broke into groups and were each assigned a strategy from Pillar 1.

After discussion, the groups reassembled, and B. Morgan asked for strategy order at first.

L. Matus reported that her group discussed first strategy of Pillar 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.

L. Matus noted that her group suggested combining the first bullet under Strategy 1 with the fifth bullet. C. Steib added that the first bullet should start with "opt-out" instead of "expand support for" to make the language more direct. Therefore, the combined bullets should read "Opt-out HIV testing as part of the routine medical care in primary urgent care settings, Emergency Departments, and at prison intake along with other key locations such as Family Planning Clinics, Sexual Health Clinics, Substance Use Treatment Clinics, and Philadelphia County Prison Health Services."

L. Matus said her group also reworded bullet three to "as a requirement of any funding provided to clinical settings, clinical leadership is responsible for implementation of routine HIV testing. Their group also commented on how those without medical knowledge may not know how biosocial screening is connected to the activities within the bullets. J. Williams responded that there were only three medical providers in Philadelphia who practiced opt-out testing. He explained that other providers explained that they did not have the financial support to do opt-out testing, so AACO was trying to provide resources and financial support. J. Williams added that there were also some providers outside of AACO's jurisdiction where the practice could not be enforced. He explained that biosocial screening tied in with the bullets due to information found within DExIS (Demonstrating and Expanding Intervention Surveillance) which focuses on identifying missed opportunities. Findings found that 70% of individuals have STIs in the year

prior to being diagnosed with HIV. When biosocial screenings do not occur, there will be more missed opportunities. The bullets may need rewording to emphasize the correlation.

G. Grannan viewed the edits from L. Matus and C. Steib as essential because it broadened the focus to a provider's entire staff, not just the clinical staff. He noted that there were direct reports of patients leaving due to mistreatment from staff. Regarding clinical interventions, clinical staff may be involved, but the broader staff (maintenance, front desk, etc.) also had an impact on care. J. Williams added that doctors and nurses needed equal say within offices. Leadership needs to consider those directly interacting with patients. This should be reflected in the EHE plan.

E. Rand noted that messages and rapport with patients are often lost because of high turnover. This is a barrier for staff in emergency departments. C. Steib suggested implementing a quarterly educational component in the form of a webinar to help with rotating staff as a barrier. K. Carter asked about the timeframe from the rotation, and E. Rand answered that it was about 4-6 weeks. G. Grannan suggested using a face-to-face educational component in place of a webinar.

K. Carter asked if older staff could train new staff within the 4-6 week period. E. Rand answered that universities and medical students are involved in the process so training may be complicated. M. Ross-Russell said that according to DExIS, university students were against standard practices and pushing for change. Because students are trained at medical schools, they are taught an updated standard of care. Most issues occur with older staff. C. Steib mentioned that new nurses had to do certifications for Rapid HIV Testing. He suggested requiring an introduction to the certification to explain Rapid HIV Testing is necessary. G. Grannan asked if the training was in-house. C. Steib responded that it was. Besides the person in charge of the training, there are also nurse educators who could disseminate information.

Regarding key partners, C. Steib noted that the EHE plan did not list AETC. J. Williams said this was an oversight and AETC would be added.

E. Gardner read Strategy 2 of Pillar 1: Increase access to HIV testing through community-based organizations. She also read the accompanying bullets. K. Robinson said that the first bullet point under Strategy 2 needed more emphasis. There needed to be extra support and feedback from analysts to guide geospatial locations. E. Gardner added that AACO should share new data to help inform decisions.

For pharmacy-based testing, K. Robinson suggested including community partners and finding ways for them to partner with pharmacists for testing. She also suggested adding more mobile teams to partner with Universities. They needed to consider how do testing at larger events or at nontraditional hours. E. Gardner suggested partnering with Wawa due to their hours and ubiquity. K. Robinson said the last bullet under Strategy 2 needed more clarification. Her team received more clarification about at-home testing kits during the group discussion, but they did not have enough information when first reviewing the strategy. The team also discussed adding a portion to the strategy that would ensure support for people regarding their results and what informational portions would be offered.

K. King-Collins addressed the need for more linkage services. People who test positive for HIV late at night have less ability to link to care. Adding late night testing is important, but there also needs to be late night linkage. L. Matus agreed, but noted that having people on-call may cause issues.

M. Ross-Russell asked if those tested at nighttime could receive reactive test results and start immediate initiation of ART. Would the patient have to go to a doctor during provider hours for the rest of follow-up? K. King-Collins responded that the tester does not typically make the decision to start ART. The clinician asks questions and gauges whether the patient is ready to start.

K. Carter asked if there were CDC guidelines that may prevent people from getting treatment immediately. G. Grannan said that getting medication is doable, but it is difficult to receive treatment immediately. L. Matus suggested offering a few days' worth of medication to individuals until they can go to a provider during conventional hours. However, she noted that administration, storage, etc. would cause issue and the mobile testing site would essentially double as a mobile pharmacy.

L. Matus explained that medical providers do not have to wait for lab results to prescribe medications. K. Carter said that a starter pack of medications should be available for patients. C. Steib suggested partnerships with emergency departments that could give them medications. He also suggested that HIV testers could undergo phlebotomy training to be able to test. K. King-Collins said providers draw one tube of blood as a confirmatory test. B. Morgan added that RWHAP dollars would pay for two rapid tests and counts as confirmatory. Two rapid tests can get people into care immediately since they do not have to wait for lab results. However, it is important to take a lab test once the person is in full care.

D. Surplus read Strategy 3: Increase the frequency of HIV testing among key populations. E. Rand said that the bullets under the strategy were both unclear and needed more expansion and explanation. Their group discussed increasing collaboration with organizations that work with key populations. This would involve ensuring that there are walk-in hours and staffing ability. They also noted a need for increased accessibility by simply opening more facilities.

E. Rand said that there needed to be more information about what health promotion activities and health assessments would look like. G. Grannan asked if increasing frequency of HIV testing was to decrease later diagnoses. B. Morgan said that around 18% of people are diagnosed concurrently with HIV and AIDS, so it is to prevent later diagnoses.

J. Williams asked the group to turn to page 13 of the plan to look at priority populations and those tested in the last 2 years, 12 months, and 3 months. He noted the significant drop-off of people tested in 2 years and then 12 months. Therefore, more frequent testing is important for all individuals. E. Rand recognized the standard pediatric guidelines that youth 16-18 should be tested once in that time period unless they have other STIs or risk factors. She suggested more official guidelines for providers to follow. G. Grannan noted that pediatricians should recognize that injection risk also includes injection of hormones and steroids. However injection services are not offered to those under 18, so the risk for HIV infection would be even higher.

S. Nash read Strategy 4 of the plan: Implement a status-neutral approach to linkage with realignment and expansion of key personnel – linkage to care includes either HIV medical care or linkage to PrEP. She also read the accompanying bullets. K. King-Collins expressed the need for a database or communication system that identifies known clients. This would help identify those lost to care and those not keeping in contact with providers. This would require better communication between providers and more open information sharing. There needed to be a

platform for provider communication within Philadelphia as well as surrounding counties to help with confirmation abilities.

K. King-Collins suggested incentivizing timely linkage. D. Gana said the group also discussed partner services and linking people to services immediately. Specifically, they needed to resolve the time gap for people getting connected to ART and nPEP. They must also consider people who are post-incarceration. This meant ability to track people post-incarceration since individuals are most likely to be lost to care within this timeframe.

K. Carter read Strategy 5 of the plan: Develop the capacity of the Prevention workforce to meet the needs of ending the HIV epidemic. He read the accompanying activities below. G. Grannan said their group had some additions for the strategy. They focused on a need for cultural competency training for the testing workforce and people who manage them. This also meant meeting people at the population's convenience e.g. altering hours. G. Grannan noted that they needed to add those over 50 as a heightened risk group for prevention purposes. This would involve adding key partners in senior service as collaborators e.g. PCA. They would need to focus on linking those over 50 to prevention services and finding a way to encourage non-testing based prevention measures. To do this, they would work on building relationships and having outreach workers base their success on connecting to key populations. The outreach workers also needed the proper tools. This might include offsite hours for "coffee meetings," a car or form of transportation, etc. K. Carter noted the importance of involving key figures in communities to disseminate information.

—EHE Workgroup Assembly—

B. Morgan explained that HIPC voted to approve EHE Workgroup. They thought it best to have the Prevention Committee and Comprehensive Planning Committee join forces to work on the plan together. OHP's suggestion was to have meetings happen during existing committee meeting times. The Prevention Committee joint group meeting could occur during their March meeting time and April's joint meeting could happen during Comprehensive's meeting time.

Old Business:

None.

New Business:

None.

Announcements:

K. Carter announced that THRIVERS would have a meeting on Saturday, February 29th, at William Way.

Adjournment: C. Steib called for a motion to adjourn. **Motion:** K. King-Collins motioned, D. Gana seconded to adjourn the February 26th, 2020 Prevention Committee meeting. **Motion passed:** The meeting was adjourned by general consent at 4:32 PM.

Respectfully Submitted,

Sofia M. Moletteri, staff

Handouts distributed at the meeting:

- February 2020 Prevention Committee Agenda
- January 2020 Prevention Committee Minutes
- Ending the HIV Epidemic—Community Draft
- EHE Feedback Worksheet - Pillar 1