

**Philadelphia HIV Integrated Planning Council
Prevention Committee
Meeting Minutes of
Wednesday, May 24, 2017
2:30-4:30p.m.**

Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia, PA 19107

Present: Jeanette Murdock, Clint Steib, Joseph Roderick, Mark Coleman, Lorett Matus, Leroy Way, Jen Chapman

Staff: Mari Ross-Russell, Nicole Johns, Briana Morgan, Antonio Boone, Jennifer Hayes

Call to Order: J. Chapman called the meeting to order at 2:40p.m.

Welcome/Moment of Silence/Introductions: J. Chapman welcomed HPG members and guests. A moment of silence followed. Those present then introduced themselves.

Approval of Agenda: J. Chapman presented the agenda for approval. **Motion:** C. Steib moved, L. Way seconded to approve the agenda. **Motion passed:** All in favor.

Approval of Minutes: J. Chapman presented the minutes for approval. Motion: C. Steib moved, J. Murdock seconded to approve the minutes. **Motion passed:** All in favor.

Report of Co-Chair: J. Chapman noted that she'd given a brief presentation about concurrence at this month's HIV Integrated Planning Council Meeting.

Report of Staff: None.

Discussion Items:

- **Committee Leadership**

M. Ross-Russell stated that each committee was responsible for determining its own leadership structure. She said the planning body co-chairs were not permitted to chair one of the committees. She explained that the Prevention Committee would need to determine who would co-chair the committee, since J. Chapman was a Planning Council co-chair. She said the particulars of designating a co-chair were up to the committee.

J. Chapman asked if the bylaws specified that there would be a co-chair that represented prevention on the Planning Council. B. Morgan explained that amendments to the bylaws were currently under review.

C. Steib asked if there was a timeline for deciding who would represent the Prevention Committee as co-chairs. M. Ross-Russell stated that there was no specified timeline, but the co-chair position should be filled soon, since J. Chapman could not serve as committee co-chair. C. Steib asked how long co-chair terms were. N. Johns stated that committee co-chair terms were not specified formally, with the exception of Positive Committee.

J. Chapman asked if committee co-chairs could step down in order to run for Planning Council co-chair. N. Johns stated that they could. B. Morgan noted that committee co-chairs sometimes stepped down to chair another committee. M. Ross-Russell added that some individuals had stepped down from a co-chair position in the past because they no longer wished to hold the position.

M. Ross-Russell stated that co-chairs facilitated the meetings. She explained that the personal opinions of the co-chairs should not guide the discussion. J. Chapman said that co-chairs gave subcommittee reports at the Planning Council meeting. L. Matus asked if committee co-chairs could vote in committee meetings. M. Ross-Russell responded that they could.

M. Coleman asked what role the co-chairs played in harm- and risk-reduction activities in the community. M. Ross-Russell said that the language of the bylaws dictated that the co-chair could not speak for or represent the Planning Council outside of their meetings, unless directed by the Planning Council to do so.

J. Chapman asked if anyone present was interested in serving as co-chair of the Prevention Committee. She stated that she'd be willing to provide support and assistance to the new chair. M. Ross-Russell stated that members could nominate others for the position. She noted that nominees could choose whether or not to accept the nomination.

J. Chapman asked if the group would like to elect one or two co-chairs. C. Steib asked if there would be a governmental co-chair of the Prevention Committee. J. Chapman stated that the Planning Council would have a governmental co-chair, but the Prevention Committee would not. C. Steib asked if J. Chapman wished to continue serving as Prevention Committee co-chair. M. Ross-Russell explained that J. Chapman could not co-chair the Planning Council and the Prevention Committee simultaneously. L. Matus asked if J. Chapman would prefer to serve as HIPC co-chair, as opposed to the Prevention Committee co-chair. J. Chapman said she'd be glad to fulfill either obligation, depending on where she was needed or elected.

C. Steib asked for a summary of co-chair responsibilities. J. Chapman stated that the Prevention Committee co-chair would have an opportunity to become involved in the Urban Coalition for HIV/AIDS Prevention Services (UCHAPS). She stated that UCHAPS held monthly calls and periodic membership meetings. She added that co-chairs would be able to do other work with UCHAPS. She stated that co-chairs would occasionally prepare presentations for the Prevention Committee and Planning Council. She added that OHP staff members would assist co-chairs in fulfilling their responsibilities as necessary.

M. Ross-Russell said that, as she understood it, the UCHAPS position was based on serving as community co-chair of the Planning Council. J. Chapman stated that the UCHAPS bylaws specified that representatives could be past, present, or future co-chairs of planning bodies. She explained that UCHAPS representatives needed to demonstrate commitment to the formal community planning process.

N. Johns stated that one primary responsibility of subcommittee co-chairs was presenting committee reports and business to the Planning Council, including bringing motions for a vote. C. Steib asked if there was a conflict of interest if committee co-chairs also sat on statewide planning bodies. M. Ross-Russell said that there was not.

C. Steib stated that he'd be interested in running for the co-chair position if it started in the fall, allowing him time to learn more about the responsibilities of the co-chair. J. Chapman said the position would preferably begin earlier than that. However, she stated that she would offer guidance throughout the summer as needed.

L. Matus asked the group if they'd like to elect a single co-chair, or if they'd elect more than one. M. Ross-Russell stated that committees were able to make decisions to add co-chairs at any point

they'd like. She stated that some committees had one chair and others had two. J. Chapman stated that, if the committee elected two co-chairs, they could work as a team. L. Matus pointed out that the Prevention Committee was new, so it may be easier to have more than one co-chair. M. Ross-Russell reiterated that the OHP staff was available to provide support to co-chairs. N. Johns noted that multiple co-chairs could provide backup in the event that one stepped down.

Motion: C. Steib moved, J. Murdock seconded that the group elect two co-chairs. Motion passed: All in favor.

M. Ross-Russell said that specifics of the election process were up to the group. J. Chapman nominated C. Steib and L. Matus as co-chairs of the Prevention Committee. L. Matus asked, to confirm, if presenting at the Planning Council and facilitating the meeting were the responsibilities of the co-chair. She asked if staff could provide slides or other materials. M. Ross-Russell agreed. She added that staff would gather and provide information as requested. She stated that staff also corresponded with co-chairs as needed. C. Steib and L. Matus accepted the co-chair nominations.

The group agreed by general consensus to elect C. Steib and L. Matus as co-chairs of the Prevention Committee.

C. Steib asked if the Prevention Committee roster had been developed yet. M. Ross-Russell stated that the original Prevention Committee membership consisted of active members of the former HPG. However, she noted that all members of the Planning Council were invited to participate in the Prevention Committee. She stated that chairs of subcommittees sometimes recruited members for their subcommittees at the Planning Council meeting. J. Chapman suggested the new co-chairs invite interested Planning Council members to join the Prevention Committee in their subcommittee report. C. Steib pointed out that the HPG had been a small group.

M. Ross-Russell stated that Planning Council members often attended subcommittee meetings when topics they were interested in were being discussed. N. Johns stated that the attendance at today's meeting was about average for committee meetings. M. Ross-Russell said many committees consisted of 8-10 members. She noted that smaller groups were able to stay more focused.

- **Prevention Activities**

A. Boone stated that he'd met with N. Johns earlier today to identify activities that were listed in the Integrated HIV Prevention and Care Plan. He began with Strategy 1.2.2, "ensure the provision of PrEP and PEP to at-risk populations." He noted that the HPG had discussed PrEP at length in recent years. He stated that the Prevention Committee would often be working on prevention issues that also affected care. J. Chapman noted that PrEP was an area of interest for the Planning Council and had been discussed during joint meetings with the HPG in the past.

A. Boone continued to Strategy 1.2.3, "ensure equitable access to syringe access services, substance use treatment, and related harm reduction services." He pointed out that a City of Philadelphia report on the opioid epidemic had recently been released. He said that data from the report could be used in the planning process.

A. Boone read off Strategy 1.2.7, "reduce the percentage of youth, including gay and bisexual men, who engage in HIV risk behaviors." He noted that the "Do You Philly" program had been developed by the Philadelphia Department of Public Health (PDPH) to connect young men in Philadelphia to prevention services, condoms, and PrEP. He stated that the program was part of

the CDC 15-1509 grant, which was being developed over the past couple years. He said the Planning Council had yet to receive a report on these activities. J. Chapman asked if Do You Philly was associated with CLUB 1509, a program developed for the 15-1509 grant. A. Boone stated that it was. He suggested the group visit the website of the Do You Philly program¹. J. Chapman asked if any components of CLUB 1509 had recently launched. C. Steib said he believed the social marketing component of the program had recently begun. He stated that his organization had recently met with Caitlyn Conyngham, the AACO prevention coordinator, to discuss PrEP. He said the PDPH was looking to expand promotion and implementation of PrEP.

A. Boone stated that Strategy 3.1.1 was “increase access to services that address social determinants of HIV risk.” He stated that social determinants were an aspect of HIV prevention.

A. Boone stated that Strategy 3.1.2 was “increase access to biomedical prevention interventions, also concerned PrEP.” N. Johns stated that Strategy 1.2.2 concerned coordinating EMA-wide provision of PrEP and nPEP. She said it was important to monitor the progress of PrEP implementation of across the EMA.

A. Boone read off Strategy 3.1.3, “assess local disparities along the Prevention Continuum.” He stated that this strategy would require developing a prevention continuum to address disparities in prevention.

A. Boone continued to Strategy 3.2.3, “increase access to clinical, pharmaceutical, and other services that address co-morbid conditions, including but not limited to Viral Hepatitis and STIs.” He noted that there had recently been presentations on Hepatitis C (HCV) in the Positive Committee and Planning Council. M. Ross-Russell stated that Governor Tom Wolf had approved an initiative to increase access to HCV treatment for all those Pennsylvanians who were Medicaid eligible, effective July 1. She suggested the group review how the change in law would affect PLWHA in Philadelphia. A. Boone stated that, in a recent presentation, A. Shirreffs reported that the PDPH would be developing promotional materials and holding focus groups about HIV/HCV co-infection in the fall.

A. Boone noted that the Prevention Committee may like to hear more about 15-1509, prison testing, a recent citywide counseling, testing, and referral (CTR) survey, and the geographic testing strategy that was being used by AACO to reduce the oversaturation of testing in certain locations. M. Coleman asked A. Boone had more information on anti-retroviral therapy (ART) adherence and confidentiality in prisons. He stated that there were issues with confidentiality affecting PLWHA in prisons. M. Ross-Russell stated that there had been changes in the way medications were distributed in prisons, which had helped to protect patient confidentiality. N. Johns said that there were different regulations in state and city facilities. C. Steib stated that he believed individuals’ names were called out to receive their medications, but the type of medication they received was not reported out loud. M. Ross-Russell stated that some inmates may inadvertently have their confidentiality compromised if someone saw their medications. She said that rumors and gossip may also compromise confidentiality. C. Steib stated that his organization had heard a presentation about confidentiality among incarcerated individuals. He said that some case managers were identified by prison populations as HIV case managers, which indirectly revealed the status of people who interacted with those case managers. Therefore, the case managers were working on various strategies for protecting client confidentiality, including representing themselves as HCV case managers.

¹ doyouphilly.org

M. Ross-Russell suggested the Prevention Committee address strategies that expired soon. N. Johns stated that most prevention items had a completion date of 2021. A. Boone stated that only Do You Philly had a timeline ending in 2017, but this was the responsibility of the PDPH. J. Chapman asked if the CTR survey had been mentioned in a recent meeting. A. Boone said it was. N. Johns stated that the CTR report would be delivered to the whole Planning Council, not just the Prevention Committee.

M. Ross-Russell suggested that the group talk to Judith Peters of the Philadelphia School District about school activities around sexual education, related to Strategy 1.2.7. A. Boone noted that Youth Risk Behavior Survey (YRBS) data had come out recently, which the group could review. M. Ross-Russell stated that Judith Peters could help identify future presenters on the topic.

N. Johns stated that the Opioid Task Force report in the packets contained some recommendations that were actionable on a Planning Council level. She said some goals in the report were in line with Planning Council goals. She stated that the Planning Council could make recommendations related to the report. J. Chapman noted that the report just came out, so it was a good time to take action based around it.

N. Johns pointed out recommendation 7 on page 19 of the report. She stated that page 21 contained recommendations related to housing and substance use treatment. She continued that recommendations 12, 13, and 15 were relevant to Planning Council goals. She stated that there was overlap between HIV-related issues and those explored in the report, and some of the actions listed in the report would fall within the Planning Council's legislatively permitted activities. She noted that recommendation 13 on page 23 expressed support for safe consumption facilities.

M. Ross-Russell asked where the discussion of the report would be placed under the strategies that now existed. N. Johns stated that the report fell under Strategy 1.2.3. She added that it also addressed mental health and substance use services, which were covered in other parts of the Plan.

J. Chapman asked if any other committees had received any presentations on the opioid epidemic. N. Johns stated that the Comprehensive Planning Committee had informally discussed the opioid epidemic in the past. J. Chapman suggested that the Prevention Committee request a presentation from someone who had served on the task force to give an overview of the reasons the task force was created, their process, or the recommendations. She noted that the task force had likely had lengthy discussions that went beyond the scope of the report. N. Johns stated that current and former Planning Council members participated on the task force. She added that the task force was very large and had multiple committees. N. Johns stated that she'd heard one member of the task force give a presentation at a conference last fall.

J. Chapman asked if the group could ask someone from Prevention Point to conduct a naloxone training with the Planning Council. M. Ross-Russell stated that some of these trainings did not provide naloxone. J. Chapman stated that she'd attended a training that did not give away naloxone, but gave instructions on how to get the product from a pharmacy. She added that other trainings did provide the product. N. Johns noted that the Opioid Task Force report encouraged naloxone trainings. M. Ross-Russell noted that not all participants in Planning Council meetings had access to insurance, which may make obtaining naloxone difficult. J. Chapman stated that the group could specifically request a training that provided naloxone.

M. Ross-Russell noted that federal funds could not be used for syringes themselves, but they could be used to pay for syringe access programs. N. Johns stated that federal funding could also

be used to support medication-assisted substance use treatment. M. Ross-Russell suggested the Prevention Committee help to document the need for these programs in the EMA and make recommendations (e.g. supporting substance use treatment programs that specifically provided certain services). She noted that there were overlaps between prevention and care in the area of substance use services. N. Johns stated that the need for these services were well-documented in Philadelphia. M. Ross-Russell noted that less data was available for other areas of the EMA. N. Johns stated that some documentation of needs was contained in the Plan. She said individuals from outside Philadelphia could be invited to present on the need for substance use services in their areas.

M. Coleman asked if data was available on a state level regarding opioid prescriptions. M. Ross-Russell said the state of PA had begun monitoring opioid prescriptions. B. Morgan said the program was called the Prescription Drug Monitoring Program. She stated that PA had been the 49th state to implement this kind of program. J. Chapman said that PA was the 3rd or 4th ranked state in the US in the number of opioid prescriptions written.

J. Chapman asked if the presentations the group was discussing would be for the Prevention Committee or Planning Council. M. Ross-Russell said that either of these could be requested. She explained that the Prevention Committee could do background work leading up to a presentation about any of the issues that had been discussed today. She said that experts could also be asked to meet with the committee individually to give further information and recommendations. She suggested that the Prevention Committee present on the Opioid Task Force report insofar as it related to the Integrated Plan objectives. She stated that the Prevention Committee could talk about their plans in the subcommittee report. Therefore, members of the Planning Council who were interested in this conversation could be invited to attend.

J. Chapman added that the presentations and information provided information that could be used during the allocations process. M. Ross-Russell pointed out that allocations may happen within the next 2 months, which didn't leave much time to prepare. N. Johns pointed out that the need for substance use services was already well-documented and widely-known. Therefore, the committee would likely be able to make a strong case in support of these services. M. Ross-Russell stated that the group could make any recommendations or requests that they'd like, regardless of whether or not they concerned funding. She said the Planning Council could also recommend to the recipient that additional grant funding be used to support particular substance use services.

N. Johns stated that many of the recommendations in the report were about practices rather than moving money around. She said the Prevention Committee could ask the Planning Council to recommend AACO look into particular methods of service provision. M. Ross-Russell stated that one recommendation could concern naloxone trainings.

L. Matus asked for clarification of the difference between the two strategies in the Plan involving PrEP. N. Johns stated that the activities were similar, but the difference was which goal they were included under. She noted that medical case management was listed many times in the plan under different strategies. She added that one of the strategies in particular addressed provision of PrEP in areas outside of Philadelphia.

C. Steib said AACO had started a re-engagement training with community HIV testers. He stated that the refresher training was specifically about nPEP and PrEP. He added that the training would be starting tomorrow and extending through the end of the year. N. Johns said that the training was for all testers. C. Steib explained that the training didn't concern testing in healthcare

settings, but his organization had petitioned to be included. He said he'd be attending and could report back to the group. M. Ross-Russell asked if the training was related to the recent CTR survey. C. Steib replied that it was. M. Ross-Russell noted that, given the survey results, several trainings had been recommended for testers. C. Steib said that HIV testers were now being required to go through phlebotomy training. L. Matus stated that the training in phlebotomy was strongly recommended, but agencies were being expected to cover some costs themselves.

J. Chapman asked if counselors and testers needed to have continuing education credits. M. Ross-Russell responded that they did not. L. Matus said that testers were asked to have 10 hours of training per year, which could include sessions at the HIV Prevention and Outreach Summit. M. Ross-Russell stated that there were some required city-sponsored trainings. However, health professionals had different kinds of continuing education trainings. She explained that mandatory case management and CTR trainings for AACO-funded sites were distinct from some other types of continuing education programs. J. Chapman asked if AACO tracked whether or not current testers had received trainings or credits. M. Ross-Russell said that testers could elect not to attend recommended trainings. She added that it was difficult to enforce training requirements. N. Johns said she believed there would be more oversight over these training requirements in the future. J. Chapman asked if these issues would come up during the CTR survey presentation, and M. Ross-Russell replied that they would. N. Johns stated that a presentation about the CTR survey had already been requested.

L. Matus referred to Strategy 3.2.3 regarding co-morbidity. She said this strategy addressed many issues. N. Johns noted that some strategies may overlap. L. Matus stated that conversations like substance use and syringe access were necessarily intertwined. M. Ross-Russell pointed out that the group didn't need to pick just one strategy to focus on. She said that some subjects spanned multiple strategies. She added that substance use, for instance, was a subject that came up frequently in the Plan.

L. Matus suggested that the group begin with Strategy 3.2.3. C. Steib said the strategy was not restrictive. M. Ross-Russell stated that Strategy 3.2.3 seemed to be limited to Hepatitis C treatment and STI screening. B. Morgan said Goal 3 was oriented toward people who were already HIV-positive. N. Johns pointed out that Strategies 1.2.2 and 1.2.3 related to PrEP and syringe access. Therefore, the group could choose to work under Objective 1.2 and address multiple activities. She said they could then prioritize between the different activities to decide what they would address first. She stated that some of the activities could be addressed by requesting a presentation. N. Johns said that the activity specifically concerning access to Hepatitis C treatment listed under Strategy 3.2.3 could be marked as completed. J. Chapman said she supported the idea of prioritizing all the items under Objective 1.2 at the next meeting. N. Johns stated that she'd email the group a list of the objectives. N. Johns added that the Prevention Committee could frame their requests to the recipient around monitoring the goals and objectives.

L. Matus said the Prevention Committee would focus their next meeting around Objective 1.2 from the Plan, including Activities 1.2.1 through 1.2.7. J. Chapman stated that Objective 1.2 focused on many prevention topics. She suggested that the group prioritize the 7 items under the objective and map out their next steps on each. They could then begin to make speaker requests as needed.

Old Business: None.

New Business: None.

Research Updates: None.

Announcements: None.

Adjournment: The meeting was adjourned by general consensus at 4:18p.m.

Respectfully submitted by,

Jennifer Hayes, OHP

Handouts distributed at the meeting:

- Meeting Agenda
- Meeting Minutes
- The Mayor's Task Force to Combat the Opioid Epidemic in Philadelphia: Final Report & Recommendations
- OHP Calendar