MEETING AGENDA

Wednesday, February 27, 2019
2:30 p.m. – 4:30 p.m.

Call to Order

Welcome/Introductions

Approval of Agenda

Approval of Minutes

Report of Co-Chairs

Report of Staff

Discussion Items:

- PDPH PrEP Campaign
- PrEP Workgroup Draft Report
- End the Epidemic
- Priority Setting
- Allocations
- Conference Room Tools

Old Business

New Business

Announcements

Adjournment

PREVENTION COMMITTEE

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

The next Prevention Committee meeting will be held on
Wednesday, March 27, 2019 from 2:30 - 4:30 p.m. at the Office of HIV Planning,
340 N. 12TH Street, Suite 320, Philadelphia, PA 19107
(215) 574-6760 • FAX (215) 574-6761 • www.hivphilly.org

Philadelphia HIV Integrated Planning Council
Prevention Committee
Meeting Minutes of
Wednesday, January 23, 2019
2:30-4:30p.m.
Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia PA 19107

Present: Keith Carter, Mark Coleman, Dave Gana, Gus Grannan, Lorett Matus, Nhakia Outland, Erica Rand, Eran Sargent, Clint Steib, Jeanette Murdock

Excused:

Absent: Joseph Roderick, Zora Wesley

Guests: Antar Bush (AACO), Blake Rowley, Caitlin Conyngham (AACO), Jen Mainville

Staff: Nicole Johns, Briana Morgan, Dustin Fitzpatrick, Mari Ross-Russell

Call to Order: C. Steib called the meeting to order at 2:38 p.m.

Welcome/Moment of Silence/Introductions: C. Steib welcomed Prevention Committee members and guests. A moment of silence followed.

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

Approval of Minutes (*November 28, 2018*): C. Steib presented the minutes for approval. **Motion**: J. Murdock moved, D. Gana seconded to approve the November 28, 2018 minutes. **Motion passed**: All in favor.

G. Grannan noted his name was spelled incorrectly, it should be Grannan not Gannon in the November 28, 2018 minutes.

Special Presentation:
CLUB 1509 – A. Bush (AACO)
A. Bush introduced himself as the Program Coordinator for CLUB 1509 and introduced E. Sargent as the Education Coordinator for CLUB 1509. A. Bush informed the Committee members that he would have to leave early and any unanswered questions can be directed to E. Sargent.

A. Bush began his presentation and explained that 1509 is a program funded by the CDC, which addresses the social determinants for individuals who are HIV negative that may be at high risk of becoming HIV positive. He provided examples of social determinants such as housing, food insecurity, transportation, primary care, and health insurance. A. Bush stated that people participating in 1509 are given a navigator and a navigator

assistant. A. Bush showed members a diagram of ideally how someone enters the program and explained that they take referrals from other agencies. He explained that it starts with HIV testing. If they test positive they go in to the RW system where there are programs for them to take advantage of. He further stated if they are negative, they previously would leave the clinic; now there is a program to help persons to stay negative, especially if they show high-risk behaviors.

A. Bush explained that 1509 leverages the RW system to provide care and support for HIV positive gay and bisexual men and trans women of color. He stated that 1509 enhanced focus on linkage to care for positive individuals through existing testing programs. He informed the members navigators help individuals retain care. He explained that negative individuals are assessed for PrEP. A. Bush informed the Committee that the navigators recently went through training to assess participants for mental health and substance abuse issues.

The CDC grant allows resources for linkages to services for MSM of color and trans women of color. A. Bush informed members that CLUB 1509 provides comprehensive services with a holistic approach. He stated that these services are including, but not limited to, PrEP and PEP, intensive adherence and retention support, enrollment in health coverage, linkage to employment and education opportunities, housing referrals, one on one goal setting and counseling, rapid linkage and engagement with the RW care system. A. Bush explained that some people will just utilize the counseling and support.

G. Grannan asked if 1509 screens for mental health and substance abuse. A. Bush explained that 1509 is a client-centered program and if they assess that there are some concerns with substance abuse, then it is up to the client to decide if they are ready for treatment. He added that 1509 would help them navigate through the process.

J. Murdock asked if the program is for anyone or if there is a specific population that they work with. A. Bush responded that it is not just for MSM and trans women of color, but it is targeted to them. He explained that all the navigators and the navigator assistants specialize in working with these specific populations. He clarified that if a cisgender, Black women seeks services with them they are not going to deny her.

A. Bush explained where to find 1509 sites, which are Action Wellness, PDPH Ambulatory Health Services, Bebashi, the COLOURS organization, Kensington Hospital, Mazzoni Center, and Philadelphia FIGHT. He explained that some of these locations have the ability to assist more clients, but the rest of them have one navigator and one navigator assistant. E. Sargent stated that only the seven locations on the slide are part of the program, but A. Bush emphasized that they do get referrals from other agencies for individuals who may benefit from these services. C. Steib asked if Ambulatory Services are the City Health Centers. A Committee member responded that it is Health Centers 2,3,4,6, and 10.

A. Bush showed the Committee data from Year Three and informed the members that they are currently on Year Four. A. Bush stated that looking at "Referrals Needed", a

decline occurs. "Referred" declines even more. He informed members the only thing that does not decline is the PrEP category. A. Bush stated that what they learned in this process is that a lot of people just sought PrEP from their initial conversation with their navigator. E. Sargent explained that when people are initially referred to the Navigation team, it comes via a PrEP referral, which typically comes through testing. She further explained that through the testing team, a brief sexual history is given to determine if they are high risk. She stated that they do a more extensive assessment through the initial conversation where some needs for other services may come up, such as housing referrals.

A. Bush explained that they learned that working as a cohesive unit provides better outcomes, such as retention. He stated that the longer the client stays may determine the other services that they may get. K. Carter inquired more about housing since members were informed in a prior meeting that AACO no longer does housing. A. Bush explained that the navigator would help them in whatever situation they are in. He explained that some shelters may have particular rules that particular populations may have challenges around. He stated that they are there to support them. A. Bush did affirm that there are not any apartments or vouchers that they can give away. E. Sargent added they are realistic and that they do not want to lead people to believe that they can provide housing, but she emphasized that the program is individualized. She stated it is more about coaching and helping participants problem-solve concerns, such as how to increase income.

G. Grannan asked if they have demographics for those on PrEP. A. Bush said that they do capture some demographic data.

M. Coleman asked why are there so many persons lost to care and if there is anything the program can do to change it. A. Bush explained to members that it can be very anxiety-provoking to make these calls for someone who does not understand how to navigate the system. He said that they give the navigators and navigator assistants specialized training to get things done in an expedited manner for the client. C. Steib asked if they are tracking adherence support and the reasons why some may stop taking PrEP. A. Bush said that it is documented if a person chooses adherence support because it is voluntary. E. Sargent stated that if they know why someone is not following up, they will document the reason why.

A. Bush showed a PrEP cascade which was divided up into the sections Screened, Referral Needed, Referred, Linked, Prescribed, and Received Adherence Support. A. Bush explained the findings were that 642 people were screened, 526 needed a referral, 523 were referred, 408 were linked, 269 were prescribed, and 235 received adherence support. He emphasized that the adherence support is voluntary so that may be why the number is so low. He described that the graph shows an overall decline pattern.

A. Bush stated that the 1509 target population reach was a total of 717 clients, with 47% of MSM of color, 7% trans people of color. A. Bush said the program's focus for Year Four is community engagement and outreach. He explained that this is important because

they find that once people know about the program, they will take advantage of it. M. Ross-Russell asked if there was a way to break the numbers down to know who they are serving. A. Bush responded that they do have that information, but wanted to highlight how they wanted to reach this specific population more thoroughly. He stated that it is not just Philadelphia, but nationally they are having problems reaching MSM of color and trans people of color. He informed the members that the cascade looks similar to national PrEP cascades, but he stated that AACO has increased navigation for PrEP through its 1802 program.

A. Bush told members if they have other questions that they can reach out to him or E. Sargent and C. Conyngham.

Report of Co-Chair:
C. Steib mentioned an email from AACO about PrEP funding and that it is now going to be funded through the state instead of the CDC. C. Steib asked C. Conyngham if she had any more information on this. C. Conyngham said that they are trying to leverage the various prevention resources to maximize the effectiveness of these services. She further stated that it is the same program and they are receiving different awards. C. Conyngham stated that the budget aspect is not her thing and she will talk to C. Terrell about possibly addressing this at HIPC meeting.

L. Matus stated the application acceptance period for the HIPC was Thursday, February 14th. She also informed members that Friday March 1st is the deadline to submit workshops for the upcoming AIDS Education Summit on Tuesday June 11th. She stated that if members have ideas or collaborations in mind that they should contact her.

Report of Staff:
New staff member D. Fitzpatrick introduced himself.

N. Johns gave an update from the Comprehensive Planning Committee that they will be bringing the Racial Equity Workgroup proposal to the HIPC and they will ask committee members if they want to participate.

Prevention Services Initiative:
C. Conyngham said that they continue to see an increase in infections in people who inject drugs. She stated that AACO continues to work with their provider sub-recipients to expand their mobile testing. In January they changed their sites to West Philadelphia, Parkside, South Philadelphia near Broad and Snyder, different sites in Kensington. C. Conyngham said that they continue to monitor those sites.

C. Conyngham informed members that the data from the sites showed that some were really engaging the populace and were received well, while some were not meeting the population of focus. AACO gets weekly data from sub-recipients, so it is more real time as opposed to the 30 days after the date of the test. C. Conyngham noted that the last encampment will be displaced on January 31st and they are working collaboratively with their partners to service those individuals as they move. She also said they hoped to be

rolling out their PrEP campaign in Quarter One and they will be taking materials to the review committee made up community and sub-recipients. This will be done prior to and during development and she informed members to stay tuned. C. Steib asked if the Committee could see it after it goes through the review process and C. Conyngham said that they could schedule a presentation around February or March.

Discussion Items:
HIPC Mission, Vision, Values
B. Morgan explained what happened at the last HIPC meeting and referenced the HIPC Mission, Vision, and Values handout. B. Morgan stated that the HIPC wants the individual Committees to examine it and identify changes they may want to make. B. Morgan informed members that at the last meeting, some members stated that the current Vision and Mission Statements are more focused on PLWH and not as much on prevention. She highlighted that the Shared Values section does mention more prevention initiatives, but she suggested the Committee take a few minutes to look over it.

B. Morgan asked the Committee for any additional reactions. C. Steib informed other members that they talked about adding an "at-risk" part in the Vision Statement. He suggested it could be like "We envision that every person with HIV disease or at high risk of acquiring HIV". C. Steib also suggested that prevention services are not really listed in the Shared Values section, stating that the only mention of it he examined is in the fourth value in parentheses. M. Ross-Russell stated that something about ending the epidemic should go somewhere in there. C. Steib informed members that this was written before the HIPC integrated and that is why the language is lacking prevention topics. L. Matus asked if the former HIV Prevention Group (HPG) had anything similar to what the HIPC has and M. Ross-Russell stated the last time HPG had something similar was years ago and prior to the CDC changing their purview. C. Steib said that this is their opportunity to be included and asked the Committee if they had any ideas. B. Morgan informed the members that it would be helpful to have some feedback in the next couple weeks to help guide the other Committees. C. Steib informed the Committee that they can look at some other suggestions made in the minutes for last HIPC meeting.

B. Morgan stated that at the last meeting, a member brought up putting shorter words or phrases in the Shared Values section. E. Sargent asked how they should send feedback. B. Morgan responded that it is whatever members feel comfortable with; it can be either email or phone. She gave members her email, which is briana@hivphilly.org or they can call the OHP number. C. Steib asked for additional questions or input and members had none.

Priority Setting
N. Johns said they are talking about priority setting because it has not been done since the HIPC has become an integrated body. N. Johns informed members that the handout for the HIPC primer may be helpful to those members who have not participated before. She described it as a simple overview of the priority setting and resource allocation process. She explained that there is a list of RW services listed on the back and stated that she would give a brief overview.

N. Johns informed the members there are two important things to note. One is that it is very different than the annual allocations, even though they are related. She said that when talking about prioritizing services, that they do not consider money unless it comes up tangentially. She provided examples such as if they are discussing whether RW is the only place where people can get something or if they are talking about health insurance. She stated that the second important thing is that the HIPC decided not to do it annually and they changed it to do it every 1 to 3 year. The Comprehensive Planning Committee traditionally has lead the process and she informed the members that anyone on the council is welcome to participate.

She explained over time, the process has changed a lot. She further stated that in the past, it really used to be a subjective experience. They would collect data over time and assign priorities in order based on discussions. She informed members that it really depended on who was in the room and what information they had. The HIPC felt that it was too subjective and changed the process to be more data driven. N. Johns stated now they are considering that they went too far with objective measures because there are some things that cannot be quite captured by data around these communities. She informed members that they may not be capturing information on newly emerging trends or lived experiences. She explained that the Comprehensive Planning Committee is going to be doing half data driven and half utilizing that data and applying it to lived experiences and collecting qualitative information.

N. Johns stated that the list of prioritized services is important because it gets utilized in a variety of ways. She stated that it goes to their RW application to HRSA and the list informs, but does not dictate, where funding is allocated. She also explained that it will be utilized in Comprehensive Planning Committee conversations and is very prominent for explaining why they do what they do in the RW system. M. Ross-Russell explained that when they shift services around they have to explain why those services changed ranks. She further stated the reason they wanted the Prevention Committee involved in the process is because it is important to explain the relationship of RW services to care and prevention.

C. Steib asked how to move forward as a Committee and N. Johns responded that they should attend the Committee meetings in which the decisions are going to be made, which will most likely be in March or April. She informed members that the Comprehensive Planning Committee will be meeting Thursday, February 21st, and they will be talking about what things are going to be considered and the categories they have set out for the priority setting process. She invited members that were interested in knowing more about the process to come to the February Comprehensive Planning Committee meeting before it goes to the HIPC. N. Johns informed members if they cannot attend the meeting that they can contact her or the co-chairs of the Comprehensive Planning Committee, A. Thompson and T. Dominique, with their concerns. C. Steib asked the members if they would like to discuss more on this before the March Comprehensive Planning meeting and members agreed they should have a meeting prior to that.

Training and Presentation Requests

M. Ross-Russell informed the members that training on roles and responsibilities came up various times at the last HIPC meeting. She stated that the HIPC will get that training in March. M. Ross-Russell referenced the Quick Legislative Reference for HIPC Support Staff handout; she stated that it is a simplified way of looking at HIPC responsibilities in relation to the legislative language. She explained to the members that the legislative references explains what the HIPC can and cannot do. M. Ross-Russell emphasized that that it is important information for members to know because as an integrated body, the roles and responsibilities of the HIPC body is the roles and responsibilities of the Committees. When they do the training on roles and responsibilities, they will discuss the process more in depth.

B. Morgan explained that the left side is the legislative side and is important because it is the legal requirements and the other side defines what the HIPC needs to do according to HRSA guidance. M. Ross-Russell highlighted that conflict-of-interest is defined in the handout and is important to know what it means when that word is used at other meetings. She explained to members that this handout basically explains the parameters of why the HIPC does what it does. She informed members they can email or call her if they have questions.

M. Coleman inquired about who was in charge of the decision making process in reference to allocating funds. M. Ross-Russell informed members that the HIPC cannot be directly involved in decision making for the actual grant making, but can discuss the money that goes into a service category, such as medical services. M. Coleman asked that if there is not representation by specific populations or service sectors on the HIPC, how would they know about emerging trends or needs. M. Ross-Russell informed members that identified need comes out of needs assessments and research. She stated that this conversation would take part in the allocations process and the priority setting process. M. Coleman inquired how this decision about priority setting and the allocations processes came to be on the HIPC. M. Ross-Russell stated that the legislation states that the HIPC needs to base their funding decisions on documented need.

B. Morgan asked the members if there is anything else that Prevention Committee has questions about. J. Murdock suggested more training on HIPC because she sometimes does not understand the process or topics covered. C. Steib stated that it comes with time and attendance to the meetings, but agrees with J. Murdock that trainings could be beneficial. G. Grannan agreed as well and stated that not only should they be versed enough in the Committee/ HIPC, but also they should be able to bring back what they learned to their constituents. Committee members agreed. C. Steib asked OHP if it is possible to have a summary of the meeting proceedings before it has to be approved. B. Morgan stated that they have done variations, but they need to know what to look for and how to send it people. B. Morgan also agreed that training on how to give a Committee report could be helpful. M. Ross-Russell informed members that OHP staff have to figure out what they can do prior to meeting minutes being released and emphasized that anything related to the minutes has to be approved by the HIPC body. G. Grannan

suggested they could have something in tentative status to show it is not in an official form. N. Johns suggested that having a debriefing after the meeting so that people can talk about what happened in that day might be beneficial.

B. Morgan stated that it is valued that members contribute specific things they would like to be trained on since there are so many possibilities. L. Matus stated this is especially important when it comes to voting in the HIPC to understand what the vote is for. J. Murdock agreed. L. Matus also expressed interest in learning how to read the graphs and spreadsheets. C. Steib stated that it is important to be able to speak out if people do not understand something. K. Carter suggested a mentorship to have someone guide them through the whole process and C. Conyngham agreed. C. Conyngham stated that she went to a conference where they paired her up with a buddy who had been there before for her to ask questions. She also discussed how they gave a list of acronyms and how that was helpful. She suggested that everyone gets a buddy no matter how or who is joining the HIPC. E. Sargent stated that it would be helpful to have a point person to be clear on what is happening. M. Ross-Russell added that members can stop OHP staff and ask them anything and they will try to support whatever comes up. B. Morgan suggested that people can email or call OHP staff or schedule an appointment. N. Johns wrote OHP staff's contact information and their areas of expertise on the board for members.

PrEP Workgroup Update:
G. Grannan stated that the PrEP Workgroup had a meeting on Wednesday, January 16th. He said that the Workgroup was emailed the report and if anyone did not receive that and/or wants to get it, let him know. He informed members AACO has the information the Workgroup produced. He suggested making that available electronically and having a database for key words. He informed the members that the next PrEP Workgroup meeting is March 20th and that E. Aaron should be coming to the next Prevention Committee meeting and presenting the report. He told members that if they have any experiences that are not represented on the report that they should make a note of it. C. Steib suggested for the Committee to go through the report together and see if there are any recommendations to be made. M. Ross-Russell clarified that once the Workgroup has something they are happy with, then it comes to the Prevention Committee to update or suggest changes. After the Prevention Committee reviews it, they will present it to the HIPC. The final plan will be an addendum to the Integrated Plan.

Old Business:
None.

New Business:
None.

Announcements:
None.

Adjournment: The meeting was adjourned by general consensus at 4:25 p.m.

Respectfully submitted by,

Dustin Fitzpatrick, OHP Staff

Handouts distributed at the meeting:

- Meeting Agenda
- Meeting Minutes from November 28, 2018
- HIPC Mission, Vision, and Values
- Priority Setting and Resource Allocations Primer
- Quick Legislative Reference for HIPC Support Staff
- OHP Calendar

February 2019

Ending the HIV Epidemic: A Plan for America

HHS is proposing a once-in-a-generation opportunity to eliminate new HIV infections in our nation. The multi-year program will infuse 48 counties, Washington, D.C., San Juan, Puerto Rico, as well as 7 states that have a substantial rural HIV burden with the additional expertise, technology, and resources needed to end the HIV epidemic in the United States. Our four strategies – diagnose, treat, protect, and respond – will be implemented across the entire U.S. within 10 years.

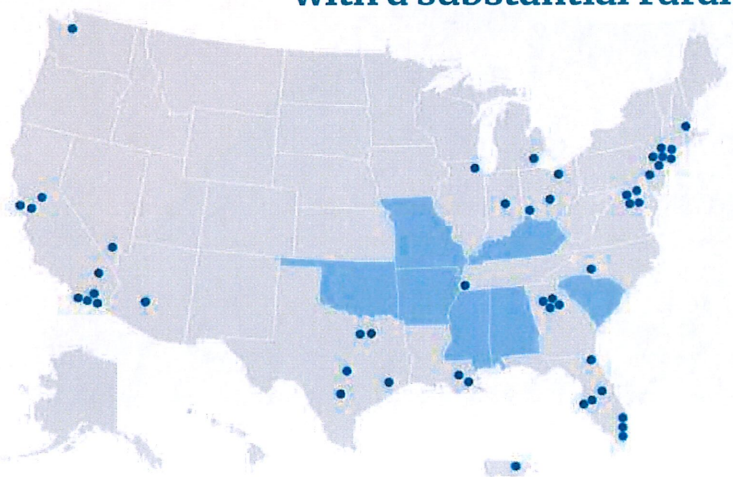
GOAL:

75% reduction in new HIV infections in 5 years and at least **90%** reduction in 10 years.

Our goal is ambitious and the pathway is clear – employ strategic practices in the *places* focused on the right *people* to:

- **Diagnose** all people with HIV as early as possible after infection.
- **Treat** the infection rapidly and effectively to achieve sustained viral suppression.
- **Protect** people at risk for HIV using potent and proven prevention interventions, including PrEP, a medication that can prevent HIV infections.
- **Respond** rapidly to detect and respond to growing HIV clusters and prevent new HIV infections.
- **HIV HealthForce** will establish local teams committed to the success of the Initiative in each jurisdiction.

The Initiative will target our resources to the 48 highest burden counties, Washington, D.C., San Juan, Puerto Rico, and 7 states with a substantial rural HIV burden.



Geographical Selection:
Data on burden of HIV in the US shows areas where HIV transmission occurs more frequently. More than 50% of new HIV diagnoses* occurred in only 48 counties, Washington, D.C., and San Juan, Puerto Rico. In addition, 7 states have a substantial rural burden – with over 75 cases and 10% or more of their diagnoses in rural areas.

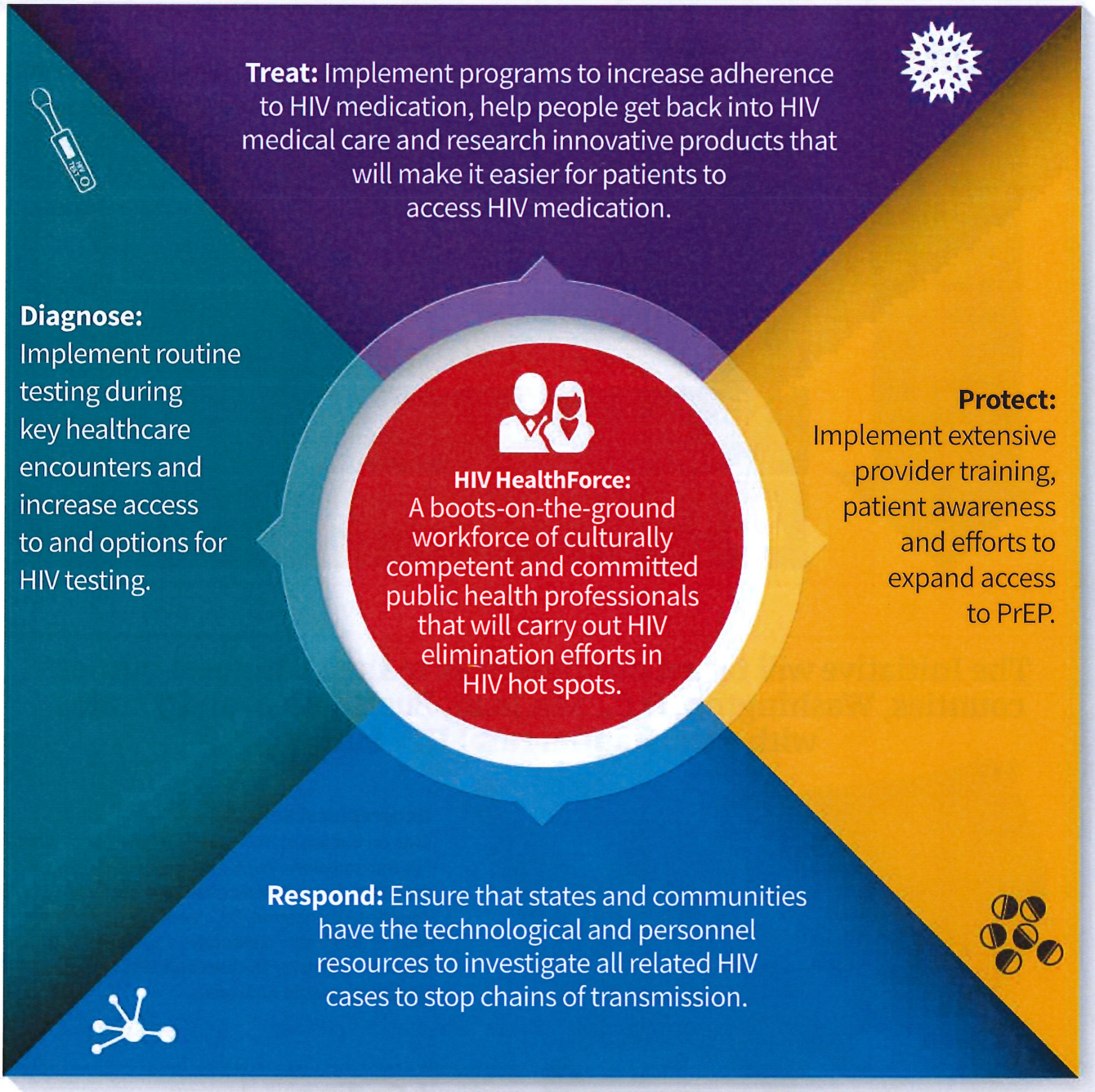
*2016-2017 data

Ending the HIV Epidemic

www.HIV.gov

Ending the HIV Epidemic - Key Strategies:

Achieving elimination will require an infusion of resources to employ strategic practices in the right places targeted to the right people to maximize impact and end the HIV epidemic in America. Key strategies of the initiative include:



Ending the HIV Epidemic

A PLAN FOR AMERICA

HHS is proposing a once-in-a-generation opportunity to eliminate new HIV infections in our nation. This initiative will work to accelerate progress and end the HIV epidemic by directing new funds to those communities affected by HIV in a phased approach, starting with the areas with the highest burden. The multi-year program will infuse 48 counties, Washington, D.C., San Juan, Puerto Rico, as well as 7 states (Alabama, Arkansas, Kentucky, Mississippi, Missouri, Oklahoma, and South Carolina) that have a substantial rural HIV burden with the additional expertise, technology, and resources needed to end the HIV epidemic in the United States. Data on the burden of the current epidemic were analyzed to identify the counties with the highest number of new HIV diagnoses, the states with the heaviest rural HIV burden, and the territorial area now hardest hit. These areas accounted for more than 50 percent of new HIV diagnoses in recent years.

The 48 counties, plus Washington, D.C. and San Juan, Puerto Rico, are listed below.

STATES, COUNTIES, AND TERRITORIES

Arizona
Maricopa County

California
Alameda County
Los Angeles County
Orange County
Riverside County
Sacramento County
San Bernardino County
San Diego County
San Francisco County

Florida
Broward County
Duval County
Hillsborough County
Miami-Dade County
Orange County
Palm Beach County
Pinellas County

Georgia
Cobb County
DeKalb County
Fulton County
Gwinnett County

Illinois
Cook County

Indiana
Marion County

Louisiana
East Baton Rouge Parish
Orleans Parish

Maryland
Baltimore City
Montgomery County
Prince George's County

Massachusetts
Suffolk County

Michigan
Wayne County

Nevada
Clark County

New Jersey
Essex County
Hudson County

New York
Bronx County
Kings County
New York County
Queens County

North Carolina
Mecklenburg County

Ohio
Cuyahoga County
Franklin County
Hamilton County

Pennsylvania
Philadelphia County

Tennessee
Shelby County

Texas
Bexar County
Dallas County
Harris County
Tarrant County
Travis County

Washington
King County

Washington, DC

Puerto Rico
San Juan Municipio

EDITORIAL

Ending the HIV Epidemic
A Plan for the United States

Anthony S. Fauci, MD; Robert R. Redfield, MD; George Sigounas, MS, PhD; Michael D. Weahkee, MHA, MBA; Brett P. Giroir, MD

In the State of the Union Address on February 5, 2019, President Donald J. Trump announced his administration's goal to end the HIV epidemic in the United States within 10 years. The president's budget will ask Republicans and Democrats to make the needed commitment to support a concrete plan to achieve this goal. While landmark biomedical and scientific research advances have led to the development of many successful HIV treatment regimens, prevention strategies, and improved care for persons with HIV, the HIV pandemic remains a public health crisis in the United States and globally.

Supplemental content

In the United States, more than 700 000 people have died as a result of HIV/AIDS since the disease was first recognized in 1981, and the Centers for Disease Control and Prevention (CDC) estimates that 1.1 million people are currently living with HIV, about 15% of whom are unaware of their HIV infection.[1] Approximately 23% of new infections are transmitted by individuals who are unaware of their infection and approximately 69% of new infections are transmitted by those who are diagnosed with HIV infection but who are not in care.[2] In 2017, more than 38 000 people were diagnosed with HIV in the United States. The majority of these cases were among young black/African American and Hispanic/Latino men who have sex with men (MSM). In addition, there was high incidence of HIV among transgender individuals, high-risk heterosexuals, and persons who inject drugs.[1] This public health issue is also connected to the broader opioid crisis: 2015 marked the first time in 2 decades that the number of HIV cases attributed to drug injection increased.[3] Of particular note, more than half of the new HIV diagnoses were reported in southern states and Washington, DC. During 2016 and 2017, of the 3007 counties in the United States, half of new HIV diagnoses were concentrated in 48 "hotspot" counties, Washington, DC, and Puerto Rico.[4]

The US Department of Health and Human Services (HHS) has proposed a new initiative to address this ongoing public health crisis with the goals of first reducing numbers of incident infections in the United States by 75% within 5 years, and then by 90% within 10 years. This initiative will leverage critical scientific advances in HIV prevention, diagnosis, treatment, and care by coordinating the highly successful programs, resources, and infrastructure of the CDC, the National Institutes of Health (NIH), the Health Resources and Services Administration (HRSA), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Indian Health Service (IHS). The initial phase, coordinated by the HHS Office of the Assistant Secretary of Health, will focus on geographic and demographic hotspots in 19 states, Washington, DC, and Puerto Rico, where the majority of the new HIV cases are reported, as well as in 7 states with a disproportionate occurrence of HIV in rural areas (eFigure in the Supplement).

The strategic initiative includes 4 pillars:

1. diagnose all individuals with HIV as early as possible after infection;
2. treat HIV infection rapidly and effectively to achieve sustained viral suppression;
3. prevent at-risk individuals from acquiring HIV infection, including the use of pre-exposure prophylaxis (PrEP); and
4. rapidly detect and respond to emerging clusters of HIV infection to further reduce new transmissions.

A key component for the success of this initiative is active partnerships with city, county, and state public health departments, local and regional clinics and health care facilities, clinicians, providers of medication-assisted treatment for opioid use disorder, and community- and faith-based organizations.

The implementation of advances in HIV research achieved over 4 decades will be essential to achieving the goals of the initiative. Clinical studies serve as the scientific basis for strategies to prevent HIV transmission/acquisition. In this regard, as reviewed in a recent Viewpoint in *JAMA*,[5] large clinical studies have recently proven the concept of undetectable = untransmittable (U = U), which has broad public health implications for HIV prevention and treatment at both the individual and societal level. U = U means that individuals with HIV who receive antiretroviral therapy (ART) and achieve and maintain an undetectable viral load do not sexually transmit HIV to others.[5] U = U will be invaluable in helping to counteract the stigma associated with HIV, and this initiative will create environments in which all people, no matter their cultural background or risk profile, feel welcome for prevention and treatment services.

Results from numerous clinical trials have led to significant advances in the treatment of HIV infection, such that a person living with HIV who is properly treated and adherent with therapy can expect to achieve a nearly normal lifespan. This progress is due to antiviral drug combinations drawn from more than 30 agents approved by the US Food and Drug Administration (FDA), as well as medications for the prevention and treatment regimens of HIV-associated coinfections and comorbidities. Furthermore, PrEP with a daily regimen of 2 oral antiretroviral drugs in a single pill has proven to be highly effective in preventing HIV infection for individuals at high risk. In addition, postexposure prophylaxis provides a highly ef-

fective means of preventing transmission from a high-risk exposure and can serve as a bridge to PrEP.

Collectively, these advances suggest that, theoretically, the HIV epidemic in this country could be ended quickly by expanding access to treatment to all persons with HIV and PrEP to all those at high risk. The administration has developed a practical, achievable plan to focus on hotspots of HIV infection, both demographic and geographic. Lessons learned and effective strategies emanating from this initiative would ultimately be applied to profoundly reduce HIV incidence nationwide through federal, state, and local health departments and nongovernmental organizations.

In the developing world, particularly in Africa, the President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria have helped close gaps in HIV treatment and prevention implementation and have addressed disparities between resource-rich and resource-limited nations. PEPFAR has brought the HIV global pandemic from crisis toward control and replaced death and despair with hope and life. The latest results achieved by US leadership and partnerships through PEPFAR, the Global Fund, and other organizations are estimated to have saved more than 21.7 million lives. PEPFAR alone is supporting more than 14.6 million people with lifesaving ART, when just 50 000 people were receiving ART in Africa at the start of the PEPFAR program in 2003.[6]

Demographic and geographic hotspots of HIV infection need a particular focus to interrupt or disrupt the kinetics of HIV spread in the United States. The coordinated multi-HHS agency initiative will provide this focus. The HRSA Ryan White HIV/AIDS Program (RWHAP) has achieved remarkable success in implementing quality HIV treatment and care. For 2017, the program reports that 85% of individuals who had at least 1 medical visit had achieved viral suppression, far exceeding the national average of 60% of HIV-diagnosed adults and adolescents. The RWHAP has significantly increased the rate of viral suppression among key populations including women, transgender individuals, black/African American individuals, adolescents and young adults, and those with unstable housing.[7]

Using this experience, HRSA will accelerate its efforts working with state and county health departments and community and faith-based organizations to play a major role in the HHS initiative to end the US HIV epidemic. The RWHAP provides the infrastructure, personnel, and expertise for effective treatment and medical intervention strategies. The CDC will be critical for this initiative by amplifying its existing programs and working in communities along with state and local health authorities to bring HIV testing to all who need it, to diagnose infections as early as possible, to conduct epidemiologic investigations of new HIV clusters, and to promote rapid linkage to comprehensive care in the RWHAP. The HRSA Health Centers Program will provide PrEP services to those identified at high risk for HIV acquisition and care for those with HIV. The IHS will focus on urban and rural tribal communities, ensuring that emerging threats are addressed and effective programs and services are marshaled in these communities to address the 4 pillars of the strategic initiative. To expand access to treating HIV, the IHS has published PrEP guidelines for local use and customization and developed electronic health record clinical reminders to assist clinical staff.

The NIH's Centers for AIDS Research will inform HHS partners in this initiative on best practices, based on state-of-the-art biomedical research findings, and by collecting and disseminating data on the effectiveness of approaches used in this initiative. In addition to syringe services programs, access to FDA-approved medication-assisted treatment for substance use disorders, in concert with counseling/behavioral services, is critically important. SAMHSA's efforts to increase providers of medication-assisted treatment, particularly in the hotspots, will help control the spread of HIV, providing access for intravenous drug users with substance use disorder and HIV to receive the treatment they need.

The president, the secretary of HHS, and members of the department are committed to ending the HIV epidemic in the United States. The president's budget will propose a way forward on this bold initiative to achieve this goal.

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PrEP Workgroup Report 2018

PrEP-Related Activities in the 2018 Update to the Philadelphia EMA Integrated HIV Prevention and Care Plan 2017-2021

Introduction

The PrEP Workgroup is a subcommittee of the Prevention Committee of the Philadelphia EMA HIV Integrated Planning Council.

In compliance with the Planning Council's federally mandated bylaws, the PrEP Workgroup advises the Planning Council, through its Prevention Committee, on awareness of, access to, and uptake of pre-exposure prophylaxis (PrEP) in Philadelphia, particularly among people disproportionately affected by HIV.

Members of the PrEP Workgroup include PrEP advocates, providers, and community members.

This report summarizes the PrEP Workgroup's deliberations as of its October 2018 meeting. It consists of three sections, as follows:

1. General principles for expanding access to PrEP and PEP services in Philadelphia that guided the Workgroup's discussions. *See page 2, below.*

2. A list of all 10 of the PrEP-specific activities included in the 2018 update of the Planning Council's ***Integrated HIV Prevention and Care Plan, 2017-2021*** by goal, objective, strategy, and page number. *See page 3, below.*

3. Annotations by the PrEP Workgroup for PrEP-related activities in the 2018 update of the ***Integrated HIV Prevention and Care Plan 2017-2021***. *See pages 14-16, below.*

    - This section provides the context for each PrEP-related activity (labeled "Key Elements") in the ***Integrated Plan***, along with a summary of the PrEP Workgroup's discussions that most closely align with the activity (labeled "Discussion").

For more information about the PrEP Workgroup, including meeting minutes, visit its page on the Planning Council's website, www.hivphilly.org.

Section 2. Summary List of PrEP-Specific Activities in the 2018 Update of the Integrated HIV Prevention and Care Plan 2017-2021

#	Activity	Goal	Objective	Strategy	Plan Location
1	Coordinate provision of PrEP and PEP	Goal 1: Reduce new HIV infections	Obj. 1.2: Reduce the number of new infections	Strategy 1.2.2: Ensure the provision of PrEP and nPEP to at-risk populations	Page 6
2	Develop and implement a plan to inform the public about the availability of PrEP and nPEP				
3	Create online campaign Do You Philly to encourage condom use, HIV testing, and PrEP uptake in Philadelphia			Strategy 1.2.7: Reduce the percentage of youth, including gay and bisexual men who engage in HIV risk behaviors	Page 10
4	Provide prevention navigation services that link MSM of color to PrEP and provide ongoing adherence support	Goal 3: Reduce HIV-related disparities and health inequities	Obj. 3.1: Reduce HIV-related disparities in new diagnoses among high-risk populations	Strategy 3.1.1: Increase access to services for MSM of color that address social determinants of HIV risk	Page 17
5	Ensure the provision of PrEP and nPEP to at-risk populations			Strategy 3.1.2: Increase access to biomedical prevention interventions	Page 18
6	Provide prevention navigations services that link MSM of color to PrEP and provide ongoing adherence support				
7	Continue and expand community education activities about PrEP				
8	Continue and expand clinical education about PrEP				
9	Monitor population level PrEP uptake in key populations in Philadelphia				
10	Educate and update clinical providers throughout the EMA on the most current evidence-based guidelines and protocols, including but not limited to routine screening and PrEP provision	Goal 4: Achieve a more coordinated response to the HIV epidemic	Obj. 4.1: Support collaboration, communication, and coordination across all sectors	Strategy 4.1.2: Continue outreach and education to clinical providers outside the Ryan White system.	Page 23

PrEP Workgroup Annotations to Strategy 1.2.2 Activity A	
Key elements	▪ Of the approximately 13,000 individuals with PrEP indications in Philadelphia, 12,000 are not on PrEP. ▪ PDPH estimates between 870 and 1,218 individuals in Philadelphia were on PrEP in 2016. ▪ Between 7% to 9% of the total population of persons with PrEP indications in the City of Philadelphia were on PrEP in 2016. ▪ Culturally appropriate PrEP and PEP services are available and accessible to target populations including PWID and transgender persons.
Discussion	▪ Assuring access to PrEP training curricula to community medical practices with evidence of PrEP capacity in ZIP codes with high HIV and STD prevalence. ▪ Facilitating culturally appropriate PrEP-themed town halls, community events, and health fairs. ▪ Promoting coordination and collaboration regarding the individual-level and public health benefits of PrEP and PEP among community based clinical programs and local community and faith-based leaders. ▪ Integrating PrEP screenings with HIV testing and Hepatitis C testing.

PrEP Workgroup Annotations to Strategy 1.2.2 Activity B	
Discussion	▪ Developing and promoting PrEP campaign talking points for navigators, hotline personnel, educators, clinical staff, and other parties who interact directly with members of the target population reinforces and leverages the campaign's information and call to action. ▪ Engaging support of the PrEP campaign by respected public personalities and social influencers. ▪ Facilitating PrEP campaign-related educational activities at churches, mosques, libraries, barbershops, beauty salons, school settings, health fairs, college campuses, and faith-based institutions. ▪ Expanding access to on-demand STI services expanded to include PrEP and PEP in order to reach under-served persons for whom PrEP and PEP are indicated (modeled on New York City's program of eight Sexual Health Clinics). ▪ Assuring HIV testers facilitate access to PrEP and PEP.

Goal 3: Reduce HIV-related disparities and health inequities Objective 3.1: Reduce HIV-related disparities in new diagnoses among high-risk populations					
Strategy 3.1.1.: Increase access to services for MSM of color that address social determinants of HIV risk					
Responsible parties	***Activity***	***Target populations***	***Data indicators***	***Baseline 2016***	***Source***
▪ PDPH ▪ Navigation services providers	Provide prevention navigation services that link MSM of color to PrEP and provide ongoing adherence support	HIV-negative MSM of color	▪ # of navigation clients ▪ # of linkages to behavioral health and social services ▪ # of linkages to PrEP in PDPH-funded programs	▪ 83 Club 1509 clients ▪ 34 linkages to supportive services ▪ 10 linkages (4th quarter 2016 only)	Club 1509 provider data exports (CAREWare)

PrEP Workgroup Annotations to Strategy 3.1.1	
Key elements	▪ PDPH provides grants to seven CDC-funded PS15-1509 cooperative agreement projects to conduct navigation services for eligible clients. ▪ As of Year 3 of PS15-1509, 704 clients have been screened for PrEP, 545 referred to PrEP, 438 linked to PrEP, and 357 prescribed PrEP.
Discussion	▪ Developing formal relationships among PDPH-funded navigation services, community medical providers, and mental health substance abuse treatment services in neighborhoods with high prevalence of HIV and STDs.

PrEP Workgroup Annotations to Strategy 3.1.2 Activity A	
Key elements	▪ PDPH funds PrEP/PEP navigation projects in five community-based clinical settings. ▪ As of January 1, 2019, all five navigation projects have received the common data variables required by PDPH for individual projects to measure and report their PrEP/PEP navigation outcomes.
Discussion	▪ Addressing barriers to accessing PrEP and PEP among uninsured and under-insured persons through initiatives that pay for uncovered costs of PrEP-related visits and labs at community medical provider sites. ▪ Supporting PrEP programs providing developmentally appropriate services to persons under the age of 25, particularly teens. ▪ Developing programs that provide evening and weekend hours to expand accessibility to PrEP services. ▪ Expanding access to PrEP and PEP "starter packs" for special circumstances that may occur in settings such as emergency departments with immediate linkage to PrEP providers. ▪ Engaging pharmacists in expanding access to PrEP and PEP, and in supporting PrEP adherence.

Strategy 3.1.2: Increase access to biomedical prevention interventions					
Responsible parties	***Activity C***	***Target populations***	***Data indicators***	***Baseline 2016***	***Source***
PDPH	Continue and expand community education activities about PrEP	▪ MSM of color ▪ Community leaders ▪ High-risk heterosexuals ▪ Sexual and drug using partners of PLWH ▪ PWID ▪ Transgender women	▪ # of technical assistance sessions provided by PDPH Clinical Advisor	▪ 30 TA sessions	PDPH PrEP Clinical Coordination Program
			▪ # of persons reached during TA sessions	▪ 670 persons reached	

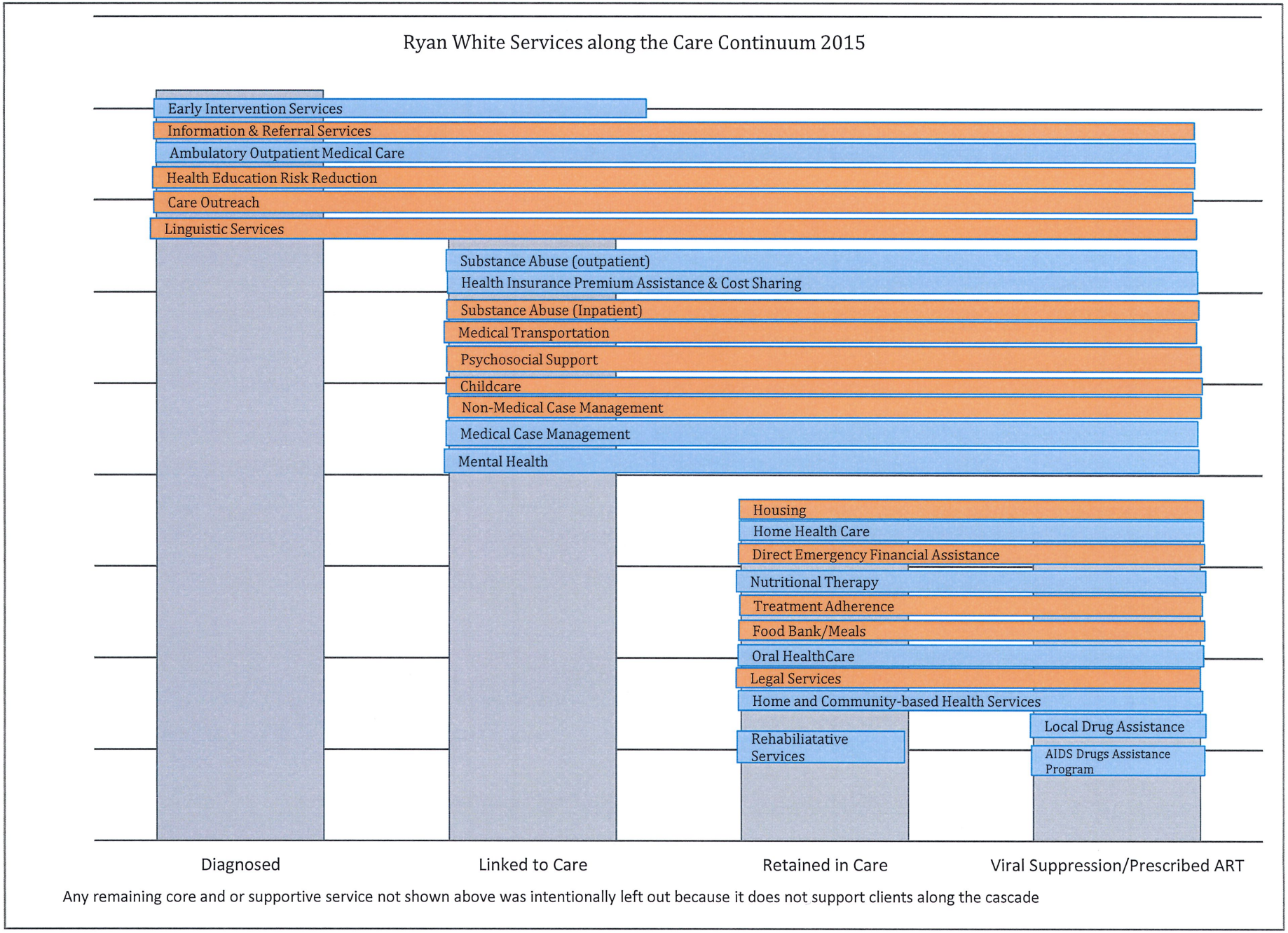
PrEP Workgroup Annotations to Strategy 3.1.2 Activity C	
Key elements	▪ In 2018, the PDPH PrEP Clinical Coordinator (1) conducted 20 technical assistance visits at clinical sites, which engaged 356 persons, (2) trained 40 certified HIV testers at 4 Testing and Linkage to Care in-service trainings, and (3) participated in 6 PrEP Workgroup meetings attended by 240 duplicated individuals.
Discussion	▪ Developing a network of Popular Opinion Leaders (POLs) who can inform the community on the benefits of PrEP and PEP, how and where to access PrEP and PEP services, and the role of adherence to PrEP.

PrEP-Related Activities in the 2018 Update to the Philadelphia EMA Integrated HIV Prevention and Care Plan 2017-2021

Strategy 3.1.2: Increase access to biomedical prevention interventions					
Responsible parties	***Activity E***	***Target populations***	***Data indicators***	***Baseline 2016***	***Source***
▪ PDPH ▪ HIPC	Monitor population level PrEP uptake in key populations in Philadelphia	High-risk HIV-negative individuals Transgender women MSM of color Youth 13-24	▪ # of HIV-negative Philadelphians on PrEP ▪ # of HIV-negative MSM on PrEP	▪ Data to be reported in 2019	PDPH PrEP Monitoring and Evaluation Plan

PrEP Workgroup Annotations to Strategy 3.1.2 Activity E	
Key elements	▪ PDPH's PrEP Monitoring and Evaluation Plan was completed in 2018. ▪ PDPH participated in the national PrEP-related HIV Technical Cooperation Group of the University of Washington's Public Health Capacity Building Center. ▪ Baseline data on PrEP uptake in Philadelphia is currently being identified and collected.
Discussion	▪ Geo-coding (1) HIV incidence data, (2) select STI incidence data, and (2) locations of providers on the PDPH roster to identify ZIP codes that indicate disparities in access to PrEP providers. ▪ Addressing PrEP access gaps identified by geo-coding through such activities as (1) building clinical community-based capacity for PrEP services, and (2) linking clinical providers with available PrEP educational programs, CME courses, and other training tools. ▪ Implementing PrEP-related lessons to be learned by 2022 in the performance of PDPH's CDC cooperative agreement project *Demonstrating Expanded Interventional Surveillance: Towards Ending the HIV Epidemic in Philadelphia (DExIS).*

PrEP Workgroup Annotations to Strategy 4.1.2	
	▪ Encouraging quality improvement projects in clinical practices on PrEP, PEP, HIV testing and STD screening. ▪ Addressing barriers to and improving access to PEP. ▪ Encouraging Community Advisory Boards in Philadelphia to disseminate information on PrEP and PEP. ▪ Facilitating greater representation of racial/ethnic minorities, women, and transgender persons in PrEP-related research.



Any remaining core and or supportive service not shown above was intentionally left out because it does not support clients along the cascade