Prevention Committee
Meeting Minutes of
Wednesday, October 25th, 2023
2:30 p.m. – 4:30 p.m.
Office of HIV Planning, 340 N. 12th St., Suite 320, Philadelphia PA 19107

Present: Desiree Surplus (Co-chair), Clint Steib (Co-chair), Gus Grannan, Lorett Matus, Keith Carter, DJ Jack,

Guest: Ghada Ayad, Bill Pearson, Emily McNamara, Toyin Olubiyi, Halran Shaw, Brian Hernandez, Patty Melisen, Javontae Williams

Excused: Erica Rand

Staff: Beth Celeste, Tiffany Dominique, Sofia Moletteri, Kevin Trinh

Call to Order/Introductions: C. Steib asked everyone to introduce themselves and called the meeting to order at 2:32 p.m.

Approval of Agenda:
D. Surplus referred to the October 2023 Prevention Committee agenda and asked for a motion to approve. **Motion:** K. Carter motioned; G. Grannan seconded to approve the October Prevention Committee agenda via Zoom poll. **Motion passed:** 6 in favor, 1 abstaining. The October 2023 agenda was approved.

Approval of Minutes (*September 27th, 2023*):
D. Surplus referred to the September 2023 Prevention Committee/Comprehensive Planning Committee meeting minutes. G. Grannan said he had wanted to make a correction on page 8 and 9 of the minutes. He said he knew there were two consumption sites in New York but he was unsure of the exact neighborhoods. S. Moletteri said the correction would only be reflected in the Prevention Committee minutes since the CPC minutes had been approved. **Motion:** K. Carter motioned; L. Matus seconded to approve the September 2023 Prevention Committee/ Comprehensive Planning Committee meeting minutes and agenda via a Zoom poll. **Motion passed: 5** in favor 2 abstained. The September 2023 minutes were approved.

Report of Co-chairs
C. Steib said they were still looking for a new co-chair. He encouraged the committee members who were interested to reach out to the staff.

Report of Staff
T. Dominique said that since M. Ross-Russell could not be at the meeting, she would be giving the report. She recalled there was a question regarding teen pregnancy rates. She said that when

M. Ross-Russell researched the information, she could not find complete data. She said they could find the data around live births but not the number of pregnancies. T. Dominique stated that there was a time when the state recorded the number of live births, deaths, and abortions of infant mortality. She said M. Ross-Russell could not find the abortion rate to answer the question more fully. She said she wanted to let the members know that because they could not find complete data, they chose not to report the information. D. Surplus thanked T. Dominique for the report.

Presentation:

-Injectable PrEP-

G. Ayad introduced herself as a Community-Based Pharmacy Resident at ACME. She said she would be presenting on Apretude and Cabenuva, which were injectable HIV medications. She mentioned before the presentation that the pharmacy was currently not administering the medication, and she does not have experience with the medicine. She said once they were allowed to administer them, it would allow for more accessibility for patients. She said they had great flexibility to meet the needs of their patients since the pharmacy at ACME was open 24/7. She mentioned that Sunrise Pharmacy in West Philadelphia does offer these medications, and she had one of her colleagues visit that location to gauge the experience of the medication. She said they could discuss this later in the presentation.

Following the introduction, G. Ayad described the agenda for the presentation. The presentation would start with an overview of Apretude for HIV-1 pre-exposure prophylaxis (PrEP). She would then speak about Cabenuva for HIV-1 treatment. Lastly, she would speak on other injectable HIV medications in clinical trials.

Apretude was the brand name of the injectable PrEP. The generic name and main active ingredient in the medication was Cabotegravir. The medication was for adults and adolescents who were 12 years old and up. Persons interested in Apretude must have a negative HIV test before use. The medicine was typically injected into the gluteal muscle. If they could not inject it into this gluteal muscle to avoid major nerves, they would inject it into the side,known as Ventrogluteal Injection. She then listed the contraindications that would bar someone from using Apretude. The first was an unknown or positive HIV status. Additionally, persons with an allergic reaction to Cabotegravir were not allowed to use the medication. If the person was using drugs that would prevent Apretude from functioning, they may not be allowed to receive the injectable. G. Ayad said she would provide more details on the last statement later in the presentation.

G. Ayad then reviewed the Apretude dosing schedule. The dosing schedule started with an optional 1-month of oral Cabotegravir to assess tolerability. The step was optional but could be recommended if the patient did not have a history of using Cabotegravir. Following the option month of oral Cabotegravir, the patient would be introduced to the initiation step. They would be given a single 600-mg 3mL injection given 1 month apart for 2 consecutive months on the last day of an oral lead-in if used or within 3 days. Once the injection was completed, maintenance would be one injection every 2 months or 6 injections every year. G. Ayad said Apretude allowed a 14-day window to administer the medication. This allowed more flexibility in scheduling appointments. G. Ayad then explained what the process would be if the patient planned to miss a

dosage. The patient would then be started on oral cabotegravir 30mg for up to 2 months to replace the 1 missed injection. They would repeat Apretude on the last day of oral therapy or within 3 days. If a patient would miss more than 2 months of dosage, an alternative oral regimen was recommended.

For unplanned missed doses, there was a different process. If the second injection was missed and the time was less than or equal to 2 months, the provider would need to administer a 600-mg (3-mL) gluteal intramuscular injection of Apretude as soon as possible. Then the patient would continue to follow the every-2-month injection dosing schedule. If the time since the first injection was greater than 2 months, the patient would be required to restart with 600-mg (3-mL) gluteal intramuscular injection of Apretude followed by a second 600-mg (3-mL) initiation injection dose 1 month later. Then the patient would continue to follow the every-2-month injection dosing schedule thereafter. If 3 months were missed, the provider would administer 600-mg (3-mL) gluteal intramuscular injection of Apretude as soon as possible. Then the patient continues to follow the every-2-month injection dosing schedule. If the period was greater than 3 months, the patient would restart with 600-mg (3-mL) gluteal intramuscular injection of Apretude followed by a second 600-mg (3-mL) initiation injection dose 1 month later. Then the patient would continue to follow the every-2-month injection dosing schedule thereafter.

G. Ayad rhetorically asked the committee how long Apretude stayed in the body. She said Apretude could remain up to 12 months or longer after the last injection. The half-life elimination was 5.6-11.5 weeks. G. Ayad said this was a discussion providers could have with patients who were deciding to discontinue Apretude. She explained that a patient could build resistance to Apretude if they discontinue use or test positive for HIV. This was also an important discussion for persons who were planning to be pregnant since Apretude can remain in the body for up to 12 months. The drug was not tested on anyone who was pregnant.

G. Ayad described Apretude's interactions with other drugs. She said anticonvulsants were medications for seizure disorders. Examples of anticonvulsants were Carbamazepine, Oxcarbazepine, Phenobarbital and Phenytoin. G. Ayad advised those taking these medications to avoid a combination with Apretude. She said these medications could reduce the efficacy of Apretude, mentioning that there were other options to treat seizure disorders. Other medications that interacted with Apretude were Antimycobatericals and Antimycobacterials. Examples of Antimycobacterials were Rifapin and Rifapentine. She said they could reduce the efficacy of Apretude. An example of an Antimycobacterial was Rifabutin. She noted that Rifabutin could be used with Apretude if the dosage frequency of Apretude was increased.

Apretude had multiple adverse side effects. G. Ayad informed the committee that the common side effects were injection site reactions, diarrhea, headache, Pyrexia, and fatigue. Patients should know that the medication could cause Hepatoxicity or liver toxicity. She said patients with liver problems should have a liver function test and then be monitored as needed. Patients should also monitor depressive symptoms and hypersensitivity reactions. G. Grannan asked if non-drug interactions were possible such as grapefruit. G. Ayad said she was not aware of any other interactions and recommended monitoring if there were concerns about interactions. K. Carter asked if they could check the packaging for information on interactions. G. Ayad replied that the major interactions were listed on the packaging. K. Carter expressed concerns that

Apretude and Cabenuva would have interactions with common medications that people over 50 years old were taking. G. Ayad said she would look into the topic. She said the pharmacist could scan the list of drugs that patients were using to see if there were interactions. She recommended that patients should monitor themselves for any chances if they were using Apretude.

The other injectable PrEP medication in the presentation was Cabenuva. The brand name was Cabenuva and it contained Cabotegravir and Rilpivirine. G. Ayad explained that Apretude was used for prevention while Cabenuva was used for treatment. She explained that used on its own, Cabotegravir could lead to resistance. Cabenuva was mainly used for treatment rather than prevention. Cabenuva was a long-acting injectable and it was inserted in the Gluteal Intramuscular area. Cabenuva had the same contraindications as Apretude. G. Ayad listed the criteria for using Cabenuva: recommended patients were those with a stable Antiretroviral (ARV) regimen, good adherence, no history of treatment failure or resistance, no active hepatitis B virus (HBV), no active HBV infection, not pregnant or planning to be pregnant. G. Ayad explained that the medicine had not been tested on those who had started their HIV regimen. Those who initially started their HIV regimen would be required to be virally suppressed before they could begin us Cabenuva.

Cabeunva had a similar dosing schedule to Apretude. The process begins with an option of 1 month of oral Cabotegravir 30mg and rilpivirine 25mg, taken with a meal. This step was done to assess the patient's tolerability. Each dose was given on different sides of the body to determine the effect of Cabotegravir and Rilpivirine separately. The initiation began with a dose of 600mg-900mg injection on the last day of current antiretroviral therapy or oral lead-in. G. Ayad noted that 2 consecutive months of initiation were required for every 2 months of dosing. Maintenance for Cabenuva was slightly different from Apretude. If the patient were on a monthly dosing schedule, they would be injecting 400-600mg of Cabenuva monthly. If they were on a 2-month dosing schedule, they would be injecting 600-900mg every 2 two months.

G. Ayad described the response to a planned missed dose. She said the patient would need to take oral Cabotegravir 30mg and Rilpivirine 25mg once daily for up to 2 months to replace the missed injection visits. For durations greater than 2 months, an alternative oral regimen was recommended. For unplanned missed doses if the time was less than or equal to 2 months, the patient would resume the dosing schedule with 400-mg (2-mL) Cabotegravir and 600-mg (2mL) Rilpivirine gluteal intramuscular monthly injections as soon as possible. For unplanned missed doses if the time since the last injection was greater than 2 months, the provider would re-initiate the patient with 600-mg (3-mL) Cabotegravir and 900-mg (3-mL) Rilpivirine Gluteal Intramuscular injections and then have the patient follow the 400-mg (2-mL) Cabotegravir and 600-mg (2-mL) Rilpivirine Gluteal Intramuscular monthly injection dosing schedule. If the patient was on a 2-month dosing schedule and their last injection was less than or equal to 2 months, they could resume their dosing schedule with 600-mg (3-mL) cabotegravir and 900-mg (3-mL) Rilpivirine intramuscular injection as soon as possible. Then the patient would continue to follow the every-2-month injection dosing schedule. If the patient had 3 injections or more, the patient had more leeway with unplanned missed doses. If the unplanned missed dose were less or equal to 3 months, the patient would resume with 600-mg (3-mL) Ccaboetgravir and 900-mg (mL) Rilpivirine Intramuscular injections as soon as possible and continue with the every-2-month injection dosing schedule. If the time was greater than 3 months, the provider

would re-initiate the patient with 600-mg (3-mL) Cabotegravir and 900-mg (3mL) Rilpivirine Intramuscular injections, followed by the second initiation injection dose 1 month later. Then the patient would continue with the every-2-month injection dosing schedule thereafter.

Similar to Apretude, Cabenuva could stay in the body for up to 12 months or longer. The half-life elimination of Rilpivirine was 13 to 28 weeks. This was longer than Cabotegravir's 5.6-11.5 weeks half-life elimination.

The drug interactions for Cabenuva were similar to Apretude since they both contained Cabotegravir. G. Ayay said patients using Cabenuva should avoid Anticonvulsants such as Carbamazepine, Oxcarbazepine, Phenobarbital, and Phenytoin. Cabenuva users should also avoid Antimycobacterials such as Rifampin, Rifapentine, and Rifabutin. G. Ayad said Rifabutin had to be avoided since it reduced the efficacy of Rilpivirine. Other drugs had to be avoided due to the inclusion of Rilpivirine. Glucocorticoids and herbals such as Dexamethasone and St. John's Wort had to be avoided when taking Cabenuva. G. Ayad said that St. John Wort was an over-the-counter drug that affected mood. She said if the patient had a history of using St. John's Wort, they had to avoid the use of that drug and Cabenuva. She then stressed the importance of having a detailed history of what patients use over the counter.

Cabenuva had similar side effects to Apretude. Common side effects of Rilvipirine were injection site reactions, shortness of breath, bronchospasm, and agitation. Users of Cabenuva also risked hepatoxicity and needed to monitor their liver function. Likewise, Cabenuva could have side effects of depressive and hypersensitivity reactions. T. Dominique asked if there was an order for Cabotegravir or Rilvipirine to be injected first since Cabotegravir could not be in the body by itself. G. Ayad answered that she did not think the order mattered since the two injections would be administered minutes from each other. T. Dominique said she was thinking of patients who would be having an immediate reaction. G. Ayad said that was why they recommended taking the oral Cabotegravir first to determine whether there would be a reaction since spotting a reaction to Cabotegravir was easier and an oral dose would leave the body sooner than an injection.

G. Ayad then discussed the other medications that were still in trials. Sunlenca was the first medication. Its generic name was Lenacapivir. The medication was recently FDA-approved in December 2022. The medication was used in the treatment of HIV-1 in patients with multiple drug resistance. The medication was administered through subcutaneous (SQ) injection every 6 months. Lenacapivir was in clinical trials in Europe to test the efficacy of PrEP. The next medication was Trogarzo. Its generic name was Ibaluzimab and it was a monoclonal antibody. The medication was used in the treatment of HIV-1 in patients with multi-drug resistance. The medication was currently in phase 3 trial and the data for its efficacy has not been conclusive yet. It was to be a long-acting intramuscular injection. G. Ayad noted there had been IV Therapy for Ibaluzimab that already was approved and had a 2-week interval dosing schedule. The last item in the presentation was the Latitude Study. G. Ayad described it as a long-acting therapy to improve treatment success in daily life. She said the therapy was currently in phase III study to evaluate long-acting injection (LAI) therapy in patients that were non-adherent to HIV regimen. She said many LAI were tested on patients who were adherent and not many tests were

conducted on non-adherent patients. G. Ayad was curious to see how therapy would affect the adherence of non-adherent patients and how this could be applied to other medications.

G. Ayad thanked the committee for inviting her and shared her email address for further questions. Her email address was ghada.ayad@albertsons.com. T. Dominique asked G. Ayad to give further details on monoclonal antibodies and the difference between them and antiretrovirals. G. Ayad explained that monoclonal antibodies use the body's own immune system to fight infections. She said antiretrovirals would go into the virus and prevent the virus from working. K. Carter asked if trials should be done with women using contraceptives to increase data for PrEP. T. Dominique answered that it was typically a requirement for contraceptives to be used in studies involving sexual health. K. Carter said he had asked that question because generally women were avoided in these trials because people feared they would become pregnant. He said he wanted women to be included in the trials from the beginning rather than later. T. Dominique said that people were generally asked about their pregnancy history and were given consent forms. If a person was known to be pregnant, they would likely be excluded from using any study drug. C. Steib asked if G. Ayad knew there were any upcoming LAI for PrEP. G. Ayad said there was one possible medication in trials in Europe and she was awaiting the results of those trials. G. Grannan asked if monoclonal antibodies had to be crafted for each person and he asked to compare the price of monoclonal antibodies versus other medications. G. Ayad said she did not believe that it would be crafted specifically for each person. She said monoclonal antibodies were like Apretude and Cabenuva in that they were brand medication and would be very expensive. She said she could foresee insurance barriers. She noted that Apretude and Cabenuva did not have co-pay cards to help with paying for the medication. She predicted that Trogarzo would follow suit once they were approved and on the market. She said patients would likely have to document that they tried and failed other regiments before they could use Trogarzo. K. Carter asked if she could send them the presentation. G. Ayad replied that she would.

K. Carter thanked G. Ayad for the presentation. G. Ayad said she had appreciated the compliment since she was a recent practitioner. K. Carter suggested they could investigate the possibility of nurse practitioners administering the medication in the patients' homes. G. Ayad agreed that it could be a great opportunity, especially for those who were homebound and could not leave. G. Ayad remembered there were some drug manufacturers that did send nurse practitioners to help administer the medication and she said it would be great if the manufacturers who produced the medications mentioned in the presentation did the same. She suggested that the pharmacies could have a program to help people receive their medication in this way. K. Carter suggested that nurse practitioners could ride in a van and administer to patients.

Discussion Item:

-HIPC Prevention Planning Agenda-

T. Dominique reminded the committee that they had reviewed the pillars of the Integrated Plan in the last Prevention Committee meeting. At the last HIPC meeting, DHH provided an update on the progress of those pillars. T. Dominique stated that the present meeting would be used to learn about the upcoming agenda items that members would like more detailed information about, which needed to be covered sufficiently in the last Prevention Committee and HIPC meetings. K.

Carter asked if they could view material from the last meeting to see what they had discussed. T. Dominique said she could pull up material from the previous meetings.

K. Carter said he wanted to know how providers were being educated about PrEP and encouraged to prescribe PrEP when their patients needed it. He also wanted evidence to show that there was an increased adoption rate of PrEP among Black and brown people and women. D. Surplus asked what the barriers to PrEP uptake were and what they were doing to address those barriers. T. Dominique asked if the committee wanted a presentation on their topics or a link to research the topic. K. Carter said he would want a presentation for his topic.

C. Steib remembered DHH mentioned there were 4 hospitals receiving the Testing in Healthcare Setting funding. He recalled that next was the end of the 5-year funding cycle. He said it was usually a January to December cycle, and he had heard that next year the funding would only be until May. He asked if there would be a new award in testing in healthcare settings or a plan if there was no new award. E. McNamara said they were expecting a new award from the CDC, but they did not know the contents of the award until they received the Notice of Funding Opportunity (NOFO). C. Steib asked when they were expecting the NOFO. E. McNamara replied that they were hoping to receive it soon. She said there were speculations on when they would receive it, but they did not know when they would receive it.

T. Dominique asked S. Moletteri to scroll through the presentation with the goal of reminding the committee of what was discussed in the previous meetings. K. Carter said he wanted more information on what the Novel HIV testing initiatives were. T. Dominique recalled that the Center of Excellence previously held a presentation on PrEP and PEP. She asked if K. Carter would like a similar presentation or if he would like to focus on some of the things he had just identified first. K. Carter said he would need to think about which choice was best for the group. K. Carter said he had an additional question on HIV tests and PrEP. He asked if people needed an HIV test to be placed on PrEP and wondered why they couldn't just use a rapid test to speed up the process of having people be initiated on PrEP. C. Steib said the rapid tests could not show whether the person was still in the window period, while the lab tests could. T. Dominique said they needed a confirmatory HIV test to avoid an adverse event due to medication or creating resistance.

G. Grannan said A. Williams brought forward some important points during the October 2023 CPC meeting. One of the issues discussed by A. Williams was how DHH was positioning community-based testing in an unfavorable light. He said they should consider whether they should treat testing as a widget and determine what other benefits the city was deriving from testing programs in their populations. T. Dominique acknowledged there were many questions that were not addressed in the October HIPC meeting. She said she had reached out to M. Ross-Russell, and the questions were sent to DHH. She said they would soon receive answers to some of the questions that were asked. G. Grannan suggested that each committee should discuss the issues and create their own approach and answers.

G. Grannan said while it was fair to criticize community-based programs, community programs provided more benefits than knowing whether a person was HIV positive or negative. He said that while he knew that the Ryan White program focused on PLWH, there was still value in

prevention programs and measures to keep people HIV-negative. He felt that DHH's approach towards clinical testing and rapid testing was not helpful.

T. Dominique encouraged the committee members to read the goals, objectives, and prevention concerns. She remembered there was a point where the members were interested in learning about stigma. She asked the committee members what goals and objectives they should be focusing on over the course of 9 to 12 months. K. Carter said stigma was difficult to measure and asked how they would measure it. T. Dominique replied that the Medical Monitoring Project (MMP) used to have a scale that was part of their interview process. She said she did not know if they were still using the 100-point scale to measure stigma. Zero on the stigma scale indicated there was no stigma while 100 indicated the person had the worst stigma of their life. T. Dominique said she was unsure if the description of the scale was correct. K. Carter mentioned that he could ask about the scale the next time he attended an MMP meeting. He then asked how they could measure stigma if everyone's definition of stigma could differ. T. Dominique said that through many interviews, the researchers behind MMP were able to see common tendencies and trends in the responses. G. Grannan said it was important to note that stigma could look different to different populations. He said he had felt stigma during post-exposure from the pharmacist. He said he had read from the Philadelphia Inquirer that Cherelle Parker wanted to send the National Guard into Kensington. He said stigma was treated differently depending on the situation. K. Carter said sending the National Guard could be dangerous and could lead to the same situation as Kent State.

K. Carter recalled that DHH spoke about a Radical Customer Service Initiative to address disparities and barriers to care. K. Carter asked what had become of this initiative and asked for additional data. He wanted to know if barriers and disparities were lessened as a result. T. Dominique said she could ask DHH for this information. T. Dominique summarized all the topics that the committee members wanted more information on.

T. Dominique remembered that they just had a presentation on injectable PrEP from a PharmD. She said they could have a presentation from DHH about the topic. K. Carter said he had remembered it was important to receive the right kind of PrEP. He asked if they could have a presentation on the types of PrEP. T. Dominique said there were three approved types of PrEP and asked if K. Carter had wanted an update on all three approved PrEPs. K. Carter agreed that it was the type of presentation he wanted. G. Ayad replied that for Truvada and Apretude, it was eligible for HIV-negative adults and adolescents; for Descovy, it was indicated for MSM and transgender women. She said they could recommend any of the three PrEP medications. She said Apretude may have insurance issues since it was not a generic medication like the others. G. Grannan said he was troubled that the only mention of exposure through injection drug use relies on drug treatment and behavior programs when people who were at high risk of HIV transmission were actively using drugs. He said they could figure out a way to integrate people who were receiving healthcare but were not engaged in the substance abuse treatment system. G. Grannan said the city should introduce PrEP to a population that research showed adopts easily oral and injectable PrEP. K. Carter said this conversation reminded him of a topic he had wanted to talk about. He said there was an increase in HIV transmissions of people over the age of 50. He said they should send prevention messages because older people do have intercourse. He said they were missing this demographic and asked what interventions were they using to prevent

HIV transmission in this population. T. Dominique acknowledged G. Grannan and K. Carter's interests in their topics. She then asked if they wanted more information about the partnerships with the Pennsylvania and New Jersey Departments of Health. She said they spent a great deal of time talking about the Philadelphia Department of Health and wondered if they were interested in learning what the other departments of health were doing. K. Carter said he would definitely want more information since New Jersey and Pennsylvania were part of their EMA and they should know what their needs were.

K. Carter said he had seen an ad on TV for PrEP. He noticed that it was more geared towards gay men. He said they should have a greater representation of all people. L. Matus said she remembered that the number of prenatal transmissions was small but on the rise during the pandemic. She asked if they could provide an update on whether the number of transmissions was still increasing. C. Steib said he would like an update on perinatal prevention services.

T. Dominique asked if the committee had comments about expanding harm reduction supplies. G. Grannan said he had talked to people in neighborhoods with harm-reduction vending machines. He said he was told that the vending machines were always empty. T. Dominique said they could find out more information about the vending machines such as how often they were refilled, whether the people who needed the service were family members, and whether the persons who had an interest in using the machines needed them immediately. G. Grannan said he had also wanted to know what would happen to the people who attempted to find naloxone but were unable to find it due to supply issues. He said he wanted more data on areas that historically had harm reduction services and those that did not. He said they should ask themselves whether it was adequate to place a vending machine in an area and have it empty versus other areas where harm reduction was distributed through a program.

On the next slide, there was a goal and objective regarding monitoring local disparities along a status-neutral continuum. T. Dominique asked if K. Carter would like to add this topic to his question about greater representation in HIV ads. T. Dominique said they could forward concerns about populations being unheard. K. Carter said they had heard much about trans women and needed more attention for trans men and the non-binary population. The committee then moved to the topic of reducing HIV-related disparities in new diagnoses among priority populations. T. Dominique said A. Scruggs was not present and she recalled that he advocated sexual wellness and prevention education in schools. T. Dominique asked if the committee would like more information on the topic in a presentation. K. Carter answered that he would like more information.

K. Carter asked if they ever investigated how each population learned new information or received new messages. For example, people over 50 years old learn new information from a newspaper and younger people learn from the internet. T. Dominique said this was one of the questions they had sent to DHH. She said DHH had sent a response to M. Ross-Russell. She said she did not know the response right now. T. Dominique said she volunteered to do a literature search to answer this question in the last HIPC meeting. She said she had not found information that clearly answered the question. She said she did find much information that advised providers. K. Carter said he was concerned about people who were illiterate. He remembered his

grandfather did not know how to read but always had the newspaper in front of him. He suggested some visual messaging.

C. Steib asked if DHH had a plan if the pharmacists went on strike. He feared it would disrupt medication adherence. T. Dominique said this was a question they needed to know sooner rather than later since it could happen in 6 days. T. Dominique said she would put that topic on her list of items she would need to find information immediately. She said as soon as she found anything out, she would send an email to C. Steib.

T. Dominique asked if there were any topics that the committee wanted to discuss in the next 9 to 12 months. The committee did not respond with additional comments.

Any Other Business:
None.

Announcements:
T. Dominique announced that the Philadelphia Housing Authority was asking people on the housing waiting list who wanted to remain on the list to update their information by Friday, October 27th.

Adjournment:
D. Surplus called for a motion to adjourn. **Motion:** K. Carter motioned, and L. Matus seconded to adjourn the Prevention Committee meeting. **Motion passed:** Meeting adjourned at 4:07 p.m.

Respectfully submitted,

Kevin Trinh, staff

Handouts distributed at the meeting:

- October 2023 Prevention Committee Meeting Agenda
- September 2023 Prevention Committee/Comprehensive Planning Committee Meeting Minutes