HIV Integrated Planning Council
PrEP Work Group
Wednesday, February 21, 2018
2-4pm

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

Present: Erika Aaron, Kathleen Brady, Meg Carter, Julia Cohen-Errio, Caitlin Conyngham, Dagan Coppocha, Cheryl Dennis, Rachel Fox, Reginald Glover, Trudy Kao, Kailah King, Laura Martindale, Nhakia Outland, J. Maurice Pearsall, John Rose, Erica Rand, Jen Shinefeld, Alexis Schwartz, Tahira Tyler, Kristin Walker, Leroy Way, Shariah Williams

Office of HIV Planning Staff: Antonio Boone, Nicole Johns, Briana Morgan, Stephen Budhu

Call to Order: C. Conyngham called the meeting to order at 2:07pm. Those present then introduced themselves.

Approval of Agenda: C. Conyngham presented the agenda for approval**. Motion:** E. Rand moved, J. Pearsall seconded to approve the agenda. **Motion Passed:** All in favor.

Approval of Minutes: C. Conyngham presented the minutes for approval. **Motion:** M. Carter moved, K. Walker seconded to approve the minutes. **Motion Passed:** All in favor.

Report of Chair: NA

Report of Staff: N. Johns informed the work group HIPC applications were available for those who are interested.

Action Items: None

Discussion Items:

- NHBS Presentation─ *Dr. Kathleen Brady*

K. Brady introduced the National HIV Behavioral Surveillance (NHBS) data to the group. She explained the NHBS was created by the CDC in 2003 to get an epidemiologic baseline for those who are deemed high-risk for HIV infection. The surveillance works in three rotating cycles: 1) Gay, bisexual and other men who have sex with men; known as the MSM cycle. 2) Persons who inject drugs (PWID); known as the injection drug use or IDU cycle, and 3) Heterosexuals at increased risk for HIV infection; known as the HET cycle. From its inception NHBS has completed 4 cycles of data collection and is in the midst of its 5th cycle. Cycle 5 began in 2017 and will continue until 2019. As of 2017, surveillance data was collected in 22 jurisdictions (in order from northeast to southwest): Boston, Long Island, NY, New York City, Newark NJ, Philadelphia, Washington DC, Virginia Beach-Norfolk, Atlanta, Miami, San Juan PR, Detroit, Chicago, Memphis, New Orleans, Dallas, Houston, Denver, Seattle, Portland, San Francisco, Los Angeles, and San Diego.

After a brief introduction to what the NHBS was, K. Brady stated she would be reviewing the Philadelphia NHBS data that has been collected thus far for the 5th cycle. She explained the NHBS slide show was created by J. Shinefeld, and noted J. Shinefeld was a primary investigator in the Philadelphia NHBS study. K. Brady explained for the means of this work group she would just be reviewing the MSM cycle.

MSM CYCLE (2017)
K. Brady explained the cycle used venue-based surveillance to collect survey data. Venues were defined as places were at least 50% of participating occupants identified as MSM. She noted the MSM cycle was the only cycle were venue-based surveillance was used.

Eligibility required:

- Identify as MSM
- Be from Philadelphia or Delaware Counties
- 18 years or older
- Have had sexual intercourse with another male in the past 12 months.

The survey racial demographics were 70% black, 14% white, 12% Hispanic, and 4% other. 52% had higher than a high school education, and 62.4% were employed either full time or part time. For the survey, 2000 people were initially interviewed and after screening, 579 individuals were used for survey data collection. From the sample, 54% were between the ages of 18-29, 24% between the ages 30-39, 13% between the ages 40-49, 9% were 50 or older.

K. Brady reviewed the healthcare characteristics of the respondents. 82.6% of participants were insured, of which 52.7% where insured through Medicaid, and 36.6% were insured through private insurance. 90.1% of respondents have a usual source for healthcare, 42.8% had a private doctor, 34.8% used a Public Health Center, and 13.2% used the emergency room for their healthcare. 83.3% had a health care visit within the past 12 months. 60.2% were offered an HIV test by their medical provider.

K. Brady reviewed use of PrEP, PEP, and sexual behaviors in the MSM cycle. In total 302 of respondents have heard of PrEP: 143 have discussed PrEP with their physicians, and 76 reported taking PrEP. She added 59 respondents reported having taken Post-Exposure Prophylaxis (PEP). For those who have taken PEP [14%], 21% have taken PrEP as well. 172 respondents have considered taking PrEP, 51.7% thought PrEP was a good idea. The most common reason for not taking PrEP is the person doesn't like taking medicine.

K. Brady moved onto the sexual behavior in the data. She stated 9 was the average number of partners reported in the last 12 months, and the median was 4. 16% reported exchange sex. 88.6% reported anal sex in the last 12 months. 362 survey participants reported unprotected anal sex. Of the 362, 58.6% were between 18-29, and 30.9% self-reported HIV+ status.
K. Brady reviewed STDS in the MSM cycle. She stated 60.8% of individuals reported having an STD test in the past year, and 20% reported being diagnosed with an STD in the past year.

K. Brady concluded the MSM cycle review with HIV and Hepatitis C prevalence. From the data, 212 tested HIV+, of the 212, 170 self-reported their status. 4% of respondents were Hepatitis C positive, and 7 of them were newly diagnosed.

A. Schwartz asked if in the next MSM cycle will they collect information about PrEP adherence and length of time taken. K, Brady replied they took blood sampling in the MSM cycle, but she did not have results from the CDC.

C. Conyngham stated Philadelphia was awarded funding for a transgender women pilot NHBS study.

- **Clinical Subcommittee**

C. Conyngham stated the feedback from the first 2 PrEP Work Group meetings has been positive but the reoccurring theme is clinician input was limited. She explained many clinicians were interested in the work group but were unable to attend based on meeting time. Because of the lack of clinical input, C. Conyngham suggested the work group should explore the idea of a clinical subcommittee. The subcommittee would meet less frequently than the work group or maybe even ad-hoc; whichever was the case, the meetings would be in the early mornings before clinicians start seeing patients. She explained the clinical subcommittee would likely meet before 8 am, and due to staffing and time constraints the meeting would likely not be at the Office of HIV Planning. After introducing the idea of the clinical subcommittee C. Conyngham asked the work group for their thoughts. K. Walker stated she was in favor of the idea and felt the work group should do anything to incorporate clinicians. E. Aaron reassured the work group all clinical subcommittee discussions would be presented to the work group, and the work group would be debriefed after the subcommittee met. N. Outland expressed concern with the idea of the clinical subcommittee. She explained the subcommittee would lead to separation of the work group, and clinicians needed to hear community input to facilitate care. E. Aaron reiterated the subcommittee would not meet as frequent as the work group, rather even as seldom as biannual. K. Brady explained the work group lacked clinical perspective due to the time the group meets. She noted the clinical perspective was important to incorporate in the planning process for PrEP facilitation.

- **Group Break Out**

C. Conyngham asked the work group to review the brainstorming handout, and break into small groups. C. Conyngham reviewed the handout with the work group and stated the handout was composed of ideas from previous meetings. Ideas were grouped in to 3 parent categories and were further expanded upon. Ideas are as follows:

1. PrEP Best Practices- Implementing PrEP into Clinical Practice:

a. Develop mechanisms to share information with clinical sites: Sharing of EMR, sexual screening tools, in-services on sexual health to providers
b. Best practices to decrease clinical barriers to retention
c. Ease in clinical flows
d. Peer to peer educational and technical assistance ─work with AETC; opportunities for Grand Rounds, preceptorship, CMEs and CNEs
e. PrEP hotline
f. Improve provider awareness; sensitive sexual health assessment trainings
g. Same Day Start:
   i. Protocols and best practices
   ii. information sharing
   iii. barriers and concerns, successes

h. Navigation at primary care clinics
   i. Types of clinical settings, access points for PrEP availability ─where PrEP services are provided
   ii. Pharmacies
   iii. Minute clinics
   iv. PCP
   v. HIV clinics, specialty clinics
   vi. Reproductive Health providers
   vii. Family Planning Clinics

2. Public Awareness and Education:

a. Outreach: street
   i. Messaging development
   ii. Women specific messages
   iii. Information to public about insurance coverage
   iv. "Spokesperson" who has influence in communities of color

b. Social Media─ awareness and/or educational
   i. Websites (e.g., PrEP Facts)
   ii. Ads on condoms
   iii. Ads on buses and subways; TV, radio

3. Access ─Ideals vs Realities

a. Insurance ─ Best practices for access ─ what is working, what are the barriers?

b. SPBP inclusion for PrEP
c. Correctional Facilities; rehab programs; Methadone clinics, Re-entry programs
d. Youth Access: confidentiality blocks, barriers and successes
e. Linkage to PrEP; increased access in more zip codes in Philadelphia
f. STDs/Sexual Health Centers as key gateways
g. Sex workers outreach and advocacy

After brief review of the handout, C. Conyngham asked the work group to separate into groups based on which categories they felt were of interest. Each group ranged between 5-7 people. Groups discussed ideas for 25 minutes and after that time, one representative of each group reported their ideas.

T. Tyler stated her group discussed the Public awareness and education regarding PrEP. Her group primarily focused on the misconceptions regarding PrEP and in their opinion mis-advertisement. The group felt PrEP marketing should be expanded, instead of just focusing on the MSM population. but advertisement should be focused on anyone who was at risk of HIV. She explained the group felt the messaging needed to be diverse, and a social media campaign should be explored. Also, she referenced guerilla marketing: such as using the ads on the streets, on buses, etc. From the PowerPoint presentation we concluded there can't be a one size fits all message, they need to be catered to all genres. She referenced the HPV vaccine commercial, at first when it included just girls, people were hesitant to vaccinate their daughters, but after boys were incorporated into the campaign the vaccine was more widespread.

T. Tyler added the group reviewed a "school of sex" handout which included new school terms for sex/sexual activities and even touches upon the use of emojis to communicate [sexually]. She suggested the handout could be discussed at future meetings.

K. Walker stated her group discussed the best practices for PrEP implementation. She explained her group discussed the idea of explanatory PrEP websites that would be housed in larger domain websites, for a greater audience. She mentioned the group also discussed the use of a shared Google Drive where it would be used as a knowledge tool. Anyone who was interested in PrEP would have access, and clinicians could upload their presentations or articles they feel are useful.

The group also discussed training for primary care providers that includes a mentoring system for new PrEP prescribers. She stated the group suggested the training could be based off of the AETC training model.

PrEP hotline, they would review Access Matters and what they have. She stated the group wished to look into Einstein and Care Clinic since they both have same day starts, and possibly a representative from either would be willing to give a 20-30minute presentation about same day starts.

S. Williams stated her group discussed access. She explained her group discussed a mandate for [HIV] testing in prisons providing access to PrEP to incarcerated men at risk. K. Brady asked if the group meant PrEP prescriptions in prison. S. Williams replied yes, the conversation was in reference to the negative view point of sex in prison. Many prisons like to present that their institution is abstinent but that is highly inaccurate. The group also recommended future assessment of how costs are communicated to patients and where insurance barriers occur at pharmacies, providers, or what is patient perception of cost barriers. Invitations to prevention and case management providers use in prisons are needed.

L. Martindale asked how we can work with the dating apps and get the PrEP locators in those apps. She suggested the dating apps are a large market. C. Conyngham stated the app advertisement does require funding but it is something to consider. C. Conyngham stated there are ways to get charitable advertisement based on the app, but they may not reach the same audience as paid apps.

Old Business: None

New Business: None

Announcements: E. Aaron stated the health department has made a PrEP for women campaign and stated she has brochures. In the brochure there is a website link that has a PrEP provider resource inventory. J. Shinefield asked what the work group is going to do about medication access and cost associated with PrEP. C. Conyngham replied there have been funding announcements to PrEP providers. Those providers should be well versed on the facilitation of PrEP and also sensitive enough to have sex normal/positive conversations with their clients. E. Aaron stated if there were providers who were not providing all the information to clients, she would be happy to visit the provider, and properly inform them.

A. Schwartz announced her women's PrEP study has a study start date at Prevention Point. She informed the committee the study's goals were to find barriers to PrEP access in women who inject drugs. K. Brady asked if the study included transgender women. A. Schwartz replied the study did not, the study had limited funding, and funding guidelines did not allow for inclusion of transgender woman.

Adjournment: Meeting was adjourned at 3:45 by consensus after a brief networking period.

Respectfully submitted by,

Stephen Budhu, staff

Handouts distributed at the meeting:

- Meeting Agenda
- Meeting Minutes
- OHP Calendar