HIV Integrated Planning Council
Prevention Committee
Wednesday, February 28, 2018
2:30-4:30
Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia, PA 19107

Present: Mark Coleman, Dave Gana, Gus Grannan, George Matthews, Lorett Matus, Gail Thomas, Robert Woodhouse

Excused: Jennifer Chapman, Clint Steib

Absent: None

Guests: Shawn Livingston

Staff: Antonio Boone, Briana Morgan, Mari Ross-Russell, Nicole Johns, Stephen Budhu

Call to Order: L. Matus called the meeting to order at 2:34pm. Those present then introduced themselves and participated in an ice breaker activity.

Approval of Agenda: L. Matus presented the agenda for approval**. Motion:** G. Matthews moved, R. Woodhouse seconded to approve the agenda. **Motion Passed:** All in favor.

Approval of Minutes: L. Matus presented the minutes for approval. L. Matus asked for an addendum for the minutes. **Motion:** D. Gana moved, G. Thomas seconded to approve the updated January 24, 2018 minutes. **Motion Passed:** All in favor.

Report of Chair: L. Matus informed the committee she was part of a virtual UCHAPS roundtable recently. The roundtable was about reaching the Latino population. Topics discussed included: forms of outreach other than social media campaigns, loosening funding restrictions, and overall sexual health/education. She added the meeting was a success, and she was impressed with UCHAPS outlook on sexual health; their outlook was positive and did not use language that could be seen as stigmatizing.

L. Matus reminded the committee the Planning Council will meet next March 8, 2018. She recommended all Prevention Committee members attend since the conversations upcoming will address important issues in the EMA.

Report of Staff: N. Johns stated the consumer survey report is complete, and copies are available for those who are interested in both the office and at hivphilly.org

B. Morgan reminded the committee the Office of HIV Planning recently hosted an overdose reversal training by Prevention Point. She stated the training was a success and it addressed possible reasons for the opioid epidemic, how to properly administer Narcan, and where Narcan was available. S. Livingston asked if the Office of HIV Planning will host another overdose reversal training. B. Morgan replied there was no plan for another training at this point, but other agencies around Philadelphia are also hosting trainings. S. Livingston asked if naloxone was provided at the training and if a training certification was issued. G. Grannan replied no Narcan was distributed and there was no certification for the training. G. Grannan explained Narcan doses were expensive, but they were available at pharmacies. S. Livingston asked if a prescription was needed for Narcan. G. Grannan replied no there is a standing order[1] in PA that was issued by Rachel Levine, M.D., PA Physician General, that allows all seeking

1. To download the standing order visit http://www.health.pa.gov/My%20Health/Diseases%20and%20Conditions/M-P/opioids/Documents/General%20Public%20Standing%20Order-001-2018.pdf

Narcan to get it without a prescription. G. Grannan noted not all states have standing orders like PA, so travel with Narcan may require a prescription. B. Morgan added New Jersey also had a standing order.

Action Items: None

Discussion Items:

- **Comprehensive User Engagement Sites**

B. Morgan reminded the committee in January Governor Wolf held a press conference to issue a statewide disaster emergency for the opioid crisis[2]. The declaration was a first for a public health emergency in Pennsylvania and will utilize a command center at the Pennsylvania Emergency Management Agency to track progress and enhance coordination of health and public safety agencies. The other main takeaway from the press conference was the Governor expressed his approval of comprehensive user engagement sites(CUES). She explained the city of Philadelphia did not plan to fund a site, but it would provide support for its creation. She stated the CUES factsheet was provided in the meeting packet, but she noted no official announcement has been made.

L. Matus asked if there was an update on Philadelphia's progress with a CUES. G. Grannan replied there have been reports from agencies around the city who are interested but no formal plans have been made. G. Grannan stated CUES are places that will offer multiple services besides supervised injection such as medical case management. He noted Seattle also uses similar terminology to CUES, to let people know the site is just not for supervised injections. He added the term "Comprehensive User Engagement Site" was not commonly used, the more common vernacular is "supervised consumption sites".

G. Grannan referenced Kral/Davidson research that analyzed data from anonymous non-sanctioned supervised consumption site in an American city. From analysis of the data, researchers were able to show the benefits of supervised injection sites, and to show overdose deaths could be avoided.

G. Grannan stated Philadelphia has made great progress on its stance on injection drug use, but he explained Philadelphia was not as close as it seemed to having a CUES. He explained for CUES to happen all state officials would have to be on board as well as the DEA. Even when all Pennsylvania state representatives were in favor of CUES federal agents still will have authority to shut them down. Non-sanctioned safe consumption spaces were still being run underground by PWID.

- **Integrated Plan Update**

N. Johns informed the committee OHP has started to work on updating the integrated plan. She reminded the committee they reviewed the plan in their September and October 2017 meetings. She explained data that the committee has requested has been received and she will review it. The data received is a 2016 baseline for activities listed in the plan and the data could indicate the effectiveness so far of the corresponding activity. She noted some of the data that was requested were not good indicators of service; some data that was requested was not available and some data lacked specificity. Also not all activities could be measured quantitatively.

N. Johns suggested the committee could review strategies under goals 1 and 3 that were related to prevention. Goal 1: Reduce new HIV infections, goal 3: Reduce HIV health-related disparities and health inequities. She encouraged the committee to review the integrated plan and if they felt anything should be added to bring it to OHP's attention, and it could be incorporated into the new update. B. Morgan reminded the committee the plan was written in 2016, and the plan was for 5 years (2017-2021). She

2. For the entire press conference visit: https://www.governor.pa.gov/governor-wolf-declares-heroin-and-opioid-epidemic-a-statewide-disaster-emergency/

explained OHP has received the data from 2016 so now the committee can go back and review activities from 2016.

S. Livingston informed the committee he has completed and submitted his HIPC application. He asked for guidance on how to proceed. The committee replied the Nominations Committee handles membership, and they meet on the second Thursday of every month from 12-2 pm. The committee made note that there was a nominations process and the applicants had to appointed by the mayor's office.

N. Johns displayed a spreadsheet that included the integrated plan and associated 2016 data. She stated the columns from left to right were as follows: Strategy #, Strategy, Activity, Responsible Parties, Target population, Data Source, and Baseline 2016 data.

N. Johns reviewed strategy 1.1.1: Promote adoption of opt-out routine HIV testing. Under the strategy there are 2 activities: 1. Provide training on third-party billing and integrating routine HIV screening into patient flow, 2. Implement site appropriate routine HIV screening policies. For the first activity under strategy 1.1.1 the parties involved were the Philadelphia Department of Public Health (PDPH), and the target population was clinicians and providers. For the second activity the responsible parties were clinicians and HIV providers, and the target population was people 13-65. The data indicators for the strategy were measured in technical assistance units (provided by AETC), and the number of tests that happen in health care settings (98,676 in Philadelphia). G. Grannan asked if each test represented an individual. N. Johns replied 98,676 represents the number of publicly funded tests conducted in Philadelphia. From testing 152 new HIV diagnoses were found. N. Johns noted more data has been requested and further updates to this strategy will follow when the data is available.

N. Johns reviewed strategy 1.1.2: Offer targeted HIV screening and education particularly among gay and bisexual men and other men who have sex with men (MSM), transgender persons, high risk heterosexuals, and people who inject drugs (PWID). For this strategy there are 3 activities associated: community outreach and provision of the best testing technology for the site, including 4th generation testing where feasible, ongoing geographic and performance analysis of test sites to improve targeting, offer opt-out HIV screening at intake. In reference to activity 1 under strategy 1.1.2, N. Johns noted fourth generation testing data was not available at this time, but community-based testing data was available. From community-based testing data around 23,000 HIV tests were issued, the positivity rate was around 1% with 118 new diagnoses.

N. Johns reviewed activity 3 under strategy 1.1.2. the activity focused on HIV testing in the Philadelphia incarceration system. Data showed over 20,000 tests were administered in jails and 117 people were diagnosed with HIV.

N. Johns explained there has not been enough data received to properly review strategy 1.1.3, and she would move onto strategy 1.2.1: Ensure condom access and promote condom use. Under this strategy there are 4 activities. Each activity was centered around condom distribution and the use of social media to "re-normalize sex"

S. Livingston stated the rate of Hep-C is increasing due to tattoo parties. At these sites in many cases needles are not sterile and are not replaced between participants. G. Grannan noted the city has taken a no tolerance stance on these parties, which forces them to be underground. G. Grannan shared his view point on the city's no tolerance viewpoint and suggested the city could explore issuing needle packets to prevent new Hep-C infections.

N. Johns moved discussion back to condom promotion data. She stated in 2016 1.5 million condoms were distributed in Philadelphia from STD control programs.

This estimate does not account for condom distribution in the other 8 EMA counties outside of Philadelphia. In Philadelphia there were 242 condom distribution centers, including the OHP.

N. Johns explained social media data was also analyzed for this strategy. Data came from the Do You Philly and Take Control Philly campaigns that are run by PDPH. The Do You Philly website had over 9600 views in 2016 and the Take Control Philly social media campaign had over 100,000 views. From the mail order requests from both campaigns over 2600 condoms were distributed. The Love Your Brotha campaign that was nested under Do You Philly was not measured because data metrics were not yet available. N. Johns noted there is a new performance measure at Ryan White clinics that asks if condoms were used at last sexual encounter. Since the measure was binary data was presented as yes/no %. 79% reported condom use at last sexual encounter.

N. Johns briefly reviewed strategy 1.2.2: Ensure the provision of PrEP and nPEP to at-risk populations. There were 2 activities under this strategy and the target populations are those who were high risk for HIV, PWID, Trans women, Black women, Latinas, MSM Youths 13-24. For both activities NHBS survey data was used as an indicator. From the NHBS data it shows MSM were the most aware of PrEP and nPEP and most likely to have taken either out of all the high-risk groups.

N. Johns moved discussion to strategy 1.2.3 Ensure equitable access to syringe access services, substance use treatment and related harm reduction services. There are three activities under this strategy and they are as follows: expand syringe access services throughout the EMA, expand access to medication-assisted treatment for opioid dependency throughout the EMA, expand access to and capacity of substance use treatment throughout the EMA. The target populations in the strategy are PWID and PLWH who have an opioid dependency. N. Johns noted there was small amount of syringe services access in the EMA, and data requests are still outstanding. Other data indicators included: number of treatment referrals, and number of Ryan White SA units provided (one unit is 15 minutes of counseling).

G. Grannan stated the committee needed to address the lack of syringe access in Camden, NJ. Their clinic has been shut down for over a year. B. Morgan replied the syringe access program was not shut down, it is just not functioning at the moment. They are working with the Camden mayor's office to get a space approved for the mobile clinic, once space is approved the clinic will be running again. The program is state run in NJ, so funding will be available. She noted there is no plan for syringe access in the PA collar counties by the PADOH.

N. Johns reminded the committee they requested the addition of two activities under strategy 1.2.3. The committee recommended the addition of increased access to overdose prevention tools (like Narcan) within the HIV care prevention programs within the EMA, and the second was to review the substance abuse treatment services within the Ryan White service system in relation to the Mayor's Opioid Task Force recommendations. N Johns asked the committee if they still wanted to proceed with the addition of the activities to the plan. She noted the committee did not have to add the activities to the plan but could work on them during meeting times, or they could be added at some point during the 5-year plan period.

N. Johns reviewed strategy 1.2.4: Reduce the amount of HIV virus within communities. Under this strategy there are two activities: ensure equitable access to ARVs and support treatment adherence activities. The target population for both activities were PLWH, and data indicators were: number of

ADAP clients, Percentage of diagnosed PLWH on ARVs, and Medical Monitoring Project (MMP) indicator related to ARV prescriptions. From data in 2016, 3400 PLWH in the EMA were enrolled in the PA's ADAP program and receiving their medication through the program. 60% of PLWH in the EMA are getting medication through PA's special pharmaceutical benefit program (SPBP). She noted the data from the MMP collection year was not available for use. B. Morgan noted the methodology was changed in 2015, the last data collection year, so trends would be different than previously seen.

N. Johns reviewed strategy 1.2.5: Eliminate perinatal transmissions throughout the EMA support treatment activities Target population was HIV+ pregnant women. In 2016, 16 cases were reviewed by the AMR board and additional data would be coming from perinatal medical case management.

N. Johns reviewed strategy 1.2.6: Identify persons with acute HIV infection and immediately link them to HIV care. The strategy had two activities associated: Promote the implementation of 4th generation HIV testing and ensure immediate linkage to HIV care and ARVs. She explained in 2016 32 acute cases in Philadelphia were identified from city-level surveillance, state-level surveillance was not yet available. Fourth Generation testing data was not available at this time. Data from AACO shows 75% of acute infections were linked to care within 14 days of infection, and 85% were linked within 30 days.

D. Gana referenced strategy: 1.2.7: Reduce the percentage of youth, including gay and bisexual men who engage in HIV-risk behaviors. He stated agencies are making an app(s) that focuses on prevention and treatment of HIV in teens. The app is expected to focus on prevention but when HIV+ individuals are identified the app will help with care, e.g.; reminder to take medicine. N. Johns suggested this may be part of a research study.

G. Grannan referenced conversation from the February Planning Council meeting. Syringe access was discussed for those under 18, and he expressed his content since the conversation seemed to be well-received by the Recipient.

N. Johns concluded integrated plan discussion with goal 3: Reduce HIV-related disparities and health inequities. She explained strategy 3.1.1: Increase access to services that address social determinants of HIV risk was involved with Club 1509 and their campaign to reach young minority MSM. She noted Club 1509 was created in 2016, so data maybe smaller than upcoming years. In 2016, 83 people were enrolled in Club 1509, and 34 linkages to supportive services. Strategy 3.1.2 called for the increase of biomedical program access. From Club 1509 10 linkages to PrEP were reported, data is still outstanding for other services.

- **PrEP Work Group**

N. Johns asked the committee if they had attended the PrEP Work Group's February meeting, and none had. In the meeting the group reviewed the recommendations from their brainstorming session. Recommendations were grouped into 3 categories: PrEP distribution (roll-out), barriers to PrEP, and PrEP messaging. The work group divided into three groups and each group focused on the one of the categories. Groups were given about 30 minutes to think of ideas, and after that period a representative from each group shared their ideas.

N. Johns also stated the work group discussed making a clinical subcommittee that would meet intermittently and would be primarily clinicians and providers. G. Grannan stated he thought the purpose of the PrEP Work Group was to have community involvement and provide a platform where community members could talk to providers directly. He suggested the committee should reevaluate if work group

activities align with the activities of the Prevention Committee. He recommended the committee needed to encourage work group members to join the HIPC and Prevention Committee.

L. Matus reminded the committee the PrEP Work Group is still looking for a co-chair. The chair has a be a HIPC member and preferably a member of the Prevention Committee. The committee discussed co-chair structure and needs of the work group. The committee suggested the work group needed to be more involved with HIPC procedure and needed to have a liaison who would attend HIPC and Prevention Committee meetings.

R. Woodhouse suggested community involvement was poor because there is a stigma attached with coming to meetings that are majority clinicians. He stated many community members have an interest participating but they may be skeptical to attend a clinician driven meeting in a planning setting. He suggested the HIPC or the Prevention Committee should explore having meetings outside of the Office of HIV Planning and within community places like churches.

L. Matus addressed the recruitment issue and suggested the committee should explore new ideas to improve recruitment.

D. Gana agreed with R. Woodhouse's comment, and he suggested community input would be needed to ensure the PLWH voice is heard.

Old Business: None

New Business: L. Matus stated the Executive Committee was exploring leadership training for HIPC members. With training HIPC members will be given the tools to chair meetings successfully.

S. Livingston suggested the HIPC should look for representation from non-HIV+ individuals. D. Gana explained to be part of the HIPC it is not required to be HIV+. L. Matus stated it was not a requirement, but PLWH have a unique voice and their voices should be incorporated throughout the HIV planning process.

M. Ross-Russell reviewed the process to become a HIPC member. She reminded the committee there are tax and utility compliances that are required by the mayor's office before an applicant can be recommended for membership. Once recommended applicants are appointed for membership by the mayor's office, OHP did not have the authority to make applicants members, the HIPC can only recommend applicants for membership assuming all clearances were in order.

M. Ross-Russell stated the Finance Committee will be discussing housing in their March meeting. She explained the Housing and Urban Development (HUD) has changed the HOPWA formula and because of this HOPWA funding will change. Philadelphia and Delaware Counties will be negatively affected, and some families may not be able to sustain housing. The Finance committee will be discussing the issue in greater detail on March 1, 2018 from 2-4pm. The meeting is open to all, and it will be a joint meeting with the Comprehensive Planning Committee. The discussion will also be presented to the HIPC in their March meeting. L. Matus asked if you can vote in a subcommittee that you are not a member of. M. Ross-Russell replied all HIPC and subcommittee meetings are open to all, and HIPC members can vote in any subcommittee.

Announcements: S. Livingston announced there is a job fair from February 28-March 4, 2018 at the Philadelphia Convention Center. The job fair is catered to college and graduate students.

G. Grannan announced Saturday, March 3, 2018 is International Sex Worker Rights Day.

M Coleman announced the Philadelphia flower show begins Saturday, March 3, 2018 at the Philadelphia Convention Center.

S. Livingston announced “Blood Sweat and Tears” is on display at the Philadelphia Magic Gardens from March 2-April 29, 2018. The opening reception is Friday, March 2, 2018 from 6-9pm.

D. Gana announced “Something Rotten” is playing at the Philadelphia Academy of Music. Tickets are available online and showing is limited. D. Gana invited all to attend.

Adjournment: Motion: D. Gana moved, G. Grannan seconded to adjourn the meeting at 4:24pm.
Motion Passed: All in favor.

Respectfully submitted by,

Stephen Budhu, staff

Handouts distributed at the meeting:

- Meeting Agenda
- Meeting Minutes
- Comprehensive User Engagement Sites Handout
- OHP Calendar