HIV Integrated Planning Council
Prevention Committee
Wednesday, March 28, 2018
2:30-4:30pm

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

Present: Keith Carter**,** Mark Coleman, Dave Gana, Gus Grannan, Lorett Matus

Excused: Clint Steib

Absent: None

Guests: Caitlin Conyngham

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

Call to Order: L. Matus called the meeting to order at 2:35pm.

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

Approval of Minutes: L. Matus presented the minutes for approval. G. Grannan asked for an addendum to the minutes. L. Matus presented the updated minutes for approval. **Motion:** G. Grannan moved, M. Coleman seconded. **Motion Passed:** All in favor.

Report of Chair: No Report

Report of Staff: B. Morgan informed the committee Philadelphia has been hosting forums related to the Opioid Task Force recommendations. So far two have already been held and more forums were upcoming. To register for a forum or to inquire about more information visit www.phl.opioids.eventbrite.com.

Action Items: None

Discussion Items:

- **Additions to the Integrated Plan**

B. Morgan reminded the committee in their last meeting they reviewed the 2016 baseline data for the integrated plan. Part of the discussion was about the addition of two activities under strategy 1.2.3 of the integrated plan. The activities were to recommend the addition of increased access to overdose reversal tools (like Narcan) within the HIV care prevention programs within the EMA, and review substance abuse treatment services within the Ryan White service system in relation to the Mayor's Opioid Task Force recommendations. B. Morgan stated the committee could either formally add the activities to the plan, work on the activities without formal addition to the plan, or table the ideas.

L. Matus asked B. Morgan what the pros and cons of an addition of these activities to the integrated plan were. B. Morgan replied with the addition the process would be formalized, but the committee would be held accountable for working on the activities.

G. Grannan asked if this was the first year Ryan White was funding services associated with the recommended activities. B. Morgan replied the plan was in effect from 2017 and some of the activities in

the plan are ongoing and some were activities that have happened in the past. N. Johns added substance abuse treatment has been funded for a long time under the Ryan White Part A grant. B. Morgan reminded the committee the reason for plan review with baseline data was to assess how well data measures match with the associated activity. G. Grannan suggested the committee should work on the activity without formally adding them to the plan.

L. Matus asked if there are any activities pertaining to substance abuse treatment in the plan. B. Morgan replied there are some activities, they may not align with the Mayor's Task Force recommendations, since the task force was not created as yet at the time the plan was written.

C. Conyngham stated there are other agencies, especially in the Philadelphia Health Department, that focus on these two recommendations. This may be "a duplication of efforts" and the committee should look to see what other agencies are working on these activities before working on them itself. B. Morgan asked if the city was working on the distribution of Narcan. C. Conyngham replied yes, the city has hired a new harm reduction coordinator, Alisson Herens, who is working to do mass overdose reversal trainings. The city is also working with Prevention Point to ensure all clinics and pharmacies are aware of the PA Narcan standing order. C. Conyngham suggested the committee could look to invite Alisson Herens to a meeting. N. Johns noted the Positive Committee discussed having the new harm reduction coordinator come in and give a presentation to the HIPC about harm reduction efforts as well.

M. Ross-Russell stated there are various strategies within the plan that coincide with the city's strategic plan. Some of the activities in the plan are not entirely up to the HIPC to fulfill. She suggested the committee may want to add those activities to ensure prevention efforts are current within the city or at the least expand upon the language in the plan under strategy 1.2.3.

G. Grannan stated even though materials and training have been made available for overdose reversal training, there is no way to ensure the uptake of the training. It is important that other agencies beside Prevention Point focus on naloxone training and its distribution.

L. Matus recommended the committee should contact the harm reduction coordinator, Alisson Herens, to have her present at a HIPC meeting about current harm reduction activities in the city. L. Matus explained from the presentation the committee can gauge what action needs to be taken; at this point we are unsure what other entities maybe working on these proposed activities, therefore we should hold off on formal addition of activities to the integrated plan. L. Matus added the committee was unsure of other Federally Qualified Health Centers (FQHCS) besides Prevention Point that distribute Narcan. C. Conyngham stated it would be easy to ask providers if they distribute Narcan.

- **Linkage to Care Tool**

B. Morgan asked the committee to review the Linking to Care handout. She explained this handout was created from the recommendations of the Points of Integration work group in 2013. The handout was a product of analysis from literature reviews and the questions were a composition of best found practices. A letter was also drafted that explained no additional data collection was needed if a HIV tester wanted to use the checklist. She noted some of the recommendations are dated since the checklist was developed in 2013, but the committee could use the recommendations as a guideline

N. Johns informed the committee the Comprehensive Planning Committee(CPC) was reviewing barriers to retention to care, and within the discussion they suggested a checklist for HIV testers would help alleviate some issues of linkage to care. The CPC suggested a script should be developed and used by

HIV testers in the event of a positive test result. As a result of the discussion, the CPC reviewed the recommendations from the Points of Integration work group. N. Johns noted the recommendations from the CPC were similar to those that were from the linking to care handout from the work group.

N. Johns stated from CPC discussion co-pays and perception of cost were the most mentioned as barriers to linkage to care and retention. Many people may not seek care because they may feel they cannot afford their co-pays. The CPC also discussed the sliding fee scale and how it is often misconstrued.

L. Matus stated the questions in handout were useful and it would help if HIV testers asked patients some of them during testing. The questions should precede test results and would be best suited for the waiting period after a HIV test. She added the questions were a good start but the committee needed to modernize the language. After modernization the committee could look to sample them on a focus group. B. Morgan added PrEP was not that well-known in 2013, hence its omission from the checklist.

G. Grannan asked if the committee had feedback from providers who used/were using the checklist. L. Matus explained this was a recommendation from 2013 but it was not implemented. C. Conyngham stated the Recipient did not have any information about providers using this checklist. B. Morgan asked if the Recipient had any information what providers were asking during testing. C. Conyngham replied most agencies use a linkage to care protocol that is developed internally. Protocols may vary from provider to provider.

N. Johns explained the CPC did have concerns with linkage to care. The CPC felt if there were not a universal HIV tester checklist clients may receive different information. The committee discussed possible measures to ensure that the clients all receive the same information about basic services and not having to pay for Ryan White services.

M. Ross-Russell explained the linkage to care model was developed in 2013 to alleviate some of the inconsistencies of messages in HIV testing. It is possible that providers and case managers may not ask the same questions of their clients, and it is possible there may be other inconsistencies throughout the care continuum. She noted in many cases clients are unaware of services provided and if there was a universal script clients would all possess the same information, in theory. The consumer survey and other needs assessments data suggest that there are inconsistencies. In many cases providers or case managers may only be aware of services offered by their clinic, and in turn they may misinform clients about the Ryan White service system. Since linkage to care has been identified as an issue, both the CPC and Prevention Committee could use the linkage to care tool developed by the Points of Integration work group as a starting point for discussion. From the CPC discussion, as N. Johns mentioned prior, they discussed the co-pays and sliding fee scales as possible barriers and mentioned use of a flyer that explained the you will be provided care regardless of cost.

C. Conyngham asked if the committee was looking to identify those who have successfully linked to care from the HIV testing system, or those who did not successfully link to care from the HIV testing system. M. Ross-Russell asked if C. Conyngham was referring to the consumer survey or the linkage to care handout. C. Conyngham replied the consumer survey results, since the handout in theory was in reference to everyone. M. Ross-Russell explained the results received by the consumer survey is from both people who were linked and not linked to care. It was not plausible to assume all people who take a HIV test are

linked to care and remain in care, even though over 90% of consumer survey respondents reported being linked to care.

N. Johns explained the recommendations come from reviewing barriers to care. This particular barrier could be fixed easier than some of the others like transportation or homelessness. The handout was just one resource that could be used to help aid information dissemination. The handout's intention was not to make a cookie cutter process but to aid providers on how to effectively communicate with clients.

L. Matus noted some of the questions are asked by providers from the handout but not all. Specifically the ones about insurance and identification are always asked.

G. Grannan stated there was another barrier that was not addressed in the handout. The handout does not incorporate the sex workers, and specific counseling needs if they receive a positive HIV test. If a sex worker receives a positive test it is illegal for them to continue to sex work in PA, therefore the HIV tester should be well versed in counseling and sensitivity training.

D. Gana suggested the handout should ask more about basic needs. The handout should ask if the client has enough food, adequate transportation, etc. The handout could have boxes after each question and clients could check the boxes to indicate "yes", or leave the boxes unchecked to indicate "no".

C. Conyngham stated the question is what the role of the HIV testers are versus the Ryan White medical case managers are. HIV testers only have a small window to try to link a client, who receives a positive test into Ryan White services. She noted Ryan White MCM are better at explaining the services available. The message that needs to be shared is treatment is free generally, with or without insurance, treatment works, and side effects are minimal. K. Carter agreed and noted the HIV testers should have streamlined documentation to give to positive testers. He suggested the HIV testers should be able to counsel clients, but clients' needs differ, and it would be best suited if first the HIV tester gives a client a set of documents explaining the services available.

D. Gana stated positive testers may not always be linked to care from the testing center. C. Conyngham stated once a positive test result is received the HIV tester will pair the client with an initial HIV care appointment. At the appointment the client is paired with MCM and a medical care provider. L. Matus replied that may not always happen especially for clients who are uninsured. Even though Ryan White does pay for your first HIV visit, many testers may not be aware of this. She agreed that HIV testers should not be as well informed as Ryan White MCM but they should be well versed about available services.

L. Matus stated the handout was useful for HIV testers to use when clients could not be immediately linked to care (same-day) in cases such as weekend or late-night testing. C. Conyngham acknowledged there are normal administrative processes of MCM but it should not take more than 2 days for a MCM to follow up with a new client. In many places it is possible for clients to receive treatment and medication within the same day as receiving a positive test result. She noted the Ryan White continuum has worked to de-stigmatize HIV and reduce barriers, and clients should be able to be linked to care immediately, in theory.

B. Morgan noted from past focus groups many consumers were unaware that they had a choice in where to go for medical services. N. Johns stated clients have also said they could only access MCM services if they were patients of that provider. In the past the Positive Committee has made brochures explaining to consumers you have a choice of providers and questions about services should be directed to the Client Services Unit.

C. Conyngham stated the same thing is observed with PrEP providers in the EMA. In Philadelphia there are many PrEP providers but that was not the case in the surrounding EMA counties.

M. Ross-Russell stated from focus groups and committee discussions it seems the best course of action is to offer a streamlined message to consumers. Sometimes inconsistencies create problems for persons trying to link to care or retain care. This recommendation comes from the intention of finding the best way for clients to be linked to care and all receive similar, if not the same, information. Yes, there are cases when people get tested and they do not wish to be linked to care immediately, but it's useful if a brochure can be given to those individuals, so they can know how to seek care whenever they choose to do so.

C. Conyngham stated this discussion presented the opportunity to review the linkage to care protocols of providers. After review a list of best linkage to care practices could be distributed across the provider network.

L. Matus asked what action the committee would need to take to make a linking to care recommendation. B. Morgan replied first the committee would need to identify what the next steps are, and then the committee would have to work with the Recipient to get some of the linkage to care protocols. C. Conyngham stated she could help with some of the information sharing. B. Morgan suggested the committee could delegate meeting time to discuss linkage to care recommendations.

D. Gana stated this was an opportunity to train HIV testers to inform clients about PrEP. If a test comes back negative the HIV tester could inform the client about PrEP and provide a list of PrEP providers.

G. Grannan asked if there was standard training for MCM. C. Conyngham replied yes there is an annual comprehensive training. G. Grannan suggested the MCM training could be altered to include harm reduction. Better health outcomes could be achieved from better MCM training. K. Carter suggested the MCM should react to the patient's demeanor and attitude. Every one reacts differently and there's no way to tell how people will react to receiving a positive test result. K. Carter stated sensitivity training is helpful. G. Grannan added providers needed to work on connecting with their clients. Services are only as effective as the connection providers are able to establish with their client. L. Matus noted the HIV tester needs to function as a MCM at the moment of a positive test result until that individual links to care.

Th committee discussed possible linkage to care messages. L. Matus asked how loss to care was defined. B. Morgan replied there are many ways to quantify that. There is an extensive literature on the topic.

- **PrEP Work Group**

C. Conyngham reminded the committee the PrEP work group meets the third Wednesday of every month from 2-4 pm. The work group did not meet in March 2018 due to inclement weather. She stated the work group is still looking for a co-chair, who is a HIPC member, and preferably someone from the Prevention Committee. The work group will start having an early morning meeting for clinicians starting in May 2018. The meeting will start at 8 am and will not be held at the Office of HIV Planning, a venue has yet to be decided. The clinician meetings will not be as frequent as regular work group meetings and the work group will be debriefed about clinician discussion/recommendations.

C. Conyngham explained the work group has taken recommendations from the brain storming sessions and has begun to review them. She invited all to attend and noted attendance has been good through the first three meetings.

Old Business: None

New Business: G. Grannan stated new legislation was passed to reduce sex trafficking. He explained the Stop Enabling Sex Traffickers Act (SESTA)[1] was passed by the House of Representatives by vote of 388 in favor to 25 opposed, on March 21, 2018. The act amends Section 230 of the Communications Decency Act, which makes online service providers immune to legal penalty for content that is posted on their websites. Since the language of SESTA is vague, potential consequences and the amount of people who are affected may be greater than original expectations.

L. Matus noted she was discussing this with G. Grannan before the meeting. The legislation is not clear and there's speculation what the effects could be on HIV prevention services such as condom distribution.

The committee discussed possible effects of the new legislation and expressed their opposition.

C. Conyngham stated there is a coalition of app owners and public health professionals who work in tandem to promote prevention-based messaging in apps. The messages could be used to inform providers of the effects of the new SESTA bill and to create a platform for a safe online environment.

Announcements: None

Adjournment: Adjourned by consensus at 4:25pm

Respectfully submitted by,

Stephen Budhu, staff

Handouts distributed at the meeting:

- Meeting Agenda
- Meeting Minutes
- OHP Calendar
- Linking to Care Handout

1. For more information on SESTA visit https://www.congress.gov/bill/115th-congress/senate-bill/1693