HIV Integrated Planning Council
Prevention Committee
Wednesday, October 31, 2018
2:30-4:30pm

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

Present: Katelyn Baron, Keith Carter, Mark Coleman, Dave Gana, Gus Grannan, Lorett Matus, Erica Rand, Clint Steib, Gail Thomas

Excused: Janice Horan, Jeanette Murdock, Nhakia Outland, Eran Sargent

Absent: Zora Wesley

Guests: Caitlin Conyngham, Blake Rowley

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

Call to Order: C. Steib called the meeting to order at 2:38pm. Those present then introduced themselves and participated in an ice breaker activity.

Approval of Agenda: C. Steib presented the agenda for approval**.** L. Matus requested an addendum to the agenda. C. Steib presented the updated the agenda. **Motion:** K. Carter moved, G. Grannan seconded to approve the agenda. **Motion Passed:** All in favor.

Approval of Minutes: C. Steib presented the October 3, 2018 minutes for approval. **Motion:** K. Carter moved, D. Gana seconded to approve the minutes. **Motion Passed:** All in favor.

Report of Chair: None

Report of Staff: B. Morgan informed the committee the new updated epidemiologic profile and the updates to the integrated plan are now on the OHP website.

Action Items: None

Discussion Items:

- **New HIV Diagnoses among PWID – Caitlin Conyngham, Philadelphia Department of Public Health (PDPH)**

C. Conyngham presented the increase in HIV infections mobilization plan with the committee. She stated HIV infections among PWID have increased over the last year. In a one-year period, the PDPH has observed a 48% increase in new HIV diagnoses among PWID. The number of cases of HIV infection in those who inject drugs has risen from 31 to 46 cases in the past 12 months. Between 2015 and 2017, between 28 and 32 PWID per year were newly diagnosed with HIV annually in Philadelphia, representing a stable 5% of all new reported HIV diagnoses.

C. Conyngham showed the comparison of the number of HIV diagnosis per population in Philadelphia for 2017 and 2018. She explained the PWID population has seen an increase in the number of HIV diagnoses in 2018 compared to that of 2017. MSM, overall have seen a decrease in the number of HIV diagnoses from 2017 to 2018. MSM who are also PWID had a negligible change from 2017 to 2018.

C. Conyngham presented the number of HIV diagnoses across PWID from September 2017 to August 2018 in Philadelphia. She explained that PWID aged 30-39 made up 50% of the new diagnoses, and

males made up 74% of the total HIV diagnoses. 54% of those who were diagnosed with HIV were also co-diagnosed with Hepatitis C. Non-Hispanic Whites made up 46% of all PWID-associated HIV diagnoses.

M. Coleman asked about the new infections among persons aged 18-30. He asked if there were any targeted activities for that age group. C. Conyngham replied the aggregate data about HIV testing is being collected by the PDPH, unfortunately at this time there is no data that can accurately convey the number of new infections in PWID aged 18-20. G. Grannan commented persons aged 18-20 make up a significant portion of new Hepatitis C infections. He asked if there was data that shows the spike in HCV infection and co-infection rate in that group. C. Conyngham replied there was not data that supports that at this time. C. Steib asked G. Grannan for the source of the data that he previously mentioned. G. Grannan replied it was from HEPCAP data. C. Conyngham suggested the committee could invite Alex Shirreffs, the HCV Coordinator, to come and talk to the committee about HCV updates.

C. Conyngham explained there has been increasing knowledge of HIV status in the population. She displayed a pie chart that showed the percentage of the population that knew their status/have been tested for HIV. In 2017, 29% of MSM knew their status, compared to 62% of heterosexuals, and 9% of PWID (from NHAS data).

C. Conyngham stated the response from the PDPH about the increase of new HIV diagnoses is the following:

- PDPH case investigation of all newly diagnosed persons
- Mobilize One Stop Shops
- Increase HIV testing in identified areas
- Community mobilization activities
- Continued data matches to further direct response

C. Conyngham explained that the PDPH has met with providers recently and jointly it was decided that one stop shops should be able to see newly diagnosed individuals immediately as well as provide the following services:

- HIV Treatment
- PrEP, PrEP starter pack
- Hep C Treatment
- MAT
- Distribution of and/ or Prescription for Naloxone
- Screening for, referrals to, and/or provisions of support services
- Insurance navigation
- Screening for and referrals to SSPs
- Medical Case Management

C. Steib asked if the prophylaxis starter packs were free. C. Conyngham replied the PDPH has been in collaboration with many providers, at this time providers may be able to offer the PrEP/PEP starter pack for free.

C. Conyngham concluded her presentation by sharing the new testing locations in the Philadelphia area. The new site lists included mobile testing sites as well. In total 7 sites will be one-stop shops, and they will be listed on the PDPH website.

C. Conyngham reminded the committee the PDPH has released health alerts about the ongoing epidemic. Copies of the health alerts are available in the conference room. Health alerts are available in a few languages including Spanish and Russian.

G. Grannan reminded C. Conyngham that the committee requested that the PDPH looks into data from the medical examiner's office about HIV testing. C. Conyngham stated she would follow up on the status of the data request, she admitted the request was being handled outside of her department, but she was happy to follow up.

D. Gana asked about the availability of the language services and information. He stated there was a big need for documents to be printed in French as well as linguistic services. He mentioned there is a large HIV positive population in West Philadelphia that speaks Creole and/or French. C. Conyngham replied he would take this information back to the PDPH and hopefully they will roll out documents in French as well.

L. Matus referenced G. Grannan's comment regarding testing data. She asked if it was feasible to expect to the HIV testing data by time the next meeting of the committee in November. C. Conyngham stated it was feasible.

C. Steib asked if the PrEP work group has resolved the scheduling issue for December with the Prevention Committee. C. Conyngham replied she would check in with E. Aaron about the dates, and then disseminate information about meeting dates going forward.

- **UCHAPS Representation**

B. Morgan reminded the committee this discussion was a continuation from that of the October Planning Council meeting. She explained that UCHAPS requires each of the participating cities to have at least two delegates, one delegate that is a representative of the local government, and the other a representative from the community. The governmental delegate is appointed by the Recipient but the community delegate and alternate can be elected by the Planning Council. She explained UCHAPS requires the community delegate to be a current, future, or former chair of the HIV Integrated Planning Council. The community delegate also must be a current member of the Planning Council. Ideally the community delegate will be a representative of HIV preventative services.

C. Steib asked who would fall under the present, past, or future chair of the Planning Council. B. Morgan stated S. Heaven and L. Diaz are the community chairs of the Planning Council; K. Baron was a former chair. M. Ross-Russell stated at this time there are no current members of the Planning Council who were former chairs.

C. Steib asked who the governmental UCHAPS delegates are. M. Ross-Russell stated C. Conyngham was the primary and M. Pearsall was the alternate.

K. Carter asked about the process to nominate someone as a UCHAPS delegate. B. Morgan stated the Prevention Committee could vote to make a recommendation to the Planning Council. B. Morgan stated at this time, two members of the Planning Council were viable, L. Diaz and K. Baron. She mentioned S. Heaven technically could be a candidate, but she was not interested in the position.

L. Matus asked about the process to elect an alternate for UCHAPS. B. Morgan replied it could be anyone at this time, that individual would just have to be able to attend the meetings. K. Baron referenced the discussion from the October Executive Committee. She explained it was suggested that an OHP staff

member should be the alternate for continuity. At this time, it has been suggested that M. Ross-Russell should be the community alternate.

K. Baron asked if UCHAPS has in-person meeting or mostly virtual. If the meetings are in-person are travel expenses covered. M. Ross-Russell explained UCHAPS meets usually every other month, and the majority of meetings are virtual or via conference call. For meetings that are in person, the meeting is usually in one of the founding cities which include: New York, Atlanta, San Francisco, Chicago, Baltimore, Washington D.C., Houston and Philadelphia. Generally expenses are covered for the community delegate, the expenses for the alternate may not be covered. Community delegates who attend UCHAPS meetings are expected to give a meeting synopsis to the Planning Council as part of their co-chair report. Whether the meetings are virtual or in-person the meeting are all day.

The committee briefly discussed the nuisances of UCHAPS. L. Matus shared her experiences with attending UCHAPS virtual round tables. M. Coleman suggested that the committee should look for representatives from the PA collar counties. M. Ross-Russell reminded the committee that historically UCHAPS representation is from Philadelphia.

L. Matus suggested the Prevention Committee should review UCHAPS representation before it was presented to the Planning Council. She asked how to proceed with a recommendation going forward. The committee briefly discussed both candidates for the UCHAPS delegate. After discussion, L. Matus suggested that both candidates should share their experiences in prevention before a selection has been made. The committee agreed with L. Matus' recommendation.

C. Steib suggested the committee should recommend that both L. Diaz and K. Baron for the UCHAPS delegate representation. Also, the committee should state that any member of the HIPC could be the alternate. Members could nominate themselves for UCHAPS representation within the Planning Council. E. Rand suggested this could be given as the report of chair within the Planning Council to give those who may be potentially interested in the alternate representative position time to think of their experiences that they wanted to share. K. Baron suggested during the report of the chair it should be relayed that there is a cost associated for travel for those who are interested in the alternate position.

M. Coleman asked does the alternate go to the meetings if the primary representative is unable to go. M. Ross-Russell explained it is expected that both the primary representative and alternate attend all UCHAPS meetings if possible. In the event that the primary representative cannot attend, it is expected that the alternate not only attends but also gives the UCHAPS report to the Planning Council.

B. Morgan suggested the Prevention Committee could plan to lead a discussion on UCHAPS representation with the Planning Council. She stated UCHAPS has just met and the next UCHAPS meeting is not scheduled as yet. The committee agreed.

- **Integrated Plan Review: Baseline Data for Goal 3**

B. Morgan stated within the meeting packet the full update of Section 2 of the integrated plan is included. She reminded the committee within its last two meeting they have reviewed the baseline data for the integrated plan. She stated the committee has already reviewed the baseline data for goal 1 and 2 prior and today the committee could review goal 3's baseline data. All baseline data is from 2016.

B. Morgan began review of the baseline data for goal 3: reduce HIV-related disparities and health inequities. Under this goal there are two objectives, 3.1: reduce HIV-related disparities in new diagnoses among high risk populations; 3.2: reduce disparities in viral suppression, both objectives have 3 associated strategies.

B. Morgan reviewed the baseline data for strategy 3.1.1: reduce HIV-related disparities among high-risk populations. Under this strategy there are 2 activities: provide prevention navigation services that link MSM of color to PrEP and provide ongoing adherence support; develop and sustain the Philadelphia 1509 collaborative to implement comprehensive HIV prevention and care services for MSM of color. For this strategy the target populations are those who are HIV-negative, MSM of color, and the collaborative partners. The data measures for this strategy are the number of navigation clients, the number of linkages to behavioral health and social services, the number of linkages to PrEP in PDPH-funded programs and the number of MOUs and collaborative protocols developed. The data from 2016 shows that there were 83 clients from 1509. 34 linkages to supportive services, 10 linkages to PrEP, and 26 MOUs and collaborative projects.

C. Steib asked what year did the 1509 grant begin. B. Morgan replied 1509 is a 4-year demonstrative grant that started in 2015. The grant is soon coming to an end. C. Steib suggested the committee could invite M. Pearsall to give a 1509 update at the conclusion of the grant.

B. Morgan moved the review of the integrated plan's baseline data to strategy 3.1.2: increase access to biomedical prevention interventions. She stated this strategy had 4 activities with target populations that include: NHAS populations, MSM of color, community leaders, high-risk heterosexuals, PWID, primary care providers, high-risk HIV individuals, trans-women of color, and youths aged 13-24. The data indicators include the number of providers prescribing PrEP, NHAS data on PrEP use, number of PrEP linkages, number of technical assistance (TA) sessions by PDPH clinical advisor, number of persons reached during TA sessions, number of TA units, number of HIV-negative Philadelphians on PrEP, and the number of HIV-negative MSM on PrEP. B. Morgan explained from NHAS, 35% of MSM have discussed PrEP with a doctor, 27% have taken PrEP; other NHAS populations talked to their doctors less than 1% of the time, less than 4% have taken PrEP. She stated of the 30 TA sessions that were reported to be provided by the PDPH clinical advisor, 670 persons were reached. The AETC provided 22 trainings to primary care providers about PrEP. All other data for the perspective data measures have not been reported at this time.

B. Morgan reviewed the baseline data for strategy 3.1.3: address social and behavioral health needs of people living with HIV that promote treatment adherence and HIV prevention. Under this strategy there are two activities. The target populations for this strategy include: PLWH and NHAS populations. The data measures for this strategy are as follows: the number of medical case management (MCM) clients, the number of MCM providers, Client Services Unit (CSU) intake data, the number of Ryan White mental health clients, and the number of Ryan White substance abuse clients. The 2016 baseline data shows there are 5,999 MCM clients and 30 Part A MCM providers. The CSU reported that 6% of clients reported a need for substance abuse treatment services at intake. Last, there are 2,137 Ryan White mental health client and 233 Ryan White substance abuse clients.

B. Morgan reviewed the baseline for strategy 3.2.1: continue RW-funded activities to retain in medical care and achieve viral load suppression for priority populations. Under this strategy there are 3 activities: ensure improvement efforts to address disparities along the care continuum in the RW clinical and MCM services; ensure clinical and support services that address the unique needs and life experiences of disproportionately affected populations; support a comprehensive and geographically diverse RW care system to ensure access to ARVs and treatment adherence services. The target populations for these activities are MSM of color, youth aged 13-24, transwomen, NBHS populations, Black women, LGBTQ youth, PWID, and those experiencing homelessness. B. Morgan explained the number of quality improvement plans, and the number of virally suppressed clients was thought to be data measures for the activities under strategy 3.2.1. At this time, the Information Services Unit has not yet reported data on the

number of quality improvement plans. For viral suppression, 84.1% of Ryan White outpatient ambulatory care clients are virally-suppressed.

B. Morgan briefly reviewed the baseline data for strategy 3.2.2: encourage the provision of trauma-informed services that provide affirming and culturally competent care for transgender women, women of color, MSM of color, PWID people experiencing homelessness, and people with limited English proficiency and health literacy. She explained the data measures are the number MCM who attend trauma -informed care and/or cultural competency training and the number of TA units on trauma-informed care. She stated AETC performed 1 trauma-informed care to providers, the number of MCM trained is not yet available.

B. Morgan concluded the review of goal 3 baseline data with strategy 3.2.3: increase access to clinical, pharmaceutical, and other services that address co-morbid conditions, including but not limited to viral hepatitis and STIs. Under this strategy there are 2 activities with the target populations being PLWH with hepatitis and sexually active Ryan White clients. She explained the data measures for this strategy are: the number of ADAP clients who receive HCV treatment, NJ and PA Medicaid eligibility for HCV treatment and Ryan White ambulatory outpatient medical care HAB and local measures. She stated 27 SPBP clients that receive HCV treatment in PA, 1 ADDP client received HCV treatment in Medicaid in both states cover HCV treatment for eligible beneficiaries. From CAREWare, 80.7% of Ryan White clients have been screened for chlamydia, 79.9% for syphilis, 83.7% for Hepatitis B and 54.1% are screened for gonorrhea.

G. Grannan asked if New Jersey required any pre-existing conditions for HCV treatment. B. Morgan replied no, New Jersey has an open formulary.

G. Grannan asked if there was a way HIV transmission laws could be incorporated into the goals of the integrated plan. He stated it if someone who is HIV-positive knowingly has unprotected sex with an HIV-negative individual there are felony charges associated. B. Morgan replied there are sections of the plan that addressed societal and institution barriers. Currently, there are no strategies or activities, that are related to that topic.

B. Morgan displayed Section 1 Part D of the integrated plan for the committee. B, Morgan read the integrated plan excerpt to the committee. Pennsylvania's "super protected data" policies, which cover mental health status, HIV status, and drug and alcohol treatment, hinder coordination within the state's various programs. Pennsylvania law considers it a felony for a person living with HIV to engage in sex work, even when using condoms and/or the activity cannot transmit HIV. New Jersey law criminalizes an act of sexual penetration without the informed consent of the other person by anyone who knows they are HIV positive. These laws impact the decisions PLWH make around disclosure and sexual behaviors. Sex workers may be reluctant to be tested for HIV because knowledge of their status can have legal ramifications. Neither state laws consider whether the intent was malicious or if transmission occurred or was likely to occur. Law enforcement may consider an individual carrying condoms as a sign of prostitution. This discourages sex workers from using/carrying condoms. The committee commented on the PA state law regarding HIV status.

G. Grannan commented on the HIV sex laws. He added that a person may be prosecuted if they had too many condoms on them. He noted the Philadelphia district attorney, Larry Krasner, may not pursue criminal charges for those who have a large number of condoms, since they may be distributing them for safe sex practices. He reminded the committee that these laws are state laws so it would not fall on the hands of the city's DA unfortunately.

PrEP Work Group Update: G. Grannan stated the PrEP work group last met on October 18, 2018. He explained the primary issues with the committee is coordination. He stated E. Aaron has been working to improve the scheduling and coordination of activities. G. Grannan stated at this time the work group will not meet for the remainder of 2018, they will reconvene in the new year. B. Morgan informed the committee an email was just sent out about the next meeting date of the PrEP work group. The PrEP work group will meet January 16, 2018 from 2-4pm.

K. Carter expressed his displeasure with the work group. He stated E. Aaron did not review the previous years' minutes from the Prevention Committee regarding PrEP. He stated because of this there has been a duplication of efforts. He added the work group has not made any progress, recommendations or even aware of its next steps since its first meeting in November 2017. He suggested that the Prevention Committee should discuss these issues with C. Terrell.

D. Gana stated he agreed with K. Carter and suggested the committee needed to address the scope of the work group. B. Rowley stated he agreed with the committee's comments, but he wanted to add that E. Aaron may have been put in a difficult place. E. Aaron may have been unwilling to talk about next steps of the work group because she may have had to pass information back to the Recipient before proceeding.

B. Morgan reminded the committee the PrEP work group is a subsidiary of the Prevention Committee. The idea of the work group is to inform the Prevention Committee of its recommendations regarding PrEP, unfortunately that has not happened. G. Grannan commented it appears the work group seems to operate more as a focus group than a work group of the Planning Council.

M. Ross-Russell reminded the committee of process regarding the work group. She reminded the committee that they had the responsibility to oversee the activities of the work group.

C. Steib suggested the Prevention Committee can address its concerns about the PrEP work group to C. Terrell in the Planning Council meeting. M. Ross-Russell suggested that the committee may want to have a discussion with C. Terrell privately before discussing it with the Planning Council.

K. Carter suggested the chairs of the Prevention Committee, C. Steib and L. Matus, as well as G. Grannan, the chair of the PrEP work group, should contact C. Terrell regarding the issues with the work group. The committee agreed. C. Steib asked the committee to send all its concerns about the work group via email so he could address it with C. Terrell.

G. Grannan stated another issue with the PrEP work group is that there seems to be a segregation between the providers and the community. There is a separate provider meeting that occurs outside of the general meetings. E. Rand stated the clinicians would meet separately from the community due to time. She explained the clinician meetings were usually in the morning and it was agreed that the discussion from the clinician's meeting would be discussed in the PrEP Work group. After E. Rand's explanation of the clinician subgroup, the committee expressed their displeasure with logistics of the PrEP work group. The committee decided going forward they would seek a private meeting with C. Terrell to discuss the issues of the PrEP work group.

Prevention Service Initiatives: No report

Old Business: None

New Business: None

Announcements: None

Adjournment: Motion: E. Rand moved, D. Gana moved to adjourn the meeting at 4:44pm. M**otion Passed**: All in favor.

Respectfully submitted by,

Stephen Budhu, staff

Handouts distributed at the meeting:

- Meeting Agenda
- Meeting Minutes
- OHP Calendar
- Integrated Plan Update