Philadelphia EMA HIV Integrated Planning Council
Comprehensive Planning Committee
Meeting Minutes of
Thursday, December 20, 2018
2:00 – 4:00 p.m.
Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia PA 19107

Present: Katelyn Baron (via phone), Keith Carter (via phone), Mark Coleman, Tiffany Dominique, Dave Gana, Pamela Gorman (via phone), Gus Grannan, Nicole Miller, Adam Thompson

Excused: Gerry Keys, Gloria Taylor, Leroy Way

Absent: Peter Houle, La'Seana Jones, Dorothy McBride-Wesley, Jeannette Murdock, Joseph Roderick, Gail Thomas, Lorrita Wellington

Guests: Jessica Browne (AACO), Maureen Gallagher (via phone), Elby Katumkeeryil, Iris Rodriguez (via phone), Carly Schaffer (via phone)

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

Call to Order/Introductions: A. Thompson called the meeting to order at 2:05 p.m. Those present then introduced themselves.

Approval of Agenda: A. Thompson presented the agenda for approval. **Motion**: D. Gana moved, G. Grannan seconded to approve the agenda. **Motion passed**: All in favor.

Approval of Minutes (*October 18, 2018*): A. Thompson presented the minutes for approval. **Motion**: D. Gana moved, M. Coleman seconded to approve the October 18, 2018 minutes. **Motion passed**: All in favor.

Report of Co-Chair:
None.

Report of Staff:
N. Johns noted that she had included three handouts for informational purposes *(see – attached handouts)*. She stated that the current meeting would be an information-gathering session, and that the intention was to get an idea of what was currently happening in the opioid epidemic outside of Philadelphia.

M. Ross-Russell stated that she had recently attended the 2018 Ryan White Conference, and that she would share her takeaways with the Planning Council. She went to say that themes included the movement toward jurisdictional End the Epidemic plans, moving toward Ryan White legislation reauthorization, and integrated planning. She stated that she was particularly interested in trainings around building leadership skills within the Planning Council. A. Thompson replied that he had also heard conversations around

reauthorization, and suggested holding a conversation about what the Planning Council would like to see as a part of reauthorization.

Discussion Items:

- **Overview of current opioid and HIV epidemics in the EMA**

A. Thompson asked the group for feedback on how to structure the discussion. T. Dominique replied that there had been questions about medication-assisted treatment (MAT). A. Thompson stated that MAT was available for people with all types of drug addictions, not just opioids. He stated that buprenorphine was a popular topic right now, and that MAT was not simply medication but also supports. He went on to say that there was stigma around MAT, and that some providers had beliefs that MAT would clog up the waiting room or invite patients that take up more time. He noted that the data did not support this. He added that some primary care physicians, especially in the HIV community, felt as though they were being pushed into becoming addiction specialists.

A. Thompson stated that the opioid epidemic was both a prevention and care issue, and that they were trying to address a number of communities.

K. Carter asked if they knew how many people living with HIV had opioid use disorder. A. Thompson replied that they did not have a good, thorough estimate. He explained that they did not know how many people with HIV filled opioid prescriptions, since many people fill those prescriptions outside the HIV system. He noted that advocates were pushing for a total estimate for PLWH with opioid use disorder. J. Browne noted that AACO did not have this data. G. Grannan added that it was notoriously difficult to quantify this since it involved an illegal activity.

A. Thompson stated that Ryan White services required screening for substance use, but there was not guidance on how to screen for substance use. He explained that the Northeast/Caribbean AETC had found that a lot of screening tools did not include all drugs, including opioids. He said there were only a couple of tools that covered all of them. He noted that, in his hospital system, he could see the number of people who had screened positive for substance use, but not which substances. J. Browne stated that AACO had a performance measure for substance abuse screening, but that it only applied to new patients. She noted that the measure only captured whether an assessment was completed, but not the responses.

G. Grannan stated that a person could be screened as positive on drug screenings due to benzodiazepines taken for anxiety. He went on to say that many people have to think about how to address their anxiety and addiction at the same time, so some people who use substances were stopping benzodiazepines and shifting to K2 and synthetic cannabinoids. A. Thompson stated that stigma around drug use has hijacked the care continuum, explaining that this causes the system to look at sobriety before viral suppression. G. Grannan stated that only looking at drug use through a lens of sobriety was problematic. He went on to say that sobriety should not influence whether a person could receive medical treatment, as seen with Hepatitis C.

A. Thompson asked the group for their perspective on using urine drug screening for all PLWH at a clinic. G. Grannan replied that this was a waste of money. E. Katumkeeryil asked if this would discriminate against PLWH. A. Thompson replied that, in this scenario, the clinic would only provide services to PWLH.

D. Gana stated that people with mental health issues were more vulnerable to HIV, so HIV testing should be approached with a mental health perspective as well. A. Thompson stated that the HIV system did not currently have a robust connection to mental health.

P. Gorman introduced C. Schaffer and I. Rodriguez on the phone, noting that both provided addiction services at Cooper University Hospital's clinic. C. Schaffer that urine screening seemed invasive, adding that it could be discriminatory to drug screen all HIV clients. She asked if anyone in the meeting was doing this, and if so, how they obtained consent. She noted that her program only took urine drug screens if a patient was going to enter drug treatment services. She stated that she had recently attended a meeting where a representative from an agency said that they planned to implement this testing, and that there had been a negative reaction in the room.

A. Thompson stated that he had been verbally screened for substance use by his physician, and he did not feel this was very robust. He asked if anyone else had received this type of screening. D. Gana replied the nurse typically asked during his visits, in a routine manner. He noted that a typical question would be, "Have you done any substances?" E. Katumkeeryil stated that this did not encourage disclosure or discussion. K. Baron stated that her organization conducted screenings with their primary care patients. She stated that their behavioral health consultants used the CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble) screening test for adolescent drug use. T. Dominique stated that there was a push to do EsPeR (personalized risk assessment) in clinics, which was a brief behavioral health assessment. She noted that EsPeR was used in the PHMC Care Clinic. She stated that a patient could do the assessment themselves on a tablet, or another person could ask questions. She added that the person being assessed would then be either referred or treated. Adam said his clinic was using the TAPS (Tobacco, Alcohol, Prescription medication, and other Substance use) assessment[1] and that it was much faster on the computer. He stated they were also getting ready to do CBT4CBT (Computer-Based Training for Cognitive Behavioral Therapy), but that this did not seem to have a thorough understanding of the opioid epidemic. T. Dominique noted that the DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, 5th Edition) changed the questions that determine dependence. She added that a person had to answer at least two diagnostic criteria with a "yes" to be diagnosed with mild opioid dependence.[2]

M. Coleman asked if there should be routine screenings in high-risk communities. A. Thompson replied that he thought that screening high risk people with questions was very different from requiring a drug test. He noted that he supported screening with questions.

[1] https://www.drugabuse.gov/news-events/news-releases/2018/06/new-clinician-screening-tool-available-substance-use

[2] https://www.asam.org/docs/default-source/education-docs/dsm-5-dx-oud-8-28-2017.pdf?sfvrsn=70540c2_2

T. Dominique stated that there were a number of people who screened positive for drug use through questions, but were negative on urine tests because they were using either fentanyl or K2.

P. Gorman stated that she found that asking very specific questions about marijuana or alcohol use prevented providers from getting more information. She noted that more generic questions were more useful, so that drugs like methamphetamines and Xanax were less likely to be missed. She went on to say that even questions around injection drug use were associated with very specific substances. She stated that open-ended questions yielded the best information, noting that providers did not get all the information they need at an initial screening. She then asked the group how they decided how to refer clients appropriately. T. Dominique replied that EsPeR was the most common screening tool for this. She stated that she had previously worked on a project where 14 – 18 year olds who spoke Haitian Creole or Spanish used an avatar to input their data into a computer. She explained that this program produced an output for the counselor that guided their conversations. She noted that the patients were more honest because they were responding to a computer rather than a person. She added that listening to the question rather than reading it was helpful. P. Gorman asked for more information about this program. T. Dominique replied that the avatar was specific to the program with youth, but EsPeR was available for everyone. P. Gorman asked if this was a paper tool or an e-tool. T. Dominique replied it could be either, and that the Treatment Research Institute under PHMC was a big user of EsPeR. She noted that this was billable, as a preventive service covered under the ACA.

T. Dominique stated that Philadelphia had just completed the National HIV Behavioral Survey (NHBS) cycle with people who inject drugs (PWID). She stated that about 600 people were screened. She noted that they had seen 46 people in a week at her employer, and that they had four people who tested positive. She added that three of these people were known positives just from the NHBS. E. Katumkeeryil stated that fentanyl causes users to inject more frequently since it wears off faster, and that this combined with decreased availability of needles could cause more HIV infections. M. Ross-Russell stated that there was a perception that PWID were no longer at risk for HIV because the HIV epidemic had shifted away from that group. She went on to say that, in each of the cases in the recent increase in HIV among PWID, there had been a number of missed opportunities in previous contacts with the medical system. A. Thompson stated that they were looking at conflicting priorities. He asked whether they might be able to offer a package of items to PWID when they were identified, such as Narcan plus an HIV test.

M. Coleman asked about the impact of stigma and disclosure from the perspective of PWID. T. Dominique stated that most people were thinking about injection and opiates as the same thing, but that there were people addicted to opioids that did not inject. She went on to say that there was extra stigma for opioid use because so many people associated it with injection. A. Thompson stated that medical school curriculum did not address this at all, and that they also had to reach existing doctors. He went on to say that this stigma was related to the law, and that this was unusual because most stigmas aren't

so supported and driven by law. He then suggested looking into the Drug User Health program at the New York State Department of Health.[3]

T. Dominique stated that there had been an NPR story that covered a nurse in Boston who had been denied life insurance, because she carried naloxone and the insurance company declared that she may be an injection drug user.[4] A. Thompson cited another article in the New York Times, in which a physician discusses her social responsibility when carrying naloxone.[5]

A. Thompson asked if anyone was still doing traditional street outreach in Philadelphia. T. Dominique replied that some people were. A. Thompson asked if they knew who was doing this. K. Carter asked if they would have better luck if mobile testing units were regularly stationed in specific places, like K-Mart. A. Thompson replied that it could be difficult to reach people who didn't perceive themselves as being at risk. E. Katumkeeryil stated that there were supposed to have new syringe exchange mobile units in 2019, including wound care and medication-assisted treatment. K. Carter asked how many vans were in the community. E. Katumkeeryil replied that the homeless outreach vans did not provide HIV testing, but they did connect with a number of people who were struggling with mental health, substance abuse, and other issues. She noted that they were not always connected with resources outside of shelters. K. Carter stated that they may need to address mental health issues before addressing substance abuse issues. A. Thompson agreed, and asked how they might go about doing that.

M. Ross-Russell stated that there had been a great deal of conversation about opioid addiction and HIV, but that there was less conversation about why a person became addicted to opioids. She explained that the path of causality may be different for everyone, and that this could be linked to the mental health discussion. A. Thompson noted that opioids were a thru line across a number of silos, including mental health and HIV services. He went on to say that he had participated in conversations in which representatives from different types of programs talked about how they could each address opioid use disorder in their programs. T. Dominique replied that mobile testing vans and HIV providers had not been included in stakeholder conversations. She explained that these vans were going out into the community out of concern about the HIV epidemic, but that other stakeholders were not representing HIV concerns. A. Thompson asked if the committee should offer a resource for these organizations.

M. Ross-Russell noted that Philadelphia had the advantages of syringe access, mobile vans, and expertise. N. Johns stated that the City of Philadelphia had a lot of activity around the opioid epidemic, but that they had less information about what was happening outside of Philadelphia.

[3] https://www.health.ny.gov/diseases/aids/consumers/prevention/
[4] https://www.npr.org/sections/health-shots/2018/12/13/674586548/nurse-denied-life-insurance-because-she-carries-naloxone
[5] https://www.nytimes.com/2018/07/10/opinion/a-doctors-responsibility.html

A. Thompson stated that he had attended a federal opioid meeting that dealt with non-urban centers. He stated that there had been a suggestion to look at hub and spoke models. He explained that, in this model, they asked how hubs that know how to effectively treat opioid addictions might share that knowledge. He cited an example from the NeuroMusculoskeletal Institute, which was going to compensate doctors for getting waivers to learn how to do drug screening. He explained that primary care physicians were now providing wound care, and that they needed to ensure that primary care physicians were comfortable doing this. He then stated that Ryan White wraparound services could be used specifically to address people who had this issue, especially since there was likely a history of incarceration for client in active addiction.

M. Coleman asked if they had included holistic resources in their lists of resources. A. Thompson replied that holistic services were not billable, but that it would be interesting to reach out to that community. He asked if they had any lists of complementary therapy providers. B. Morgan replied that they had a few in the OHP resource inventory. She noted that these primarily included organizations that had been part of the Ryan White system when these were fundable services, and that they had not conducted outreach to complementary therapy providers.

A. Thompson asked if there would be a way to find out how many mobile testing units were in the suburban PA counties. N. Johns replied that they would need to contact the PA Department of Health about this. A. Thompson replied that they needed this information about the eight suburban counties between the two states. He stated that they wanted to know if anyone was paid to do outreach, and specifically if anyone was doing outreach to people with opioid use disorder. He stated that it would also be useful to find out what diffused evidence-based interventions (DEBIs) and evidence-based interventions (EBIs) they were still doing. N. Johns replied that it would be interesting to know about access points for substance abuse treatment in these communities, particularly in Delaware County, which did not have a health department. A. Thompson asked if they could obtain the number of MAT providers in each county.

M. Ross-Russell asked if AACO was still working with the PA Department of Health regarding testing at 69th Street Station, and suggested working with AACO on this. B. Morgan noted that the Prevention Committee was asking similar questions about HIV testing in the PA Counties, especially with the high rates of concurrent HIV/AIDS diagnoses in the counties. M. Coleman asked for more information about homelessness in Delaware County. M. Ross-Russell replied that the Philadelphia HOPWA grant included Delaware County as well, so the HOPWA grantee may be able to provide more information about homelessness among people with HIV in Delaware County.

The group agreed to write a letter to the PA Department of Health to ask for more information about the PA counties. They agreed to ask about DEBIs and EBIs that were being provided, MAT providers, HIV testing, mobile units for both testing and outreach, and opioid prescriptions covered through SPBP. A. Thompson asked who they should contact with questions about mental health and substance abuse services. M. Ross-Russell replied that she could ask at the PA HIV Planning Group meeting.

A. Thompson stated that the previous consensus was that most new infections came from people who did not know their HIV statuses, but that there were also concerns about people who knew their statuses but were not retained in care. T. Dominique stated that people who were new to injection drug use did not always know how to protect themselves. M. Ross-Russell stated that the newly-diagnosed drug users referenced in the CHART were people who participated in the HIV prevention system. E. Katumkeeryil stated younger populations were more likely to take risks. A. Thompson added that injection drug use was less stigmatized among younger people, too.

A. Thompson asked if they had any HIV testing marketing materials for white people who lived in suburban areas. He asked if the materials they had could be repurposed. He added that he had never been in a room in which a focus group had been conducted with white people about their syringe exchange needs.

A. Thompson asked whether there was a bridge between older, more experienced drug users and younger, less experienced users. E. Katumkeeryil stated that Kensington had networks of users who knew each other. She stated that they had seen younger people who were newer to the community who shared information amongst themselves, but they were not being mentored. She said there was a tight-knit community that had been in the neighborhood, and then a new community coming in. D. Gana stated that people were coming to Kensington from all over the country. A. Thompson stated that every success they had had with drug user health had come through working with drug users themselves to push messages. He explained that the committee could arm the people with the knowledge they had.

D. Gana noted that the National Alliance of State and Territorial AIDS Directors (NASTAD) had Medicaid claims data for opioid prescriptions.

N. Johns stated that the committee was supposed to start the priority setting process in January, and asked the group if they wanted to stick to this timeline. A. Thompson stated that he liked the idea of determining the process in January. He noted that they would still want the information they were asking for for in order to complete the priority setting process. N. Johns stated that they could also look to prepare their data gathering activities. She added that they needed to complete the priority setting process before the summertime allocations meetings. M. Ross-Russell noted that the jurisdiction might receive its award sooner this year.

T. Dominique stated that the University of Pennsylvania hoped to start providing MAT on its mobile unit in April, as well as at clients' homes. She noted that this had been approved by the Institutional Review Board (IRB), and Prevention Point Philadelphia would be one of the primary partners.

Old Business:
None.

New Business:
N. Johns stated that OHP was planning listening sessions to talk with folks living with HIV out in their communities. She went on say that they were looking at using similar questions to the focus groups from a few years ago. She stated that they would also use these sessions to get ideas around other community issues, and that they would use participant questions and feedback to develop FAQs and information resources for the community. She noted that they planned to visit all nine counties in the EMA. M. Ross-Russell added that they hoped to find locations outside of provider agencies so that participants would feel more comfortable sharing honest feedback and concerns.

Announcements:
M. Coleman announced that the Homeless Memorial was taking place that evening. N. Johns noted that it was moved indoors to the church at Broad and Arch due to rain.

T. Dominique stated that a PrEP study for YMSM and trans women under 30 was about to close. She noted that the two arms of the study were Truvada and long-acting injectables. She added that they were only recruiting black MSM, or trans women of any race.

Adjournment: The meeting was adjourned by general consensus at 4:02 p.m.

Respectfully submitted by,

Briana L. Morgan, OHP Staff

Handouts distributed at the meeting:

- Meeting Agenda
- Meeting Minutes from October 18, 2018
- Opioid Dependency and Other Substance Use (from Plan)
- CHART: HIV Spread Among People Who Inject Drugs
- CHART: Hepatitis C Virus Infection in Philadelphia
- OHP Calendar