Philadelphia EMA HIV Integrated Planning Council (HIPC)
Meeting Minutes of
Thursday, May 9, 2019
2:00 p.m. – 4:30 p.m.
Office of HIV Planning, 340 N. 12th St., Suite 320, Philadelphia PA 19107

Present: Juan Baez, Michael Cappuccilli, Mark Coleman, Maisaloon Dias, Lupe Diaz (Co-Chair), Alan Edelstein, Gus Grannan, Sharee Heaven (Co-Chair), Peter Houle, Gerry Keys, Richard LaBoy, Lorett Matus, Nicole Miller, Christine Quimby, Erica Rand, Joseph Roderick, Samuel Romero, Terry Smith-Flores, Gloria Taylor, Coleman Terrell (Co-Chair), Gail Thomas, Lorrita Wellington, Melvin White

Absent: Keith Carter, Evette Colon-Street, Janice Horan, La'Seana Jones, Brian Langley, George Matthews, Dorothy McBride-Wesley, Jeanette Murdock, Eran Sargent, Jason Simmons, Adam Thompson, Zora Wesley, Jacquelyn Whitfield, Steven Zick

Excused: Katelyn Baron, David Gana, Pamela Gorman, Dena Lewis-Salley, Nhakia Outland, Clint Steib

Guests: Henry Bennett, Alvin Connelly, Ameenah McCann-Woods (AACO), Desmond Thomas

Call to Order:
L. Diaz called the meeting to order at 2:06 p.m. The group then introduced themselves and participated in an icebreaker activity.

Approval of Agenda:
Motion: M. White moved, G. Taylor seconded to approve the agenda. **Motion passed:** All in favor.

Approval of Minutes:
G. Taylor noted that she had asked to be excused from the April meeting, but that she had been marked absent in the meeting minutes. **Motion:** M. White moved, M. Cappuccilli seconded to approve the April 2019 meeting minutes as amended. **Motion passed:** All in favor.

Report of Chair:
No report.

Report of Staff:
M. Ross-Russell reported that New Jersey would host an End the Epidemic listening session that evening from 6 – 9 p.m. She went on to say that the next Brown Bag event would be held on Friday, June 7 and would include a lesson on affirming terminology. She noted that the first Brown Bag event was supposed to be on the history of the epidemic, but that it would be rescheduled due to low turnout.

M. Ross-Russell then reminded the group that they had agreed to create a racial equity workgroup in January *(see – attached handout)*. She noted that no one had signed up for the

workgroup. She explained that they needed people to volunteer to participate, or they would have to seriously consider tabling the workgroup. She stated that those interested should contact Nicole by Friday, May 17. She added that this conversation would need to return to the Planning Council if no one signed up. M. White asked when these meetings would be scheduled. M. Ross-Russell replied that they had not yet been scheduled, since they did not have members. She asked anyone interested to see her at the end of the meeting.

Public Comment:
None.

Presentation:

- **Treatment Update – *Dr. William Short***

W. Short thanked the Planning Council for having him. He stated that he wanted the presentation to include something for everyone, so there was a lot of material available *(see – attached slides)*. He noted that he would discuss the National Institute of Allergy and Infectious Diseases (NIAD)'s plan to end the epidemic, as well as medications, injectables, PrEP, and caring for pregnant women with HIV.

W. Short shared a story about diagnoses in 1982, noting that life expectancy was 8 – 15 months at the time. He shared that many people lived in the hospital until they died. He stated that 1.1 million people were currently living with HIV in the United States, and that 15% of people living with HIV were unaware of their status. He noted that the unaware account for more than half of new infections. He next stated that 32,000 people were newly diagnosed with HIV in 2017 in the United States, and that new diagnoses were relatively flat.

W. Short then reviewed the four areas of implementation around the End the Epidemic (ETE) initiative. He stated that the first pillar involved focusing on high incidence areas, including 7 states and 48 counties. He noted that there were 3,700 counties in the United States, and that 48 of these counties account for 50% of new HIV diagnoses. He stated that the second pillar was early diagnosis and immediate linkage to care. He noted that there were much higher rates of viral suppression among people in Ryan White programs.

W. Short next discussed why earlier antiretroviral treatment (ART) was important. He noted that, in his office, this meant same day medications. He explained that same day starts helped people to get on treatment before they left the office and got scared. He further explained that clients who had first day starts would then have excellent health outcomes when they returned to the office a month later. He then provided studies that demonstrate the benefits of starting people on ART on the day of diagnosis.

W. Short stated that the third pillar of the End the Epidemic initiative was about expanding PrEP. He stated the current estimate showed that 1.1 million people could benefit from PrEP. He noted that 44% of these people were African-American, while 25% were Latino. He added that there had been an increase in HIV diagnoses among people who inject drugs, and that PrEP could help to address this.

W. Short asked what people know about the HIV cure. G. Grannan replied that there were two patients that had had bone marrow transplants, and only one was officially cured. W. Short agreed. He explained that Timothy Ray Brown, also known as the Berlin patient, was the only one who had officially been cured. He noted that they were still a couple of months out from designated the London patient cured. He explained that both patients had received bone marrow transplants from donors with mutations in their CCR5 proteins, which prevented HIV-1 from attaching to the proteins. He went on to explain that bone marrow transplants had a 30% mortality rate. M. Cappuccilli noted that this was also an extremely expensive procedure. W. Short added that there was a third person who was potentially cured.

W. Short stated that zidovudine (AZT), the first drug to treat AIDS, was approved in 1987. He noted that the second drug was dideoxyinosine (ddI). He explained that people living with HIV/AIDS had complicated drug regimens involving many pills for years, until a treatment regimen involving just one pill a day was released in 2006.

W. Short then reviewed a list of the HIV drug approvals in 2018, noting that there has been one new drug approved in 2019. He next stated that the Strategies for Management of Antiretroviral Therapy (SMART) study[1] showed that people with HIV should not stop ART after they start, and the Strategic Timing of Antiretroviral Treatment (START) study[2] showed that they should start ART right away. He stated that the START study was shut down early because there was such a large reduction in infections, heart disease, kidney, and cancers. He noted that ART can help prevent cancer, and that the longer people with HIV were off ART, they more likely they were to develop cancer.

W. Short stated that there were currently over thirty ART options available. He noted that integrase inhibitors were most commonly used today. E. Rand noted that they have better tolerability. W. Short stated that integrase inhibitors also had minimum interactions and that 90% of people were virally suppressed within two weeks. He went on to say that they were not for everyone. He stated that there were some interactions, including with Tums, and that weight gain could also be an issue. G. Grannan asked how grapefruit juice interacts with integrase inhibitors, and W. Short replied that grapefruit juice was fine. He explained that calcium and magnesium bind with the integrase inhibitors, so taking Tums and integrase inhibitors at the same time would result in integrase inhibitors leaving the body with stool.

W. Short then reviewed the Tsepamo study,[3] which conducted birth surveillance to evaluate the safety of ART in pregnancy. He noted that animal studies showed birth defects with Atripla. He then stated that pregnant women tended to be excluded from trials, so they did not have a lot of information on the effects of ART. He stated that the study found neural tube birth defects in Botswana, and that some of these birth defects were incompatible with life. He stated that they had not seen an increased signal to date in the United States, but that they would need over 2,000 exposures to assess this. He noted that the currently only had 200. He explained that he had been trying to get providers to report to their registry so they would have the necessary data.

[1] https://www.ncbi.nlm.nih.gov/pubmed/17135583
[2] https://www.nejm.org/doi/full/10.1056/NEJMoa1506816
[3] http://programme.ias2017.org/Abstract/Abstract/5532

W. Short stated that physicians were moving patients to two-drug regimens rather than three-drug regimens, since drugs were becoming more potent. He described Juluca as the first two-drug regimen, noting that it performed as well as the three-drug regimen, but could be difficult for people with stomach acid issues and people who are pregnant. He stated that Dovato was the second two-drug regimen, which had done well when compared to Tivicay + Truvada. He noted that this was a treatment change for many providers, and that the treatment guidelines would not change until they had more data.

W. Short moved on to discuss injectable ART. R. LaBoy stated that monthly injectable ART would be coming out in late 2019, and that the injections would require clinical visits. W. Short agreed, explaining that the treatment was a two-drug therapy including an integrase inhibitor and a non-nucleoside reverse transcriptase inhibitors (NNRTI). He noted that a study showed that the therapy was non-inferior to oral ART. He added that it might be approved in December 2019.

W. Short then stated that injectable ART required four injections at the first visit, two in the left buttocks and two in the right side. He noted that it would be one per side for subsequent visits. He stated that it required a z-track injection and related staff training, since many nurses were not familiar with the technique. He explained that there were still many question about implementation, noting that pharmacists would not be able to administer the medication. T. Flores asked how much this therapy would cost. W. Short replied that this was not yet known since the treatment had not been approved. He noted that the total cost would include the drug itself as well as the injection and staff time. He added that there were many logistical issues to address.

T. Flores asked if Biktarvy could be used for PrEP. W. Short replied that Truvada was the only drug currently approved for PrEP. He noted that Biktarvy was a three-drug regimen.

W. Short then shared that only one out of every three or four of his patients know what U=U is. G. Grannan asked if there was any research about PrEP among people who inject drugs. W. Short replied that the Bangkok Tenofovir study[4] was the basis of the CDC PrEP recommendation, but that this was an understudied area. He went on to say that providers who were counseling patients for PrEP needed to ask about what areas were being exposed in order to address risk.

W. Short stated that another drug currently used for ART, Descovy, had fewer side effects than Truvada. He noted that the DISCOVER study[5] showed that Descovy could be used effectively as PrEP, adding that the study included men who have sex with men (MSM) and transwomen.

W. Short moved on to discuss perinatal transmission, noting that perinatal transmission most frequently happened at placenta separation. He stated that Kathleen Brady (AACO) had provided him with data on perinatal transmissions in Philadelphia. He went on to say that, in Philadelphia, there had been one perinatal transmission in 2014, two in 2015, none in 2016 or 2017, and hopefully zero in 2018.

[4] https://www.ncbi.nlm.nih.gov/pubmed/23769234
[5] https://clinicaltrials.gov/ct2/show/NCT02842086

W. Short next noted that breastfeeding was the one exception to undetectable equals untransmutable (U=U). He explained that the breast had two types of virus, and that breast tissue activated virus outside of the blood stream. He noted that the annual transmission rate was 6 per 100 breastfeeding parents living with HIV.

M. Cappuccilli asked if there had been research on medication implants. W. Short replied that there had been research on both implants and rings, but that this research was trailing behind injectable research.

C. Terrell stated that the federal government would not release End the Epidemic funds until the budget was approved, but that there would be a great deal of planning to do soon.

W. Short added that death rates for HIV dropped overall, but that there had been a 43% increase in deaths due to opioids among PLWH.

M. Ross-Russell stated that the PrEP pillar of the End the Epidemic initiative focused on the use of federally-qualified health centers (FQHCs). She stated that southern states did not have as many FQHCs, and asked if there was a movement toward opening more. W. Short replied that funding and access to services were extremely limited in southern states, and that people living with HIV often sought medical care after they became very sick. C. Terrell stated that the CDC would take the lead in HIV testing and diagnosis, and HRSA's HIV/AIDS Bureau (HAB) would take the lead in HIV care through Part B and Part D. He noted that the Bureau of Primary Health Care would be funded to roll out PrEP.

H. Bennett asked why a person would choose injectable ART. W. Short replied they wouldn't be for everyone. He stated that some people had a hard time taking pills, especially some people with a history of sexual abuse. He went on to say that other people found taking pills to be a constant reminder of their HIV, while still others didn't want pills in their homes due to unaware family members. He explained that it would be another option for people who don't want to take a pill, but many people will still want to take a pill.

T. Flores asked how many people with HIV had undetectable viral loads. W. Short replied that over 80% of Ryan White clients had undetectable viral loads.

H. Bennet asked for the definition of an undetectable viral load. W. Short replied that this depended on the test, but that it typically meant fewer than 50 copies/mL in a clinical setting, although "undetectable" in studies typically meant <200 copies/mL or <400 copies/mL. He noted that these levels had to be maintained for six months or longer for a person to have an undetectable viral load.

Allocations Preparations:

- **Legal/Other Professional Services –** *Juan Baez*

  J. Baez began with a review of the HRSA definition of legal/other professional services *(see – attached handout)*, noting that the legal services needed to be related to a person's HIV. He explained that this included issues related to benefits, such as addressing the termination of a client's Medical Assistance benefits. He stated that this also includes issues related to

discrimination, as well as preparing healthcare powers of attorney, durable powers of attorney, and living wills. He went on to say that this could include permanency planning for clients and their families, as well as income tax preparation for people receiving premium tax credits under the Affordable Care Act.

J. Baez reviewed utilization data for legal services/other professional services. He noted that clients fluctuated while legal units increased from 2015 through 2017. He also reviewed consumer survey information, noting that 118 of 392 survey respondents had identified a need for legal services in the past year. He noted that, of respondents who had needed these services in the past year, 58.5% had used the services while 41.5% needed them but did not get them.

Finally, J. Baez reviewed unmet need data and recipient service considerations. M. Cappuccilli asked if there was a difference in the provision of service across the EMA. M. Ross-Russell replied that there was a single provider of the service in the EMA. She noted that Philadelphia and Southern New Jersey funded legal services, but the PA Counties did not. C. Terrell added that clients from the PA Counties did receive services. J. Baez noted that he worked for the legal services provided. M. Ross-Russell noted that any Ryan White-eligible clients who lived in the EMA could access the service.

- **Housing Services –** *Sharee Heaven*

S. Heaven reviewed the HRSA definition of housing services *(see – attached handout)*. She noted that housing services funding could not be used for direct cash payments or mortgage payments. She stated that the total number of clients had decreased from 2015 – 2017, and that housing dollars had fluctuated over that period. She stated that the client cost for housing assistance had decreased from 2016 to 2017. She then reviewed data from the consumer survey as well as unmet need and recipient service considerations.

L. Diaz asked what "CSU intake" referred to, under the unmet need section. M. Ross-Russell replied that Client Services Unit (CSU) intake was the central intake system for either new clients or clients who are returning to HIV care after being out of the system. M. Coleman asked if Department of Housing and Urban Development (HUD) programs would include Philadelphia Housing Authority (PHA) housing. S. Heaven replied that PHA was its own program, and direct emergency financial assistance (DEFA) was separate from HUD and PHA. M. Ross-Russell replied that Housing Opportunities for People with HIV/AIDS (HOPWA) was also a different program, while DEFA housing was funded through Part A. She noted that housing services were also funded within the Philadelphia EMA.

S. Heaven noted that this category did not cover permanent housing, but rather temporary or transitional housing.

- **Dental Services –** *Michael Cappuccilli*

M. Cappuccilli reviewed the HRSA definition of oral health care *(see – attached handout)*. He stated that oral heath care was about 4% of the budget in the EMA, but that HRSA recognized dental as a core service. He stated that most federal programs do not acknowledge the importance of dental care, so he was grateful that this was a core service.

M. Cappuccilli stated that dental providers provided comprehensive dental care, although emergency care is often what brings people to the dentist. He went on to say that the service covers dental care, while full crowns for aesthetics were often not covered under Part A. He explained that the primary consideration was keeping people healthy, since poor dental health led to poor nutrition. He noted that the service did require HIV care documentation, including lab results.

M. Cappuccilli stated that a dental patient should be continually treated in medical care, including labs a couple of times a year. He noted that regular patients in the dental office could be linked back to medical care through the dental office. He went on to say that oral care was very important because over half of people living with HIV (PLWH) in the EMA were over 50 years old, and older people have more dental problems. He noted that smoking prevalence was higher among PLWH, and that incidence of gum disease was higher among people who smoke. He added that gum disease was associated with cardiovascular issues.

M. Cappuccilli noted that most people receiving dental services in New Jersey and Philadelphia received services through dental schools, while Ryan White clients in the PA Counties mostly received dental services through subcontracted community-based organizations. He added that providers needed to have a certain number of unduplicated clients and visits in their programs.

M. Cappuccilli stated that dental services tended to be relatively stable from year to year, and that client cost was typically about $500. He noted that the average client would come to the provider two or three times per year. He then stated that there had been an increase in funding to dental care through Part B and Part F from the previous year to the current year.

M. Cappuccilli reviewed consumer survey data, noting that there had been 392 respondents, of which 247 had identified a need for dental care in the past twelve months. He noted that the "needed but did not get" percentage was 15%. He then stated that he had been thinking about what questions they might still have about the unmet need data, specifically asking for more information on the Medical Monitoring Project (MMP). C. Terrell replied that the MMP used structured interviews for people who were in care, while CSU Intake data would include people new to the system who might not recognize that they need dental care. M. Cappuccilli stated that this might indicate that people in medical care were getting effective messages about the importance of dental care.

- **Food Bank/Home-Delivered Meals –** *Alan Edelstein*

A. Edelstein stated that food bank/home-delivered meals was a supportive service. He then reviewed the HRSA service definition *(see – attached handout)*. He noted that vouchers primarily referred to grocery store gift cards, and that meals can include bags of food in addition to hot meals and home-delivered meals. He stated that food was a basic human need, and most people who needed the service had very low incomes.

A. Edelstein then reviewed the number of clients and units for the service. He noted that the number of clients and units had decreased from 2015 – 2017, as had the actual spending on

the service. He noted that the allocations remained stable over time. He explained that the difference in these figures was due to the way that funding was often reallocated to the category when there was underspending at the end of the year. He went on to say that gift cards or vouchers could be expended quickly and saved to provide food in a later period.

M. Cappuccilli asked why the projected clients were so high. M. Ross-Russell replied that she had used the figures associated with the actual spending on the services rather than the allocated dollars.

A. Edelstein then reviewed funding by Ryan White Part before reviewing the consumer survey and unmet need data. He noted that, of the 392 consumer survey respondents, 158 reported a need for the service. Of these, 75.3% had used the service, while 23.5% needed food bank/home-delivered meals but didn't receive the service. He stated that the need reflected through Medical Monitoring Project (MMP) data seemed low at 5.8%.

Finally, A. Edelstein reviewed the recipient service considerations for food bank/home-delivered meals.

Committee Reports:

- **Executive Committee**

M. Ross-Russell reported that the Executive Committee had discussed two main issues. She stated that the co-chairs had talked about timing of Planning Council meetings, since OHP had been contacted by individuals who wanted to participate but could not attend during standard business hours. She stated that they had raised the question of whether the Planning Council should hold a quarterly meeting from 5:30 – 7:30 p.m. She stated that the Positive Committee would meet on the evening of June 18 from 6 – 8 p.m., and that this meeting would serve as the pilot for the idea.

M. Ross-Russell reported that the Executive Committee was also exploring the development of a policy around research participation requests. She explained that the Office of HIV Planning was recently contacted with a request about Planning Council participation in a National Institutes of Health (NIH) study about PrEP. She further explained that, in this scenario, the Planning Council would act as a community advisory board (CAB). She stated that the timeline had been very short, and would have required a response within days. She then stated that this type of request, which fit with the Planning Council's roles and responsibilities, would normally need to come before the Planning Council for a vote. She stated that this had brought up the question of how to handle situations where the turnaround time was too quick to allow for a vote by the Planning Council. She explained that the Executive Committee was planning to draft a policy on how to address situations like this one, which would include determining who would be responsible for making the decision.

B. Morgan noted that the Comprehensive Planning Committee was currently looking for two committee co-chairs.

- **Finance Committee**

No report.

- **Nominations Committee**

M. Cappuccilli reported that the Nominations Committee had recommended six new applicants to the Planning Council. He stated that they were looking for more members from the PA Counties, as well as African-American males from Philadelphia. He stated that the committee was planning their summer social, which would be held immediately following the June Planning Council meeting. He noted that members who would like to contribute could bring a purchased dessert with them.

C. Terrell stated that the Planning Council had good representation from people living with HIV, but that there was room for improvement around representation from youth. He stated that young minority gay and bisexual men were disproportionately impacted when it came to new HIV diagnoses, and that the CDC often asked about representation from this group. L. Diaz replied that the Nominations Committee often talked about this, adding that one of the newly-recommended Planning Council applicants fell into this category. D. Law noted that they had had an applicant that had not completed the application because they had not supplied the tax clearance. She noted that the applicant had not responded after being asked to submit the tax clearance. S. Romero agreed that the Nominations Committee often discussed this issue, and that this was part of the reason that they were working on an online application and social media campaigns.

G. Grannan asked how the tax clearance would be addressed if an applicant was homeless. C. Terrell replied that the mayor's office had been very willing to work with the Planning Council on this. He noted that a person who was homeless would not owe property taxes. D. Law stated that OHP staff would also assist people with this issue when needed. E. Rand asked if information about an applicant's HIV status would be shared with the Planning Council, and D. Law replied that it would not. D. Law noted that the applications were blinded. H. Bennet stated that St. John's Hospice and Broad Street Ministries also provided addresses for people who are homeless.

- **Positive Committee**

B. Morgan reported that Positive Committee would meet on Monday.

- **Comprehensive Planning Committee**

No report.

- **Prevention Committee**

L. Matus reported that Prevention Committee had finished reviewing the PrEP Workgroup Report, and that they would finalize the updates at their next meeting. She asked those present to share the PDPH PrEP campaign.

Old Business:
None.

New Business:
None.

Announcements:
M. White wished all mothers a happy Mother's Day.

R. LaBoy announced that National HIV Vaccine Awareness Day would be on May 18. He went on to say that the University of Pennsylvania was hosting an event called "Take Control, Be Aware" at the William Way Center on May 16. He noted that dinner would be served at 6pm and that the event would include TED-style talks and performances. He added that Dr. Ian Frank would provide an update on HIV vaccines, including research being done in Philadelphia.

G. Grannan announced that June 2 would be International Whores Day. He noted that there were no events associated with the day.

E. Rand announced that the Children's Hospital of Philadelphia would host a Youth Pride health and wellness fair at the Roberts Research Center on June 1.

Adjournment:
Motion: P. Houle moved, G. Grannan seconded to adjourn the meeting at 4:26p.m. **Motion passed:** All in favor.

Respectfully submitted,

Briana L. Morgan, staff

Handouts distributed at the meeting:

- Meeting Agenda
- Meeting Minutes from April 11, 2019
- Racial Equity Workgroup Purpose and Scope
- Legal Services/Other Professional Services Description
- Housing Services Description
- Oral Health Care (Dental) Description
- Food Bank/Home-Delivered Meals Description