Philadelphia EMA HIV Integrated Planning Council
Prevention Committee
Meeting Minutes of
Wednesday, July 24, 2019
2:30 PM – 4:30 PM
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, Lupe Diaz

Absent: Janice Horan, Nhakia Outland, Joseph Roderick, Eran Sargent, Zora Wesley

Guests: Sade Benton, Khalil Tanksly, Tyrell Mann-Barnes, Claire Burns-Lynch, Caitlin Conyngham (AACO), Akash Desai (AACO)

Staff: Briana Morgan, Nicole Johns, Sofia Moletteri

Call to Order:
C. Steib called the meeting to order at 2:37 PM.

Approval of Agenda:
C. Steib called for a motion to approve the July 24, 2019 Agenda. **Motion:** L. Diaz moved, D. Gana seconded to approve the agenda. **Motion passed:** general consensus.

Approval of Minutes (*June 26, 2019):*
C. Steib made a motion to approve the meeting minutes from June 26, 2019. **Motion:** G. Grannan moved, D. Gana seconded to approve the minutes. **Motion passed:** general consensus.

Report of Co-Chairs:
C. Steib reported that co-chair L. Matus would be arriving later. Otherwise, there was no report.

Report of Staff:
N. Johns reported that the Positive Committee would have an evening meeting on September 10th from 6 PM - 8 PM. The meeting would cover U=U and mental health. Health professionals Dr. Acri and Dr. Kevin Moore would lead the conversations. N. Johns asked that everyone distribute flyers widely and email her with any questions or concerns.

Prevention Services Initiatives:

—Update on New HIV Diagnoses among PWID (Caitlin Conyngham)—

C. Conyngham informed the attendees that AACO just wrapped up submission of an End the Epidemic 1 year planning period grant. Since the grant was just submitted, it is still unclear what will be funded and

how the guidance will change. AACO will soon have more information to present to the full council since the start date for Ending the HIV Epidemic Plan (EtE) is October 1st.

C. Conyngham explained that there had been an increase in HIV infections among PWID in Philadelphia. She said AACO presented this information at the Prevention Conference to CDC and other various stakeholders. In 1992 there was a peak of 819 new infections in PWID, followed by a significantly steady decline. The decline was likely due to the opening of Prevention Point, an important harm reduction service. The decrease in new infections in PWID was about 25-32 individuals a year up until 2016. However, in September 2018, the number of new infections spiked, and the final June 2018 data identified a 115% increase of new infections in PWID since 2016. While the number of those infected is still lower than MSM, she noted that such a sharp rise in new infections calls for concern. She said PDPH identified a current risk network of PWID of 242 people: 133 newly diagnosed since 2018, 25 cases linked to laboratory data, 38 partners of index cases, and 46 priority cases. She clarified that priority cases identifies individuals who don't report or have medical evidence of injection drug use, but there might be other factors that would warrant further investigation. For example, those who contracted Hepatitis C within the last three months would fall under the priority case category. She explained how these priority cases are important, because they allow AACO to assess whether or not its investigative techniques are satisfactory.

Regarding risk network characteristics, C. Conyngham noted a small increase in infections among females, though men are still in the majority. She then expressed AACO's goal to soon pull data for infections in trans individuals, as there is not currently much data on trans populations. She then pointed out the increase in new infections among the non-Hispanic black population, while numbers in the Hispanic population essentially remained the same. Regarding age, she noted a bell-shaped curve in which new infections mostly effect the 30-39 age range, though there was a slight increase of risk for those who are 50+ years. In terms of HIV transmissions, she reported a noteworthy increase of MSM who inject drugs, recognizing that this must be considered in response efforts. She then noted the 12% of individuals who have evidence of HepB infections and the 10% of individuals who are triple infected with HepB, HepC, and HIV. C. Conyngham acknowledged that if there is no evidence of testing, people do not get put into the analysis. Thus, it must be recognized that the 48% of persons in the analysis with evidence of Hepatitis is not necessarily representative since there is less testing than desired among the population.

C. Conyngham stated that there has been significant internal cross-department coordination at PDPH. She explained that Hepatitis C was a priority, and the city recently issued an advisory around Hepatitis A due to its increase among PWID and homeless populations. She identified the important collaborations with the Opioid Program, the Immunization Program, and Public Health Preparedness.

Regarding testing, AACO identified four testing providers to participate in the mobilization to increase HIV testing. Two, she explained, are mobile locations for broader reach, and the other two are set locations. She noted the increase in emergency department outreach. A majority of newly identified infections come from healthcare settings. This is because people are going into healthcare settings for other health related concerns, ultimately receiving an HIV test as result of the primary complaint.

She mentioned that prior to focused efforts for PWID, there were about 171 community-based tests per month, and after mobilization efforts, there has been a near doubling of about 295 tests per month. She reiterated that a vast majority of diagnoses are coming from clinical settings, and the whole initiative has been well received by clinicians. C. Steib asked about the age range percentages for newly diagnosed PWID. C. Conyngham read the data aloud for percentage/age range: 8% of people are 20-24, 19% are 25-29, 36% are 30-39, 15% are 40-49, and 22% are 50+. G. Grannan pointed out that harm reduction programs in Philadelphia are prohibited from working with people under the age of 18, so these younger individuals can only get syringes from a pharmacy.

For Partner Services, AACO has been conducting a specific survey containing questions related to injection drug use so AACO can glean knowledge regarding linked cases. She mentioned that Partner Services was also working to provide linkage to care. G. Grannan asked about the network data partner numbers and who that might include. C. Conyngham explained when they do partner services, they include sex partners, syringe sharing partners, or a combination of both. AACO's Partner Services are useful, but there has not been a huge difference in the specifically PWID Partner Services than there is in the overall Partner Services activities. She said they have received approximately the same number of partner names which averages to 1.5 per person.

M. Coleman asked about strain among healthcare services that may be present because of Hahnemann's closing. C. Conyngham said that many healthcare providers are feeling the strain in Philadelphia. Related to HIV, there has not a change in the Drexel Partnership and there are no notable issues related to Hahnemann. She remarked that there are certainly larger conversations about other services, however, such as OB/GYN that are largely impacted.

K. Carter asked what the exact point of transmission is. C. Conyngham said that that is hard to identify where the exact point of transmission is e.g. shared syringes, shared equipment, sexual encounters. However, she did note the overall higher injection frequency due to the rise of fentanyl use and its half-life. G. Grannan asked if there were any cases reported regarding hormone injection. C. Conyngham explained that AACO investigates all cases that come in and look at medical charts and pull from medical providers to determine the patient's risk based on the CDC HIV risk. She noted the lack of knowledge regarding why there are no cases for people who inject hormones—do the cases not exist or are they not being reported? G. Grannan then asked about the 36% report for crack injection (does she know if Prevention Point is distributing harm reduction for crack injections (Vitamin C)? C. Conyngham said she did not exactly know and that G. Grannan made a good point regarding a significant use of polysubstance injection. She said there is often a misconception around what syringes are used for and who is injecting what and how. What is known is that there is a significant reuse in syringes with 62% of people injecting more than 4 times a day and 19% over 10 times a day based on surveys conducted.

She said that they see high rates of overdoses in the population and high rates of exchange sex. She said that 60% of the men who reported exchange sex had given money for sex and drugs, and 82% of people who confirmed receiving money for sex or drugs were female. 65% of people were incarcerated in last month and 81% of people were ever homeless. G. Grannan asked if the reported 54% overdosed is just for opioid or not. C. Conyngham said the survey only asked if people had overdosed, not about the substance. Furthermore, data coming in from healthcare settings does not contain syndromic data.

C. Conyngham discussed the "One Stop Shop" care sites providing services. She said that 92% of index linked cases were ever linked to care. However, there is a significantly lower retention in care at about 56% with 64% of those having attained viral suppression for the PWID population. She mentioned that new cases of PWID with HIV actually have a slightly higher retention in care and viral suppression rate as compared to the overall Philadelphia care continuum.

B. Morgan asked if the retention measure mentioned is the medical appointments at least 90 days apart, and C. Conyngham confirmed this. B. Morgan continued to ask if the retention rate for new PWID infections could theoretically be a bit higher since the survey is dealing with an outbreak only about a year long. C. Conyngham said that no matter how the retention number is broken up, there are always existing barriers and different care patterns for wherever people exist on the care continuum. The takeaway, she summarized, is how AACO, care facilities, the Planning Council, etc. can address existing barriers.

She said that on Thursday, July 25th, AACO would be speaking with other jurisdictions that are also facing an HIV outbreak. She continued to say that around four months ago, New Jersey put out a health advisory regarding the increase in new HIV infections in specific counties.

M. Coleman asked about high-risk populations and PWID and whether PrEP providers try to play more of a role in risk reduction. C. Conyngham said there is a large effort around referring people to PrEP as well as frequent testing. She said there has been an initiative to integrate PrEP into not only medical settings, but also places that can more directly reach at-risk populations such as Prevention Point. All of the aforementioned One Stop Shops (10 sites in total) also all provide testing, treatment, and PrEP. These places also have MAT, MCM, etc. so they can build a proper care team with as many services as possible. G. Grannan asked if C. Conyngham could share the presentation with OHP, and he also asked if she could talk about progress around trying to trace HIV through confirmed overdoses. C. Conyngham said medical professionals have attempted HIV testing through a number of samples, but they can't truly test for HIV on people who overdosed and did not survive. Therefore, it is a technological issue.

—Demonstrating Expanded Interventional Surveillance (Akash Desai)—

A. Desai next discussed the DExIS process. He said that Philadelphia is one of 20 jurisdictions to receive funding for Demonstrating Expanded Interventional Surveillance, otherwise known as DExIS.

He said that the purpose of DExIS is to address each of the national HIV prevention goals of reducing new HIV infections, increasing access to care, and reducing HIV-related disparities and health inequities. The project will provide for an in-depth evaluation of sentinel cases of HIV transmission and pursue organizational, system, and community level interventions to prevent future transmissions. Ultimately, through DExIS, AACO will develop a cohort review of recent HIV infections to identify missed opportunities for prevention. They will also implement individual-level interventions among the cohort of members and their risk networks to improve HIV Prevention and Care Continuum outcomes. Lastly, they will develop and implement individual-level interventions among the cohort review process to close system-level gaps in HIV prevention. He identified the priority populations as MSM of color, youth ages 13-24, and transgender persons who have sex with men.

A. Desai explained that AACO was looking into how they could successfully identify aforementioned populations. Once they did, AACO would facilitate standardized interviews that would allow them to understand how different populations interact with care while also looking at medical charts. AACO would also work on linking these individuals to care or enhanced partner/prevention services. Next, the Case Review Team (CRT) would review collected data, identify patterns, and make preliminary recommendations. Once they review those cases, the Community Action Team (CAT) would discuss patterns, review CRT recommendations, and propose additional recommendations. The Policy Implementation Team would then develop action plans based on system-level analysis of program data and performance evaluation. They would also look at the recommendations and see which ones are most sustainable and if they are long-term, short-term, high impact, and low effort. The last step would involve offering technical assistance grants to grassroots organizations for capacity building.

He highlighted the open communication between CAT and CRT. Though CAT is the second team, they will be reporting back to CRT with new ideas to review cases and identify patterns. He mentioned the six areas of expertise within DExIS, listing some of the organizations that would be backing each area: Treatment (CHOP), Legal, Regulatory (AIDS Law and the Office of LGBT Affairs), Social and Culture (William Way), Support (Department of Behavioral Health), Research (PENN and Temple researchers), and Prevention (comprised of volunteer testing providers).

A. Desai went over the working draft for interviews. He stated that the hypothesis for HIV testing is that most people are aware HIV testing exists but may not know how to access it, may not be able to, or may not feel comfortable using it. Regarding HIV prevention, it was hypothesized that across the board, messages for U=U, condoms, PrEP, and syringes do not resonate with populations of priority and the threshold to accessing services is too high. The survey would ask about attitude/knowledge/use around PrEP/PEP, insurance status, access to primary medical care, and social experiences. The survey would also address stigma and hypothesized that internalized and externalized stigma negatively impact access and uptake of HIV prevention services. The survey would also collect information around substance use, mental health, exposure to justice system, housing status, and experiences with the Philadelphia Department of Public Health. G. Grannan countered the prevention hypothesis, stating that messages regarding syringes likely resonate with populations of priority since syringe exchange was actually developed from PWID. A. Desai said that the hypothesis is not yet set and may be proven wrong. It may be uncovered that other messages are not resonating well with respondents.

A. Desai listed the fields of chart abstraction: demographics, sexual orientation and gender identity (SOGI), STI testing, HIV testing, insurance status, substance use, mental health, other medications comorbidities (including Hepatitis). He then listed the sources of records: partner services, testing and linkage to care sites, medical facilities (inpatient, ED, urgent care).

C. Steib asked if the case report would be redone so there could be less digging for information. C. Conyngham responded that some information is easily attained as a provider, but what DExIS is mostly seeking is information over a three year time period to see what is in someone's medical chart and what is not. For example, if a 22 year old's case is in question and they went to get care for gonorrhea at the age of 20, were they tested for HIV? If they came back later, did they get information about PrEP? She

continued to explain that scenarios are evolving, and DExIS is an opportunity for people to tell a story. G. Grannan asked about capacity for accessing data outside the EMA and other networks. A. Desai said for it depends on the state and difficulties in certain jurisdictions, as surveillance is only for Philadelphia.

A. Desai reviewed the meeting guidelines for DExIS. He mentioned that DExIS would also stress the idea of confidentiality and ask all members to sign a Pledge of Confidentiality. As for the DExIS leadership team, he listed the names of those working under AACO on DExIS and recognized the Division of Disease Control as the Partner Services. K. Carter asked if DExIS would focus on transgender individuals as well. C. Conyngham said that this would certainly be a focus, and questions would address how trans individuals personally felt about their services and if the services were affirming.

Discussion Items:

—Strategies for Engaging Youth—

B. Morgan mentioned that the topic of engaging youth is a reoccurring topic for the Prevention Committee. She included some materials in the meeting packet for everyone to take a look at. B. Morgan stated that in 2014, there were a series of focus groups for young gay and bi men regarding their access to HIV resources. She wanted to include recommendations from this report and remind everyone that it is a good resource for informational purposes. She suggested that if anyone wanted to share the documents, they could possibly prepare to talk about them at the next meeting. She said the Atlanta study from the handouts was from 2017, and the second study was from 2014, so they are fairly recent and relevant. B. Morgan asked the group how they would like to go forward. G. Grannan expressed how there may be a larger problem regarding the city's approach towards youth health—he wondered if it may be too paternalistic. He explained it might be important to consider a structural remedy for the ban on harm reduction for people 18 and under. C. Conyngham asked for clarification—is there a lack of conversation around harm reduction or can youth not access harm reduction policy-wise? G. Grannan said that at his previous practice, they could not distribute condoms to people under 18. C. Conyngham mentioned that condoms are in schools, which is a huge but limited victory, so there is certainly room for improvement and opportunity.

C. Steib mentioned that at his practice, they test individuals 13 years and over as well as give them condoms. He said that the issue with in-school testing is that they only do STI testing, excluding HIV testing. He explained that some charter schools allow it, but there are not many. C. Steib continued, saying testing sites rarely do community testing, because there aren't many funds or enough staff to do so. He posed question, where does it fall to test youth? M. Coleman suggested that poor sex education and limited availability of resources hinder engagement with youth.

C. Steib said Judith Peters might be invited to give a presentation to answer questions about the school system/HIV testing. B. Morgan asked if the group had any specific questions for J. Peters. B. Morgan explained that J. Peters covers a lot of topics in her professional life, so the group would need to narrow down what sort of information they would like. C. Steib was interested in a general overview on what she does and data collection that could highlight barriers to prevention. He also wanted to know if the sex education is standardized. B. Morgan and N. Johns said it is not the same for each school. B. Morgan

elaborated, saying for some schools, an organization may come in to teach a certain program, and a community review panel assesses it to see if it meets certain criteria/is appropriate.

K. Carter wanted to know what the HIV testing process. C. Steib said that it is different for each place. In some places, patients do not have to ask for it and at some places they do. Sometimes providers try to determine if someone needs it based on sexual history/activities. L. Diaz said this approach is problematic, since youth may not be honest about their sexual history. C. Conyngham agreed, but said that some confidential youth medical information cannot be shown to the parent. C. Steib said that at many places, when caring for adolescents, they let the guardian know that there will be time alone for the youth and provider—however some issues still arise since parents may still want to be involved. K. Carter asked if 13+ year olds need parent's permission for testing, and C. Steib said no.

T. Mann-Barnes asked if there is an official way to inform parents/guardians how to talk with their child about STIs/HIV. C. Steib said it is dependent on the provider, but in terms of talking to the parent or having protocol, there is nothing official or mandated. T. Mann-Barnes asked if there was strategy for engagement in public universities from the top-down level. C. Steib said there is testing at universities, but community testing funds are limited. However, at his practice, they were able to set up a couple of student health centers that do testing themselves. He figured that might be a good strategy to check in with universities. C. Conyngham said that there are some engaged and excellent student services that are well-equipped to provide PrEP. There may be barriers with those on private insurance, but many schools are engaged with the PrEP clinical advisor. The issue, she continued, is that students might not get to the student health center to even realize that resource is available. C. Steib said that another strategy may including going through the LGBTQ+ groups on campus.

E. Rand mentioned that pediatricians are notably hesitant to talk about sexuality or HIV with the patients. Even after geographical data is shown to pediatricians to explain that their populations are at risk, it remains a barrier. C. Steib, agreed that this narrative exists in many practices.

C. Steib considered the idea of engaging Police Athletic League (PAL) centers. He explained that the centers have sports tournaments which could allow for a significant amount of HIV tests for youth. D. Gana said that in universities, there is a coalition of GSAs that often assemble at the William Way Center. B. Morgan asked C. Conyngham if there were any university-wide campaigns regarding HIV testing or PrEP. C. Conyngham said college students who are in Philadelphia can see city-wide campaigns, and there was a notable amount of engagement with the website as compared to other populations.

T. Mann-Barnes asked about the aforementioned website. C. Conyngham said the Department of Public Health created a city-wide campaign to increase awareness of PrEP called Philly Keep on Loving. She continued to explain that there was both general and targeted advertising. There was a lot of engagement from trans individuals, women, gay and bi men, and many youths under 18 years old as well. A goal of the campaign was to ensure individuals knew they could access confidential services for PrEP.

B. Morgan said they could reach out to J. Peters and also could review school district profiles about sexual health education. L. Matus asked if the committee could also focus on recommendations and solutions, not just barriers. B. Morgan said she could pull together data that could also help the group. For

example, they could look into the Youth Behavior Survey, a high school survey about sexual behavior and drug use, as well as depression/bullying/safety/etc. She suggested the group look at the data and figure out their path form there. In terms of solutions, the committee could have a panel discussion with youth providers.

C. Conyngham asked what the group felt like their role was in providing help to schools since schools are under a separate jurisdiction. She mentioned that the average age of testing is over 35, and efforts might be better directed in looking at provider-level data. N. Johns mentioned the focus groups that the Office of HIV Planning conducted—she offered to give a presentation on the focus groups, explaining that there is rich data that may have been overlooked/underutilized. The focus groups included Philadelphia youth, so the committee would benefit from that information. C. Steib agreed that the data would be helpful. B. Morgan said that this report is available online for anyone to look over and bring back any questions.

E. Rand asked if there was a way to collect data around retention in care for youth. She guessed that adult providers have more trouble keeping people in care. C. Conyngham said she would try to pull a care continuum for youth. She then mentioned that the quality improvement team within the care system has been looking at disparities in providers. However, since providers have a variety of disparities, they may cancel each other out in large data sets and ultimately go unrecognized at the higher level.

—PrEP Workgroup Report Next Steps—

B. Morgan announced that the PrEP Workgroup Report was approved by the full council. C. Steib further explained that it was approved to be added to the plan as an appendix until it could be updated with the new plan. He thanked everyone for their participation in the process.

—Ending the HIV Epidemic—

B. Morgan said there isn't a lot to talk about yet, but more information would hopefully arrive in August. At that point, it will be an ongoing agenda item.

Old Business:
None.

New Business:
None.

Announcements:
M. Coleman announced that the Philadelphia Trans Wellness Conference was July 25th until Saturday, July 27th at the Convention Center.

K. Carter said that William Way would be hosting the THRIVERS group for those who have gotten past being long-term survivors of HIV and are thriving in life. D. Gana said it is a very positive approach for PLWH. The event would happen July 25th from 12-2 PM.

B. Morgan announced that the PA HIV Planning Group will hold a stakeholders meeting with an accompanying online version. It would take place next Wednesday, July 31st, from 2 - 6:45PM. A link will be posted on OHP's Facebook and Twitter.

Adjournment:
C. Steib called for a motion to adjourn. **Motion:** D. Gana moved, L. Diaz seconded to adjourn the July 24th, 2019 Prevention Committee meeting. **Motion passed:** general consensus. Meeting adjourned at 4:18 PM.

Respectfully Submitted,

Sofia M. Moletteri, staff

Handouts distributed at the meeting:

- July 24, 2019 Agenda
- June 26, 2019 Prevention Committee Meeting Minutes
- Recommendations to increase YMSM engagement in HIV prevention
- Linking HIV-positive adolescents to care in 15 different clinics across the US
- The Metropolitan Atlanta community adolescent rapid testing initiative study
- DExIS: Demonstrating Expanded Interventional Surveillance slides