Philadelphia HIV Integrated Planning Council
Comprehensive Planning Committee
Meeting Minutes of
Thursday, January 16, 2020
2:00-4:00p.m.
Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia PA 19107

Present: Susan Arrighy, Keith Carter, David Gana, Pamela Gorman, Gus Grannan (Co-Chair), Lupe Diaz, Clint Steib, Alan Edelstein

Absent: Katelyn Baron, Sade Benton, Mark Coleman, Evette Colon-Street, Janice Horan, Marilyn Martinez, Kenya Moussa, Erica Rand, Joseph Roderick

Excused: Allison Byrd, Peter Houle, Gerry Keys, Jeanette Murdock, Gail Thomas (Co-Chair)

Guests: Jessica Browne (AACO), Caitlyn Conyngham (AACO), Evelyn Torres (AACO), Javontae Williams (AACO), Renee Cirillo, Terrence Carroll, Blake Rowley, Beth Gotti, Desiree Surplus

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

Call to Order/Introductions: G. Grannan called the meeting to order at 2:06 PM. He asked everyone to introduce themselves with their name, pronouns, and what they have done in the new decade thus far.

Approval of Agenda:
G. Grannan presented the agenda for approval. **Motion**: K. Carter motioned, D. Gana seconded to approve the agenda. **Motion passed**: all in favor.

Approval of Minutes (*November 21, 2019*) G. Grannan presented the previous meeting's minutes for approval. **Motion**: D. Gana motioned, K. Carter seconded to approve the November 21, 2019 meeting minutes. **Motion passed**: All in favor.

Report of Staff:
N. Johns reported that the Positive Committee was working on a 20th anniversary project featuring PLWH who have been part of HIPC, past or present. The project would be a book of some kind. She asked people to call or email her to recommend someone or personally participate.

Report of Chair:
None.

Discussion Items:
—Ending the HIV Epidemic (EHE)—
G. Grannan asked everyone to refer to their copies of the EHE draft report. J. Williams introduced himself and explained that he wanted to go through the plan in the form of a group discussion. J. Williams said he was a newer staff member at AACO and was brought on to be the EHE Coordinator. The CDC had introduced a 1 year planning process to end the HIV epidemic in Philadelphia through a variety of strategies. He was hired in September 2019 to make a draft of the plan by December 30th.

J. Williams explained New York had announced it would end the HIV epidemic within the next 18 months, and in the United Kingdom, new infections among gay men had fallen 76%. Progress was being made both nationally and internationally. He explained that Philadelphia was also looking to make significance progress. Within the next 9 months, they would host a public comment session, and on

March 1st, 2020, they would introduce a new level of public meetings and community engagement activities.

J. Williams noted that the first 17 pages of the plan consisted of prose about what HIV looks like in Philadelphia, and the actual plan started on page 18. There were four pillars to the plan: Pillar (1) Diagnose, Pillar (2) Treat, Pillar (3) Prevent/Protect, and Pillar (4) Respond. He noted that there was an additional, "invisible pillar" on workforce development, expanding across all pillars.

At the top of pillar, it reads the overarching goal. The second level is the strategy that is the theme that allows for creation of activities. J. Williams asked for volunteers to read the details of the first pillar.

Refer to the EHE Draft Plan page 18 for Pillar 1 details of the plan. C. Steib read the first goal under Pillar 1: Over the 5 year period, 97% of PLWH will be aware of their status. He added that HIV is not evenly distributed among all different groups. P. Gorman read the first strategy: Increase access to HIV testing through bio-social screening in medical settings including primary and urgent care settings, Emergency Departments, and at prison intake.

K. Carter read the activities under Strategy 1 of Pillar 1. J. Williams asked everyone to highlight the last activity which emphasized the importance of technical assistance and support to assess barriers and expanding routine HIV testing.

J. Williams asked if everyone thought the activities supported the strategy. K. Carter asked for a definition of "bio-social screening." C. Conyngham responded that bio-social screening acknowledges biomarkers in healthcare (use of morning after pill, opioid overdose, other STIs). Pinpointing the bio-social markers through a social screening would allow for better targeted HIV testing.

T. Carroll if hospitals had stopped testing all patients that came through. C. Conyngham responded that the initiative had not stopped, and they still wanted to test everyone as routine care. Routine testing was an end goal rather than a starting point.

G. Grannan mentioned that the plan seemed to be set up for those who have equal access to healthcare, and the plan did not acknowledge the barriers before reaching the clinical setting. There needed to be a larger focus on accessibility. He explained how there was documented instances for sex workers, PWID, and others who could not access services due to the security guard before even entering the building. He noted that there are also structural barriers as well. For example, transgender individuals are often mistreated in medical settings, or smaller towns reduce anonymity and patients may feel uncomfortable seeking medical attention.

J. Williams added that barriers can start at reception as well. AACO heard complaints about the environment in clinical settings, but they were still figuring out how to address it. G. Grannan suggested that the best way to address it would be to provide care in a setting with already-established, respectful relationships. K. Carter added that there should be implicit bias training for RWHAP providers, since people may be unaware of their bias and how it is affecting clients. G. Grannan noted that getting too close to clients is also appropriate, so the emphasis needs to be on acting appropriately.

J. Williams said that there needs to be incentive for people to want to change how things operate—those who interact with clients most are typically paid and trained the least. Those who are regularly interacting with the clients should have more pull in decisions making and general operations so they can take ownership of and pride in their work. This could be done through grants requirements and the implicit bias training. K. Carter added that the AACO helpline needed more advertisement so that people can report their issues and problems can be solved with providers/services.

C. Steib said he liked the activities under Strategy 1, but there was no implementation portion. J. Williams responded that AACO was collecting implementation ideas and suggestions for a separate document. They wanted all the feedback they could get, since the plan was going to change. For example, he mentioned how one person suggested an Urgent Care specifically for PLWH. Such feedback would be helpful. E. Torres said they realized that the activities needed to be funded, and they were expecting to receive more awards from the CDC. There would soon be a NOFO for the Treat Pillar as well as one for implementation of activities. K. Carter added that transportation was a barrier that needed more focus.

C. Conyngham read the second strategy under Pillar 1: Increase access to HIV testing through community-based programs. J. Williams clarified that Strategy 1 focused on clinical settings while Strategy 2 concerned community settings. L. Diaz read the three activities under Strategy 2. Refer to page 18-19 of the plan for the language. J. Williams noted that Strategy 2 is about meeting clients in the middle and increasing accessibility. C. Conyngham agreed that the strategy sought to meet people at the time and place that aligned with their needs.

D. Gana commented on how self-test kits may fail to connect people to services. C. Conyngham responded that the kits were distributed over 8 weeks, totaling 500 requests for tests. 60% of requests were from individuals within Philadelphia. There were two cards within the kit: one had information about reading the results, and the second was about connecting to services. If you had a negative result, there was information about connecting to PrEP. If the result was positive, it gave information for the AACO helpline and Health Center 1.

D. Surplus said that testing people at pharmacies can present difficulties with linkage to care, and at-home testing may make the linkage even more challenging. P. Gorman asked about false positives in testing kits. C. Conyngham said that the oral swab was the least accurate testing method, but it is also the easiest. The key of the at-home test kits is that it breaks down barriers—any test is better than no test. E. Torres noted that there was an evaluation in process of how many people linked to care and had tested positive via the at-home test. There needed to be a quick turnaround if the at-home kits did not prove successful, thus they are evaluating every step of the process.

B. Rowley asked about how AACO was mitigating the costs of the at-home test kits. C. Conyngham said that for now, they were buying the test kits and administering them for free. However, the kits are only available online which is a barrier. Those accessing the test kits also have to be over 16 years old (FDA requirement) and live in Pennsylvania. The boxes were small enough to fit in a mailbox and were delivered in an unmarked white box.

G. Grannan said that since there was no confirmatory result, people testing at home who did not get into care would not count as PLWH according to the city. J. Williams said that AACO was trying to expand their accessibility and was hoping to get a 24/7 service going which may encourage people to connect with AACO. C. Conyngham added that it is on the recipient of the test kit to do what they want with their results, because AACO wanted an easy and low barrier process. G. Grannan asked if people who tested negative and seek PrEP would get testing again, and C. Conyngham responded that there would be a more sensitive test in the clinical setting. P. Gorman said that for Strategy 1, they may want to consider laboratory test process and reflex HIV RNA Real-Time PCR as a suggestion to medical care facilities.

C. Conyngham read Strategy 3: Increase the frequency of HIV testing among key populations. N. Johns read the corresponding activities on page 19 of the plan. P. Gorman commented on how the activities spoke to specific concerns that individuals had earlier, e.g. transgender populations, sex workers, and PWID.

J. Williams emphasized "key populations," explaining that they need to prioritize testing populations that have disproportionate infection rates. Regarding PWID, there were 71 new HIV diagnoses (a 115% increase) even with Philadelphia's syringe program. Therefore, gaps need to be filled. They were already starting to transition to status-neutral approaches: either people get linked to PrEP or they get linked to treatment. The goal was to support expansion and increase compensation. Even for a negative result, J. Williams noted the importance of post-session counseling, since education and connection to PrEP services is a large part of prevention.

E. Torres informed the committee that for the National HIV Behavior Surveillance, they hone in on certain populations and gather accurate and representative information. She added that they were currently doing more research regarding transgender women. They worked with community leaders, and they were currently working with a transgender woman as the community coordinator. They have interviewed 168 transgender women with the help of a well-known community leader.

G. Grannan mentioned the HIV felony law—if someone does not know their status and transmits HIV to another, it is defensible. However, it is not defensible if someone has an undetectable viral load. He suggested that such a law may be an incentive for people to not get tested.

D. Surplus suggested that pharmacists should be able prescribe PrEP, but they need a collaborative practice agreement. She suggested looking into places such as Walmart, ACME, etc. C. Conyngham agreed that people have closer relationships with their pharmacists and may see them more often than doctors. Therefore, it is an untapped resource that AACO was looking into. D. Surplus added that there is an anonymity factor for going to a pharmacist in a grocery or convenience store.

A. Edelstein read Strategy 4 of Pillar 1 on page 19 of the plan: Implement a status-neutral approach to linkage with realignment and expansion of key personnel – linkage to care includes either HIV medical care of linkage to PrEP. He also read the accompanying activities: refer to page 19 for activities. R. Cirillo read Strategy 5 on page 19: Develop the capacity of Prevention workforce to meet the needs of ending the HIV epidemic. C. Conyngham explained bidirectional as the responsibility of not only the tester to link people to care, but also of a medical provider to be accessible and have an "open door" to actually deliver the PrEP and care a patient needs. This meant being able to take appointments quickly and responsibly. B. Rowley added if anyone meets any biosocial markers, they should get tested.

R. Cirillo asked about Field Services Unit in the second activity of Strategy 4 and what that would look like. J. Williams responded that is someone was tested as part of their routine health screen and tested positive, the provider would call AACO Field Services Unit, and they would go to the site to offer services to the positive individual. The Services Unit would be able to access information about patients and follow-up with the patient. To do this, AACO would gather hospital systems and brainstorm a way to combine systems information and store it on a universally accessible and secure database. R. Cirillo said this is basically to deliver services where these don't exist usually.

G. Grannan asked if the Field Services Unit would be making linkage or if they would be doing confirmatory testing. J. Williams said that was still in the works. G. Grannan asked about overhead for confirmatory testing. C. Conyngham said that the number of people newly and previously diagnosed who come from community settings is much smaller than the people who have been diagnosed at clinical testing. Confirmatory testing in community-based setting would be happening with the rapid test, delivery of ART, etc. People should be moving through the algorithm quickly and have all services delivered.

J. Williams asked if they wanted to talk about community engagement activities instead of Pillar 2 since time was running low. The group agreed to discuss engagement activities by consensus. He asked everyone to detach and give him Pillar 1 from the plan if they wrote comments and concerns.

J. Williams said the one year planning agreement was 3 months in with 9 months remaining in the year. The goal for the rest of the 9 months was to strategize a way to take public comment specific to and reasonable for Philadelphia. R. Cirillo said there needed to be more connection with youth. She suggested social media as a tool to connect with youth in a way that was quick and yielded a good response rate. It was also a good tool for those who want to remain anonymous or cannot physically show up. J. Williams said they had been considering virtual town halls.

C. Steib said that the Prevention Summit would be good for community engagement. He also suggested connecting with resource centers in schools. J. Williams asked the committee how to provide a space that would allow people to feel comfortable being honest and open.

D. Gana suggested GSAs (Gay Straight Alliances) as a place that youth tend to be more open and honest. K. Carter asked J. Williams to define youth and J. Williams said 13-24 years old. K. Carter said that paying youth or offering incentive for their participation may be an ideal method. P. Gorman added that that could be done for PWID as well. G. Grannan reminded everyone that the syringe access program does not allow anyone below 18 years old.

R. Cirillos asked if they were training ambassadors from key populations for the plan. B. Rowley noted that 13-17 and 18-24 are very different populations though they are both considered youth—figuring out how to break up those groups would be important. He also questioned how they should go about bringing industry into the conversation as a way to benefit and involve the community as a whole. J. Williams said that New York used that practice and businesses were interested in participating in EHE, and AACO would look into the idea.

P. Gorman mentioned those delivering the testing and how it was necessary to educate them on how to get the message of care across and ask questions.

J. Williams thanked everyone and encouraged people to invite him to any meetings that would allow for him to educate and engage with the community.

Old Business:
N. Johns reminded everyone that the Comprehensive Planning meeting in November 2019 was about housing and RWHAP funding. She mentioned that housing was a part of EHE's Pillar 2, so she suggested framing committee discussions around how their housing discussion would fit into the plan. N. Johns said they would likely pick the topic back up next month in February 2020.

New Business:
None.

Review/Next Steps:
G. Grannan asked people to review their past discussions around housing as well as Pillar 2 of the plan. N. Johns asked if in March 2020 the committee wanted to review the EHE plan and Integrated Plan to see how they could work together. She reminded everyone that the EHE plan was just for Philadelphia and the Integrated Plan was for the whole EMA. G. Grannan noted that the PDF of the Integrated Plan was available on the OHP website.

Announcements:
K. Carter said that Prevention Summit would take online submissions for workshops until Friday March 6th, 2020, at 5 PM. The submission was electronic, and anyone can also contact them if they need assistance with the submission.

M. Ross-Russell reported that there would be a webinar on January 28th about resource allocation and would feature a presentation about the Philadelphia EMA's regional reallocation process. The webinar would be on TargetHIV.org which also had informational resources for Planning Council members and recipients. The webinar could also be accessed after the 28th in the website archive.

She then reported on the January 23rd webinar about consumer participation in the Planning Council through the Planning CHATT website. The webinar would spotlight Atlanta and San Francisco EMAs to discuss strategies for including and amplifying community voices. N. Johns noted that the webinars were shared via email.

R. Cirillo said that the Point in Time Count was coming up on January 29th, and they were looking for additional participants. It greatly informed funding for the HIV+ homeless population, a population typically undercounted. G. Grannan said that Office of Supportive Housing and Prevention Point would be able to provide more information.

Adjournment: G. Grannan called for a motion to adjourn. **Motion:** L. Diaz motioned, D. K. Carter seconded to adjourn the January 2020 Comprehensive Planning meeting. **Motion passed:** all in favor. The committee adjourned at 3:44 PM.

Respectfully submitted,

Sofia M. Moletteri, staff

Handouts distributed at the meeting:

- January 2020 Comprehensive Planning Meeting Agenda
- November 2019 Comprehensive Planning Meeting Minutes
- January/February 2020 Meeting Calendar
- Ending the HIV Epidemic in Philadelphia: DRAFT: December 30, 2019