HIV Integrated Planning Council
Prevention Committee
Wednesday, September 23, 2020
2:30 PM – 4:30 PM
Office of HIV Planning 340 N. 12th Street, Suite 320, Philadelphia, PA 19107

Present: Clint Steib (Co-Chair), Dave Gana, Dena Lewis-Salley, Erica Rand, Gus Grannan, Keith Carter, Lorett Matus (Co-Chair)

Guests: Caitlin Conyngham (AACO), Champagnae Smith (AACO), Javontae Williams (AACO)

Staff: Beth Celeste, Debbie Law, Mari Ross-Russell, Nicole Johns, Sofia Moletteri

Call to Order: C. Steib called the meeting to order at 2:33 p.m.

Welcome/Introductions: All attendees introduced themselves with their pronouns.

Approval of Agenda:
C. Steib called for a motion to approve the September 23, 2020 Agenda. **Motion:** G. Grannan motioned, L. Matus seconded to approve the September 2020 agenda. **Motion passed:** 50% approved, 50% abstaining.

Approval of Minutes *(February 26, 2020):*
L. Matus called for a motion to approve the February 2020 meeting minutes. **Motion:** G. Grannan motioned, D. Lewis-Salley seconded to approve the February 2020 minutes. **Motion passed:** 71% approved, 29% abstaining.

Report of Co-Chairs:
L. Matus said she was glad to hear that everyone was doing well. She reported that it had been a while since the committee last met, so they would do their best to get back on track.

Report of Staff:
N. Johns reminded everyone that OHP was hosting a fall training series for those interested, new and veteran members alike. The trainings are every other Friday from 12 – 1:15 p.m. and will later be posted on the OHP website. She asked those interested to email her at nicole@hivphilly.org with any questions. The registration page allows for someone to register for however many they want all at once. The upcoming training, this Friday, was about needs assessments.

Report from AACO:
C. Conyngham brought up slides on the shared screen, adding that in the interest of time, she would move through the slides quickly without skipping too much detail. She would send the slides to N. Johns to distribute if needed. She noted that she would be discussing Diagnose and Prevent, Pillars 1 and 3 of the EHE plan. The discussion would include the two topics, community engagement and sexual wellness.

C. Conyngham recalled the four pillars of EHE: Diagnose, Treat, Prevent, and Respond. She reported that approximately two weeks ago, the national EHE dashboard was launched on the website, ahead.hiv.gov. The dashboard provides district, county, and state level information. She said that the number of new HIV infections in Philadelphia is 390, reminding attendees that the goal is 100. The goal was also to increase the amount of people who are aware of their HIV status. The current percentage of positive people aware of their status was 91%, but they needed to get the percentage to 95%. She noted that the national numbers differ from the local numbers.

C. Conyngham reviewed the pie chart on slide four, titled "PLWH Unaware of their HIV Status (n=1,958)." The largest group unaware of their status was MSM. Following this was youth, then heterosexuals, and then people who inject drugs (PWID). The numbers for youth included all risk groups. She explained that they need to have 650 diagnoses a year to reach 97% of people aware of their status by 2025. She said 87% of people are linked to care, meaning that 13% of individuals diagnosed with HIV are not linked to care. Unless this rate improves, in 5 years, there will be 436 diagnosed PLWH not linked to care.

C. Conyngham referred to the slide about PrEP coverage, noting that 50% of people with indications should be prescribed PrEP, yet they are currently well below 50% for PrEP coverage in Philadelphia.

She explained that the health department has reviewed their approach to providing care, noting that there needs to be changes. They need to use community input (community engagement) and local data. They are currently developing the City-wide EHE plan influenced by working with HIPC. This work included community listening sessions, population consultation, and town halls. They are currently on version 3.5 of the plan. She reminded everyone that the plan is constantly updated based on feedback from community engagement efforts.

C. Conyngham read the slide titles, "The EHE Plan and *NEW* Updates." Please refer to slide 10 for the updates on Pillar 1: Diagnose and Pillar 2: Prevent. She noted that Activities 1.2.1 and 3.1.1 were of the most focus. This involved centering health equity in their work and the addition of a full-time health equity specialist. They also put a field services program in place. In all, PDPH would fully accomplish the new updates by centering health equity, internal reorganization, their field services program, enhancing Health Center 1, and adding Commutations Lead.

C. Conyngham next reviewed the "Engagement in Community-based HIV Testing System" slide. Please refer to slide 15 for HIV testing data for 2018, 2019, and the future. She said that the data showed improvements in community engagement for testing from 2018 to 2019, but there was still room for better engagement—as is shown by the goals.

She explained that to focus on community engagement, PDPH needs to do the following: invest in strengthening relationships with communities and individuals; develop new partners and collaborators; take a whole person approach to sexual health and wellness; provide culturally relevant, affirming services; and provide easy-to-understand HIV information.

C. Conyngham directed attention to the Community Engagement inverted pyramid chart. Please refer to this chart on slide 15 for more information. She explained that PDPH needed to take an approach that was especially flexible. PDPH noted that flexibility in scheduling is especially

important to individuals. Therefore, they would promote at-home HIV testing kits. Regardless of the results from the at-home testing kit, the kit would either link the tester to primary care treatment or PrEP.

PDPH was also looking more into PDPH funded community-based HIV testing. One model leads with HIV testing as a traditional community-based model, linking people to care. It is community driven and does not have many other services available. The other model, the integrated sexual health model, has traditional HIV testing and linkage but also offers other STI services. C. Conyngham explained that the sexual health model is typically more effective. The PDPH was currently figuring out how to ensure that the PDPH funding is directed to diagnosing and linking key populations.

C. Conyngham noted that sexual health clinics have been a focus for other jurisdictions, especially NYC. She read the statistics for NYC sexual health clinics. 1 in 42 MSM attending NYC STD Clinics were diagnosed with HIV within a year, 1 in 20 MSM diagnosed with P&S Syphilis in NYC were diagnosed with HIV within a year, and 1 in 15 MSM (1 in 7 Black MSM) diagnosed w/ anorectal chlamydia/gonorrhea in NYC STD Clinics were diagnosed with HIV within a year.

She further explained that diagnosing people while discussing other sexual health concerns is most effective. This discovery was found within DExIS, a studying which identifies missed opportunities. DExIS found that most people with HIV also had other STIs.

Regarding sexual health hubs, C. Conyngham said that one-stop-shop models were most successful and need compassionate and culturally competent care.

C. Conyngham reviewed the slide "Changes to PDPH" regarding changes for Health Center 1. To further review these changes, please see slide 20. In all, she said that PDPH is hoping to scale up in Health Center 1.

C. Conyngham reviewed the slide "Changes to partner organizations" regarding changes for CBOs. To further review these changes, please see slide 21. She explained that the right column contains the proposal of a new CBO model for 2021-2025.

C. Conyngham explained that community feedback and data need to have equal parts in leading the EHE plan. They were also looking at ways to sustain engagement in the plan. Recipients of health department funds also need to forge relationships, creating inter-agency relationships. AACO would be creating a public-facing dashboard that would assess the performance of individual facilities to enforce performance-based contracting.

Due to all the new responsibilities and changes in workflow, C. Conyngham said there would be several changes for the workforce. These changes include: a constant review of the Ending the HIV Epidemic plan; a shift in duties and workflow to meet community needs; increased support for skills development, capacity building, and career advancement; equitable compensation for frontline prevention staff; and a shift in duties and workflow.

Clients, she explained, need to be treated as whole people beyond their HIV status. The goal was to meet people where they are at, have more services available/one-stop-shops, hold a status neutral approach, increase engagement, and actively practice compassion. C. Conyngham asked people to assess their own programs, focusing on collaboration, one-stop-shops, and making

connections. She asked everyone to look out for any upcoming health department funding announcements.

C. Steib noted that the presentation slides mentioned nPEP would be distributed to 100% of people seeking it. He asked if all ERs offered this. C. Conyngham said that AACO's impression is that most if not all ERs offer it, but delivery is not always equitable based on perceived risk. For example, people reporting sexual assault may receive it more often than PWID. C. Steib asked for a definition on health equity and status neutral. C. Conyngham responded that a status neutral care approach is the idea that regardless of HIV result, a client should still have next steps. For example, HIV positive individuals should be linked to care. For HIV negative individuals, health care providers should get them linked to PrEP and evaluate any other needs. Similar to those with a positive HIV result, providers should also schedule follow-ups with HIV negative individuals. Everyone should have a fair and just opportunity to healthcare that is suitable and appropriate for them.

C. Conyngham said she would send an infographic for status-neutral care to distribute.

J. Williams said he would now give an EHE update. They are currently on version 3.5 of the EHE plan and approaching the final document to be released to public. He emphasized that though there would be a "final" version, the document is a living document and will still change based on community feedback. He thanked the committee for their pillar by pillar/activity by activity feedback.

J. Williams noted the biggest change in the EHE plan: sexual health hubs. He said AACO is looking at organizations led by black and brown folks, undocumented folks, and LGBTQ folks. AACO had a maximum of $75,000 for capacity building in this area. The deadline for this would be October 1, 2020 and can be found on the RFP section of the Philadelphia webpage.

AACO was looking at system-wide structural changes geared towards ending the HIV epidemic. Funding may come from many different places but would all be working towards the same goal. J. Williams announced that the next EHE event would be about Latinx Communities and the EHE. It would be in English on September 30, 2020 and Spanish on October 1, 2020.

J. Williams announced that AACO was also welcoming new staff. They were welcoming D. Shaw, AACO CDC PS2-2010 Coordinator. They were to be in charge of coordinating EHE implantation efforts.

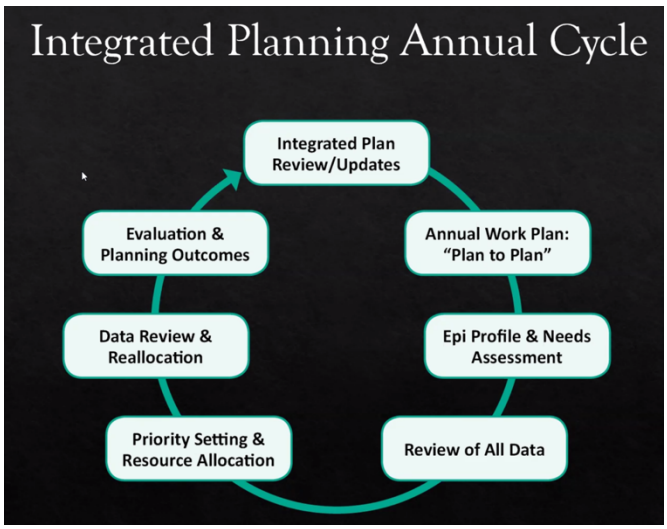
The AACO Virtual EHE Job Fair was on October 1, 2020. The time of the fair was TBD. He noted that the most beneficial people at the health department are those who come from the community/worked with community before government.

J. Williams reminded everyone that the EHE draft plan survey is on the OHP subdomain. They need more respondents and community input. Responses will help the PDPH understand priorities.

Discussion Items:

—Committee Structure/Focus—

M. Ross-Russell said they should discuss committee structure. This conversation is to ensure the committees reflect the work of the council, specifically the Integrated Planning Annual Cycle, seen here.



HIPC/other subcommittees and Prevention could discuss if they wanted to change structure. N. Johns read the description of prevention committee from the bylaws: (Article 1, Section 1) the Prevention Committee reviews, deliberates, investigates and makes recommendations on prevention activities that are relevant to or may be incorporated into the Integrated HIV Prevention and Care Plan and its updates, and any other activities as assigned by the Planning Council.

M. Ross-Russell noted that though the bylaw language was generic, they could keep the language in mind while discussing their role within the integrated body. She added that HIPC is currently in a position of moving towards ending the epidemic. This plan reflects the work of 30 years. What does this mean in relation to the Prevention Committee?

M. Ross Russell said there are two pillars in the EHE specific to Prevention: Diagnose and Prevent. The previous guidance for the Integrated Plan and the EHE plan would likely be melded together for guidance on the new Integrated Plan. Though this is not certain, she explained, the new plan will likely be influenced by EHE.

M. Ross-Russell asked the group to think about prevention-related activities on the prevention and care continuum. On the care continuum, there are three prevention related portions: diagnose, linkage, and reaching undetectability.

L. Matus asked if the committee was looking to update the bylaw paragraph. M. Ross-Russell said that this discussion could happen officially at the Executive Committee level, but subcommittee level feedback was needed. She said that bylaws are often generic and often do not need to be changed, though the committee can still consider a change. Ultimately, she said it was up to the committee to decide whether they wanted to change the bylaws, activities, name, etc.

C. Steib reminded everyone that the full council briefly discussed committee structure. He added that if they were to move into a new direction/subcommittee change, it would be to more equitably distribute the work of the council between committees.

N. Johns added that other jurisdictions have mostly moved away from the model that HIPC is using. Most other EMAs use a structure based on the planning cycle. M. Ross-Russell agreed and said that other EMAs use models consistent with developed plans, the planning cycle, itself, or the activities they carry out so they can split up the work evenly.

M. Ross Russell added that community members may want to be more involved in the council if they understand the structure. This may help interested community members to participate in specific committees to do certain, specific work.

N. Johns added that any special populations committees or other committees which could be added or modified could work on bits and pieces of the Annual Planning Cycle. If the council wanted to add any committees, she said they could all work off this cycle, contributing their part of the whole. How to structure and assign tasks to each committee is determined by the council. Committees could even be formed based on the Cycle, itself.

N. Johns put the Integrated Planning timeline on the screen. The plan is as follows: (2016) wrote the 5 year plan, (2018) updated plan with 2016 baseline data, (2020) monitor plan progress with 2017-2018 data, and (2021) next 5 year plan development. As they move forward, they are looking to do another update/monitoring of the plan because they have updated data. The expectation is that in 2021, they will have finished their 5-year plan. She said they can start planning for the integrated plan or wait until they have guidance.

G. Grannan said that it was worth considering what sort of voices each subcommittee represents. He said that Prevention Committee is the only forum in which populations that are at risk but not diagnosed as positive have input. He thought it was worth recognizing the importance of Prevention Committee and its preservation.

N. Johns agreed, mentioning that Positive Committee had discussed having more general meetings with community members for specific groups or populations. These could be informal gatherings and do not have to be official on the committee-level. This might be a way to ensure that populations/communities are involved. G. Grannan said that there is inevitable crossover between Prevention Committee and CPC, so it would be reasonable to review and streamline.

L. Matus asked about the Integrated Plan/EHE and how it may determine committee structure. M. Ross-Russell said this is up to the committee. However, moving forward there is a large focus on ending the epidemic. There are two prevention-related pillars and two care-related pillars in the EHE. Regarding the Integrated Plan, M. Ross-Russell explained that HRSA and CDC sent out a letter in June saying they put the Integrated Plan guidance on hold because of COVID-19.

C. Steib asked if they could get a presentation on other committee structures from other EMAs, explaining that other examples may offer some insight. M. Ross-Russell said she would look into this.

—Work Plan for 2020-2021—

N. Johns said that it was the time of year to sketch out their work plan. They could plan out what they want to do for the next few to several months, keeping in mind it can be a flexible schedule. N. Johns noted that Prevention has talked in the past about the legislation that Representative Sims brought forward regarding comprehensive sex education. This, she explained, is a longtime interest of this committee as well as an activity within the EHE and Integrated Plan. She explained that specific work is does not need to be immediately decided. The committee can suggest general topics to review. N. Johns said they may want to look at the bill being proposed, and how they can help or assess the bill.

N. Johns said the committee could also look into linkage and retention for people reentering the community post-incarceration. Due to COVID-19 and in general, this is a vulnerable time for people to acquire HIV or disengage from care. She noted that the committee should also find time to monitor the Integrated Plan. This can be added to the calendar when more data becomes available. Some of the data is readily available while other data may take time to gather.

N. Johns explained that the topics mentioned were "hanging" topics discussed in past meetings. N. Johns asked if there were any ideas of what could be involved in work plan. L. Matus asked for clarity between work plan and integrated plan, N. Johns said that the Integrated Plan is a written plan with CDC/HRSA guidance, but the work plan is not necessarily related and can lead to many different activities that the council or committee carries out.

J. Williams suggested discussing struggles in leadership. The Prevention Committee could consider activities to plan around leadership/a leadership pipeline. To elaborate, he said that HIV testers and counselors need to have influence on the work that gets done, but for this to be possible, there needs to be a leadership pipeline. They could also discuss more about mental health. He noted that when the Integrated Plan guidance arrives, they could also discuss gaps within the EHE that HIPC can fill with the Integrated Plan.

G. Grannan liked the idea of workforce development as a topic. If they are going to undertake this topic, he said it was important to focus on how this is an organizational and systemic issue with whole providers/facilities. He warned against simply looking on the organizational level. He said it was important not to lose sight of the fact that frontline workers are not the sole problem and it reflects larger, structural issues.

N. Johns said that the council is system-focused and cannot dictate anything on the organizational level. However, it is in their purview to ensure services are equitable, high quality, and not promoting stigma. Therefore, they could put forward best practices, recommendations about internal practices, training, etc. She suggested that the committee discuss how the customer service problems may be barriers. N. Johns said this topic has been discussed before, and they have a lot of information to support the conversation. N. Johns noted that the topic also came up at the allocations meetings.

M. Ross-Russell said that this topic revisits a conversation in a larger HIPC meeting. This specifically deals with a paradigm shift to move away from a provider-centered environment to client-centered environment. She mentioned that AACO was looking at ways to make services meaningful to the client instead of blaming the client or expecting the client to meet unreasonable expectations. She noted that this is a better model for how they look at services, train workers, and serve populations. Hopefully this would reduce barriers from a system perspective and help frontline staff to do their jobs more effectively.

G. Grannan, C. Steib, and L. Matus said they should look at leadership and workforce development in the next month. N. Johns put this on the calendar for October 2020. She added Integrated Plan Monitoring to the October calendar as well. N. Johns asked the committee is the discussion for leadership should occur over two months. G. Grannan and L. Matus said two months would be best. N. Johns listed leadership/workforce development and Integrated Plan Monitoring for November 2020 as well. M. Ross-Russell reminded the committee of C. Steib's suggestion to look at other EMA committee structures. N. Johns suggested presenting this to the full council and then bringing it to Prevention Committee's October meeting. The group agreed.

L. Matus said that in January 2021, they should revisit EHE. M. Ross-Russell said EHE would likely be an implementation by January and the city would probably do something around the EHE plan for World AIDS Day. L. Matus said that they would also have a better idea about the funding streams, so they could look at new HRSA funding for Prevention in January as well. M. Ross-Russell said that a possible change in federal administration may also impact what they are doing. She added that COVID-19 may also have lingering effects or have become more apparent by that point. L. Matus suggested adding COVID-19 to Work Plan for January 2020.

N. Johns noted that CPC was working on needs of elders and psychosocial support/mental health in the fall. She suggested the two committees see how they can divvy up the mental health work. M. Ross-Russell mentioned how there are topics around elders relating to prevention. There is often misleading information about how elders do not need to worry about prevention, but this is not true.

C. Steib said that if there is a crossover with topics, the two committees (CPC and Prevention) could merge to have one meeting. This way, they could also test the waters to see what a structural change may look like. N. Johns said that the COVID-19 discussion in January may be a great opportunity for the crossover.

Old Business:

L. Matus asked for clarification on the next Prevention Committee dates. N. Johns said they are not set yet, but they are historically the fourth Wednesday. She added that every Nov/Dec is usually combined into one meeting and moved toward beginning of December. As of now, it would be the 28th for October, but the Nov/Dec meeting was up for discussion. L. Matus said that they could try the 18th for November at 2:30 p.m. Everyone agreed.

L. Matus asked if they should look into January. N. Johns said that January 27th would be the fourth Wednesday, but they can change it if need be. G. Grannan said they should not plan the January meeting date until they could collaborate with CPC about it.

N. Johns said she could put a tentative CPC and Prevention date on the calendar and have the committees discuss the date when it is closer. G. Grannan said they may also want to move the CPC meeting in January back a week, so they would discuss this further in CPC. N. Johns said they could revisit this in November.

M. Ross-Russell reported that HIPC is about to enter the nominations process of review of applications. There are two pieces to this: (1) if a member wishes to continue and their membership is up, they must go online and complete application, and (2) if there is anyone who is good or appropriate for Planning Body, have them apply. They were especially in search of young black and brown MSM as members. She asked that members send anyone interest the link to the application. She added that HIPC is also an excellent opportunity for frontline staff to they be trained for leadership and enhance their skills. N. Johns added that more HIV+ applicants is also needed since there are legislative requirements and HIPC goals for membership.

New Business:

None.

Announcements:

None.

Adjournment: C. Steib called for a motion to adjourn. **Motion:** D. Gana motioned, G. Grannan seconded to adjourn the September 23, 2020 Prevention Committee meeting. **Motion passed:** The meeting was adjourned by general consent at 4:26 p.m.

Respectfully Submitted,

Sofia M. Moletteri, staff

Handouts distributed at the meeting:

- September 2020 Prevention Committee Agenda
- February 2020 Prevention Committee Minutes