Meeting Agenda

VIRTUAL:
Wednesday, February 24, 2021
2:30 p.m. – 4:30 p.m.

- Call to Order
- Welcome/Introductions
- Approval of Agenda
- Approval of Minutes *(January 27, 2020)*
- Report of Co-Chairs
- Report of Staff
- Discussion Items
    - Recommendations based on DExIS, EHE, and NHAS
- Other Business
- Announcements
- Adjournment

Please contact the office at least 5 days in advance if you require special assistance.

The next Finance Committee meeting is
VIRTUAL: February 25, 2021 from **2:30 – 4:30 p.m.**
Office of HIV Planning, 340 N. 12TH Street, Suite 320, Philadelphia, PA 19107
(215) 574-6760 • FAX (215) 574-6761 • www.hivphilly.org

Prevention Committee

HIV Integrated Planning Council
Prevention Committee
Wednesday, January 27, 2021
2:30 PM – 4:30 PM
Office of HIV Planning 340 N. 12th Street, Suite 320, Philadelphia, PA 19107

Present: Keith Carter, Mark Coleman, David Gana, Gus Grannan, Kailah King-Collins, Lorett Matus, Erica Rand, Clint Steib

Guests: Akash Desai, Blake Rowley, Adam Williams, Javontae Williams (AACO)

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

Call to Order: L. Matus called the meeting to order at 2:31 p.m.

Welcome/Introductions: Everyone introduced themselves and answered the question: "What are you looking forward to in 2021?"

Approval of Agenda:

C. Steib called for a motion to approve the January 27, 2021 agenda distributed via email. **Motion:** K. Carter motioned, D. Gana seconded to approve the January 2021 agenda. **Motion passed:** 70% in favor, 30% abstaining. The January 2021 Prevention Committee agenda was approved.

Approval of Minutes *(October 28, 2020):*

L. Matus called for a motion to approve the October 2020 meeting minutes. **Motion:** K. Carter motioned, G. Grannan seconded to approve the October 2020 minutes. **Motion passed:** 80% in favor, 20% abstaining. The October 2020 Prevention Committee minutes were approved.

Report of Co-Chairs:

No report.

Report of Staff:

M. Ross-Russell reported that the National HIV/AIDS Strategy for 2021-2025 was released. The plan has been sent out to all HIPC members. The plan is aligned with the EHE plan, and she strongly recommended that HIPC members review and read the plan. The committee would be reviewing the plan in the near future.

L. Matus thanked J. Williams and the other participants at AACO for their work on EHE. J. Williams reported that D. Shaw was now leading the implementation of the plan. They also had a new EHE advisor, A. Thomas Ferraioli. The committee and Council should be able to talk to them in the near future.

Discussion Items:

—DExIS—

N. Johns said that within the email, there are slides from A. Desai's presentation as well as the meeting notes from the HIPC DExIS presentation. S, Moletteri also created a worksheet to help guide the DExIS conversation if needed which was also sent via email.

M. Ross-Russell explained that, because DExIS focuses on missed opportunities for individuals newly diagnosed, this would be an excellent discussion for the Prevention Committee so they could review the information and dig into the details. N. Johns brought up the questions from the worksheet developed to kickstart the conversation on DExIS findings. She suggested that the DExIS results could be discussed in comparison to what the Prevention Committee already knew about community experience.

K. Carter felt that the biggest missed opportunity was when a patient tested positive for an STI but did not receive an HIV test. He asked why providers were not doing more HIV testing at these sites. C. Steib suggested more educational training for providers. He said that all general practitioners throughout the city may not understand the process of HIV testing. He added that some providers may not want to deal with HIV testing or the possibility of a positive result. The City of Philadelphia and health departments had means to train/educate staff around HIV testing. He suggested that there be a statement from the health department that could be sent to providers about HIV testing and encouraging more frequent testing. This could be done through medical schools or licensures.

A. Desai agreed with C. Steib. He said that those on the DExIS team wanted to explore the connection between STI and HIV testing. They are trying to release a health alert/update to providers. This would be from PDPH official health portal for best practices around STI testing and linkage to care for either PrEP or ART. They also wanted to do more looking into targeted and in-person education. It may be effective to look into providers that had higher STI tests and lower HIV tests. A complication, however, was finding a way in which providers would be open to further education and training. This could be done through the office manager of a practice or offering providers continuing education credit. They also had to look into which providers should be prioritized. FQHCs would be an option, and then they could then talk to individuals within organizations to fine tune approaches for each providers.

K. Carter said they could target upper management to make policy implementations within the provider organizations. He said that AACO had many providers and facilities relying on them, so reaching organizations through AACO was a strong possibility. New infection rates had gone down over 10 years, he explained, but missed opportunities outlined in DExIS stop it from going down further. K. Carter also acknowledged that providers make incorrect assumptions about clients' sexual behavior.

G. Grannan said that they should not look at testing decisions as solely a provision problem – they needed to also acknowledge stigma against criminalized populations. For those who did not want to take an STI test, it needed to be understood that such a decision had a rational basis in that person's life. If they were to look further into criminalized populations, they need to consider possible criminal charges for transmitting HIV and what might motivate or discourage criminalized populations.

J. Williams agreed that this was an important conversation and that they needed to expand their idea of prevention. He asked how testing fit into a larger scheme of prevention. They have to consider people who do not get tested and what other prevention methods were important. A. Williams added that there

was enormous infrastructure in the city that was going to have contact with the community members due to vaccine distribution. He said that this was an opportunity to at least make an offer to integrate HIV services/education with the vaccine rollout. Since those distributing the vaccine need to sit with patients for 15 minutes (to gauge if there would be an allergic reaction), this might be an ideal time to inform people about PrEP. A. Williams said that increased review of clients' comprehensive sexual history was also important, and providers needed to be more aware of this.

G. Grannan said there were many issues with the COVID-19 distribution, and some people were rumored to have their health information sold from one of the locations distributing vaccines. Therefore, many people, especially criminalized populations, would likely not feel comfortable talking to providers. A. Williams agreed, but he felt that there were other places offering vaccines, so they could still look into this. He added that because of COVID-19, many other issues have been swept aside, HIV prevention included. Part of the conversation, A. Williams suggested, should involve the history of medical malpractice especially within communities of color. He explained that remaining silent for those issues only added to the problem and medical mistrust.

B. Rowley said Gilead had a number of resources which spoke directly to comprehensive sexual history and cultural humility training (mistrust/distrust from communities who have been harmed or have had barriers within the medical field). They also had resources for providers to help them think about their systems and how they could develop more comprehensive systems to get people into care and enact prevention methods early on.

C. Steib asked B. Rowley if Gilead had representatives not specific to HIV that could still promote or distribute information around HIV, Hep C, and sexual history with pharmacies. B. Rowley said that in terms of Gilead's drug representatives, they were supposed to only speak about specific products. However, he suggested that he and C. Steib talk personally. He could get in touch with Hep C representative, asking them to drop off information to certain places that needed it.

C. Steib said that some practices were not interested in HIV testing because they were afraid to receive a positive HIV result. Providers may not know how to handle a positive HIV result for a number of reasons. A. Desai said that this conversation often came up in DExIS. They needed to figure out how to shift the conversation so sexual health was prioritized. Was there a way to bring in facilities that had best practices to help other facilities? This could be done through higher management of one organization speaking to higher management of another. He explained that encouraging a cultural shift underpinned many of their conversations.

L. Matus said that with COVID-19 testing occurring, it would be interesting to see if there was a shift wherein HIV testers collaborated with COVID-19 testing and vaccine sites. In some states, however, she noted that COVID-19 testing was down because people wanted a vaccine.

C. Steib returned to G. Grannan's point around criminality. He asked if, in the past, HIPC or Prevention Committee had someone from the AIDS Law project to present and offer a fuller understanding around the laws regarding HIV transmission. He asked if there was any work being done to change the laws. M. Ross-Russell said that AIDS Law presented before COVID-19 in the fall of 2019, so they could follow up with them to see what additional information they could provide. She added that there was discussion within NHAS around criminalization and impact on process/populations.

K. Carter looked at the second theme of DExIS: *Relationships with healthcare providers matter; people often experience being dismissed or judged in healthcare interactions*. He said that this was a big issue and may cause clients not to return. He suggested they look more into how providers were respecting their

clients and how they could do better. Respect, he explained, starts at the door of the practice with the customer service. B. Rowley added that this extended to general medical mistrust and responding to a client accordingly. He said it was important for clients to say who they are before providers push a lens upon them. This required people to be trained in understanding their own biases first, and digging into how their personal lens affects how they see someone else. K. Carter agreed and said that people are not broken, the system is broken. J. Williams agreed and said he heard this from C. Terrell. He explained that the system of fragmented healthcare had come to light during the COVID-19 crisis.

J. Williams mentioned that outreach depending on COVID-19 vaccines may be complicated, since vaccines were not always reaching communities of color. Therefore, such outreach would miss whole communities. The question, then, what could they do to recommend policy changes and communication that would impact stigma, including testing. What could the Planning Council advocate for?

M. Coleman added that there were large disparities within Black communities in the City of Philadelphia to technological access. He explained that there were large numbers of seniors facing issues with the digital divide. This, he said, added to health disparities.

G. Grannan said that in light of medical interaction, stigma was very prominent at pharmacies when receiving HIV medications. When addressing stigma, they should be as thorough as possible by also going for ASOs, Health Departments, and other locations that would have to deal with the issue once or twice a month. To further explain, he said there was a large number of people using PrEP or HIV positive who interact with these locations. He suggested that they look into every place people may be confronted with stigma.

K. Carter said they should start to look at their Integrated Plan as a helpful starting point. They could also look at pillars from EHE. A. Desai said that DExIS was meant to fit into Pillar 4: Respond (though Pillar 1: Diagnose was also influential). They looked at individuals with acute HIV and groups of related transmission clusters. The way DExIS was envisioned, he explained, was to respond to outbreaks but also prevent them. J. Williams said all activities in Pillar 3: Prevent would be essential for guiding Prevention Committee's work. He mentioned the extra pillar added to Philadelphia's EHE plan, Pillar Zero. This pillar focused on access to services, housing, stigma, communication, cultural competency, etc, PrEP, better access to testing, education, and PEP were included in the Pillar 3 activities.

C. Steib said that long-term injectables for HIV medications may change how services operated, so this was a factor to consider moving forward. Under the prevention umbrella and Pillar 3: Prevent, reaching out to behavioral health locations, pharmacies, universities, and schools may prove helpful. They could find ways to reach these places to provide education and training.

M. Ross-Russell suggested they move to question number 3 on the worksheet to discuss how the key themes could be enacted to make positive change within the RWHAP system. She said that A. Desai mentioned that within the DExIS findings, there were certain instances where people wanted PrEP and were told no. A. Desai said that was correct, and clients asked for PrEP and the provider refused on multiple occasions. They received this information from medical charts. Regarding why the providers refused, they were concerned about the number of labs to be completed before they began PrEP. The provider did not comply with standard practices of care, so it is possible that they could create a grievance line. M. Ross-Russell suggested they come up with a recommendation on how to move forward in such instances of PrEP refusal. If they were focusing on ending the epidemic, it was necessary to minimize such occurrences. Providers funded under RWHAP needed to comply because of AACO's contract monitoring. Providers who were not funded would not be as easily reached, but they could still somehow offer recommendations.

C. Steib said that there were certain patient-centered medical homes. He said that in one home, they had a list of new implementations that included diversity and inclusion. These designations required that the entire staff undergo training. He suggested looking further into this. C. Steib also suggested health alerts around barriers that could be sent to RWHAP providers. They could consider using surveys to find out where the gaps were and honing in on them. Such health alerts could support/remind RWHAP providers about DExIS key themes.

A. Desai said that, regarding individuals dismissed when asking for PrEP, they could develop a consumer education kit. There was a consumer education kit in NY which outlined consumer rights and needs. Once clients were aware of their rights, AACO could circle back to providers and train them intensively.

M. Ross-Russell asked if it was possible to include consumer information on PDPH's PrEP page. A. Desai said that they could put it on Philly Keep on Loving. They could also make sure CSU staff is trained on this toolkit so they can help them.

K. Carter asked if the doctor had to justify why they were not offering PrEP and if there was any follow-up. C. Steib said that providers needed to be held accountable. K. Carter added that clients have to be reminded that they could change their doctor if they were not receiving proper care. He noted that people also needed to file more grievances. A. Desai said that if the doctor was refusing to offer PrEP, that needed to be documented, possibly in EMR.

N. Johns read the fourth question on the worksheet. She asked if there were other thoughts on stigma other than what had already been voiced. J. Williams mentioned that CPC was helpful with the conversation around housing, which made its way into the EHE plan, especially within Pillar 2: Treat. In the same vein, the committee could look at EHE's Pillar Zero strategies on stigma and to brainstorm specific recommendations for the planning cycle. He said that EHE was the launchpad for a broader EMA-wide initiative for the Integrated Plan.

For this body, J. Williams asked if they came up with specific scenarios where people experienced stigma and if they thought of ways to combat them. For example, if they identified an area of stigma, what would be their recommendation for providers? If someone was not being prescribed PrEP, what would they recommend so that the Health Department could intervene? Once they distilled recommendations, they could create actionable work. M. Coleman said that in terms of inclusiveness, he felt that prejudices and biases needed to stop to get over gaps in care.

A. Desai agreed, adding that bringing in a high level perspective was essential to drive the conversation. DExIS was looking to come up with specific recommendations. HIPC could also look into those as well, especially the third key theme. He felt that many providers did not properly discuss risk, so clients may not find PrEP useful.

A. Desai said that when discussing risk, they needed to focus on not enforcing stigma. He suggested the use of certain language while abandoning harmful language. He said that once DExIS developed those materials, HIPC could look them over and minimize use of harmful language.

B. Rowley asked why people could not walk home with PrEP at the same day. K. Carter seconded this, especially since they were trying to distribute ART more quickly. J. Williams said that this was a possibility, but HIPC needed to figure out recommendations to enact such policy changes. If they wanted to make a same-date start for PrEP, HIPC needed to advocate for that and communicate to the prevention team at AACO.

A. Desai said it was a matter of the Planning Body leveraging the tools and information they had. K. Carter asked if they could have a PrEP on demand townhall for providers and consumers. This could make people more aware of the practice. He suggested B. Rowley give a presentation on what Gilead was offering. B. Rowley said this was possible and that HIPC needed to figure out if they were interested. He said that the tools were ready and available to offer PrEP on demand. He added that PrEP on demand had worked in other locations, and enacting such change in Philadelphia would take collaboration.

M. Ross-Russell reiterated that the focus was now on HIPC and Prevention Committee to think in terms of what was said to make recommendations/directives to the recipient. In the allocations process, much of the work began within directives. She said that several of Prevention Committee's discussion topics today could be rephrased into directives.

A. Desai suggested that any recommendations through the Planning Council could be proposed in discussion can be given to the Policy Implementation Team (PIT) at DExIS as well. Once these recommendations came through HIPC, the DExIS team could fold them into the discussions. This could work as a way to disseminate these conversations through the system to people who had power to make changes and could benefit from the conversations.

A. Desai asked if it was possible for the Planning Council to make a recommendation for same-day PrEP. M. Ross-Russell said that she would have to find out if this was possible. The reason for this was that RWHAP Part A did not pay for PrEP. Therefore, it was likely that they could make the recommendation, but they could not put money towards it. J. Williams said that the community needed to work on leveraging Ready Set PrEP, especially since PrEP money had already been given to health facilities and clinics. Therefore, recommendations could be made and tied back to what providers had already agreed to do. Given everything, M. Ross-Russell said HIPC could likely make recommendations as opposed to directives.

B. Rowley noted that Gilead still provided PrEP for free for those who are uninsured, underinsured, or uninsurable. C. Steib mentioned that when people have issues with paying for labs, agencies often eat the costs until the client is insured. This sometimes became an issue.

—Situational Analysis & Pillar Zero—

N. Johns said that the last time they looked at the EHE plan as a committee, the Guiding Principles and Pillar Zero were not yet included. N. Johns read the guiding principles for the EHE plan (page 20) and the four parts of Pillar Zero (page 21).

L. Matus asked for clarifications about next steps for the February 2021 Prevention Committee meeting. She suggested that they look to make recommendations. M. Ross-Russell said that for next steps, they could review materials such as EHE, DExIS, and NHAS to inform the recommendations. They could specifically look at the situational analysis, their current discussion, potential discussion items/recommendations/etc., so they could enhance the discussion and ensure it was based in facts, data, materials, etc.

Old Business:

None.

New Business:

J. Williams said he was now Senior Coordinator for HIV Prevention Services and was working with B. Hernandez (coordinating the HIV Self-Testing Program through Philly Keep on Loving) and D. Shaw, (PS2010 Coordinator, specifically the EHE Coordinator for Implementation). He also worked with A. Alex who focused on the Outbreak Response Plan. He explained that they were the prevention staff at AACO, so they would be happy to participate in Prevention Committee meetings. As HIPC and Prevention Committee drafted specific policy or practice standards, he said that the AACO prevention team would love to give input and offer advice. Attendees congratulated J. Williams.

M. Ross-Russell thanked both J. Williams and A. Desai for the meaningful discussion today.

Announcements:

None.

Adjournment: C. Steib called for a motion to adjourn. **Motion:** K. Carter motioned, G. Grannan seconded to adjourn the January 27, 2021 Prevention Committee meeting. **Motion passed:** The meeting was adjourned by general consent at 4:23 p.m.

Respectfully Submitted,

Sofia M. Moletteri, staff

Handouts distributed at the meeting:

- January 2021 Prevention Committee Meeting Agenda
- October 2020 Prevention Committee Meeting Minutes
- DExIS Feedback Worksheet
- DExIS Minutes from December 10, 2020 HIPC Meeting
- DExIS PowerPoint Presentation from A. Desai

2021-2025 National Strategic Plan: Feedback Worksheet
Prevention Committee
Wednesday, February 24, 2021

This conversation will focus on Goal 3 of the National Strategic Plan, outlined as follows:

Goal 3: Reduce HIV-Related Disparities and Health Inequities

3.1 Reduce HIV-related stigma and discrimination

3.1.1 Strengthen enforcement of civil rights laws (including language access services and disability rights), reform state HIV criminalization laws, and assist states in protecting people with HIV from violence, retaliation, and discrimination associated with HIV status, homophobia, transphobia, xenophobia, racism, and sexism.

3.1.2 Ensure that health care professionals and front-line staff complete education and training on stigma, discrimination, and unrecognized bias toward populations with or at risk for HIV.

3.1.3 Support communities in efforts to address misconceptions and reduce HIV-related stigma and other stigmas that negatively affect HIV outcomes.

3.2 Reduce disparities in new HIV infections, in knowledge of status, and along the HIV care continuum

3.2.1 Increase awareness of HIV-related disparities through data collection, analysis, and dissemination of findings.

3.2.2 Develop new and scale up effective, evidence-based or evidence-informed interventions to improve health outcomes among priority populations and other populations or geographic areas experiencing disparities.

3.3 Engage, employ, and provide public leadership opportunities at all levels for people with or at risk for HIV

3.3.1 Create and promote public leadership opportunities for people with or at risk for HIV.

3.3.2 Work with communities to reframe HIV services and HIV-related messaging so they do not stigmatize people or behaviors.

3.4 Address social determinants of health and co-occurring conditions that exacerbate HIV-related disparities

3.4.1 Develop whole-person systems of care that address co-occurring conditions for people with or at risk for HIV.

3.4.2 Adopt policies that reduce cost, payment, and coverage barriers to improve the delivery and receipt of services for people with or at risk for HIV.

3.4.3 Improve screening and linkage to services for people with or at risk for HIV who are diagnosed with and/or are receiving services for co-occurring conditions.

3.4.4 Develop and implement effective, evidence-based, or evidence-informed interventions that address social and structural determinants of health among people with or at risk for HIV including lack of continuous health care coverage, HIV-related stigma and discrimination in

public health and health care systems, medical mistrust, inadequate housing and transportation, food insecurity, unemployment, low health literacy, and involvement with the justice system.

3.4.5 Develop new and scale up effective, evidence-based or evidence-informed interventions to improve health outcomes and quality of life for people across the lifespan including youth and people over age 50 with or at risk for HIV, and long-term survivors.

3.4.6 Develop new and scale up effective, evidence-based or evidence-informed interventions that address intersecting factors of HIV, trauma and violence, and gender especially among cis- and transgender women and gay and bisexual men.

1. Which of the listed objectives feel most pertinent to the Prevention Committee?

2. How can RWHAP be leveraged to support these goals?

3. Which goals could we address quickly? Which are longer-term?

What recommendations do you have based on the January Prevention Committee conversation around DExIS?

Resources to help with recommendations:

- From the EHE Plan, **Pillar 3: Prevent** and **Pillar Zero.** Pillar Zero involves access to services, housing, stigma, communication, cultural competency, etc. Pillar 3: Prevent addresses PrEP, better access to testing, education, and PEP activities.
- From the National HIV/AIDS Strategic (NHAS) Plan, **Goal 1: Prevent New HIV Infections** which focuses on PrEP, PEP, testing and linkage to care, etc., and **Goal 3: Reduce HIV-Related Disparities and Health Inequities**, which focuses on stigma, racial justice, inclusion of community voices, social determinants of health, etc.

Please provide recommendations for each "barrier to prevention" using the resources provided above (EHE and NHAS), as well as the Prevention Committee suggestions:

Numbers 1-6 are from topics discussed in the January Prevention Committee meeting. Each topic contains already-mentioned suggestions or resources from this meeting. You can refer to the January 2021 Prevention Committee meeting minutes for more details on each topic.

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1. No HIV testing once testing positive for an STI.

-Suggestions mentioned in January meeting:

-A statement from the Health Department for providers to discuss and encourage more frequent HIV testing.
-Coordination with COVID-19 testing.

-**Resources mentioned in January meeting:**

-FQHCs
-AACO's CSU
-Best practices that prioritize sexual health
-COVID-19 testers and vaccine distributers

Based on January Prevention Materials, EHE, and NHAS, what would you officially recommend for Prevention Barrier #1?

2. Refusal to administer PrEP on the provider level.

-Suggestions mentioned in January meeting:

-Same-day PrEP administration (recommendation/directives possible, but HIPC could not guide this on a funding level)
-Trainings for providers
-Have clients file more grievances
-PrEP On-Demand Town Hall
-Consumer Education Kit

-Resources mentioned in January meeting:

-New York's consumer education kit
-PrEP On Demand Town Hall

Based on January Prevention Materials, EHE, and NHAS, what would you officially recommend for Prevention Barrier #2?

3. HIV testing within criminalized populations

-Resources mentioned in January meeting:

-AIDS Law Project (for HIPC/committee presentation)

Based on January Prevention Materials, EHE, and NHAS, what would you officially recommend for Prevention Barrier #3?

4. Community distrust with providers & a look at stigma

-Suggestions mentioned in January meeting:

-Pharmacies as a place to combat stigma

-Resources mentioned in January meeting:

-Gilead's cultural humility training

-For the future: Prevention Committee could review the DExIS materials for recommended and harmful language to combat stigma (not yet available).

Based on January Prevention Materials, EHE, and NHAS, what would you officially recommend for Prevention Barrier #4?

5. Lack of education from providers/fear of dealing with HIV+ results

-Suggestions mentioned in January meeting:

-Targeting upper Management within provider organizations

-Resources mentioned in January meeting:

-Best Practices that prioritize sexual health

Based on January Prevention Materials, EHE, and NHAS, what would you officially recommend for Prevention Barrier #5?

6. The Digital Divide preventing access to care

Based on EHE and NHAS, what would you officially recommend for Prevention Barrier #6?