Meeting Agenda

VIRTUAL:
Wednesday, May 26, 2021
2:30 p.m. – 4:30 p.m.

- Call to Order
- Welcome/Introductions
- Approval of Agenda
- Approval of Minutes *(February 24, 2021)*
- Report of Co-Chairs
- Report of Staff
- Action Item
  - Recommendations from February 2021
- Discussion Item
  - NHAS Goal 3: Objective 4
- Other Business
  - June 2021 Meeting
- Announcements
- Adjournment

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

The next Finance Committee meeting is
VIRTUAL: TBD
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, February 24, 2021
2:30 PM – 4:30 PM
Office of HIV Planning 340 N. 12th Street, Suite 320, Philadelphia, PA 19107

Present: Keith Carter, David Gana, Gus Grannan, Lorett Matus (Co-Chair), Clint Steib (Co-Chair), Evan Thornburg

Guests: Asha Alex (AACO), Brian Hernandez (AACO), Drexel Shaw (AACO), Anna Thomas-Ferraioli, Adam Williams, Javontae Williams (AACO)

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

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

Welcome/Introductions: C. Steib introduced himself and asked everyone to introduce themselves and their area of representation. J. Williams said that he was not able to stay for the whole meeting, but he invited AACO prevention staff to the meeting today.

Approval of Agenda:

C. Steib called for a motion to approve the February 24, 2021 agenda distributed via email. **Motion:** G. Grannan motioned, D. Gana seconded to approve the February 2021 agenda. **Motion passed:** 75% in favor, 25% abstaining. The February 2021 Prevention Committee agenda was approved.

Approval of Minutes *(January 27, 2020):*

C. Steib called for a motion to approve the January 2021 meeting minutes. **Motion:** G. Grannan motioned, K. Carter seconded to approve the January 2021 minutes. **Motion passed:** 63% in favor, 37% abstaining. The January 2021 Prevention Committee minutes were approved.

Report of Co-Chairs:

L. Matus reported that there was a notice from Prevent HIV on new information verifying PrEP as a preventative service. This notice also offered a link for the special enrollment period. She explained that Dr. K. Brady also distributed an email that informed everyone of PDPH's decision to update COVID-19 vaccine guidelines to include PLWHA in Phase 1B distribution.

Report of Staff:

M. Ross-Russell reported that today's meeting would be N. Johns's last. Her last day with OHP was March 3, 2021, and she had taken a new position at Merck. N. Johns said that she would also be attending the Executive Committee meeting before her departure. Additionally, she announced that those who had registered for HIPC and committee meetings in advance may have received a cancelation notice. However, this was not the case, and OHP was simply switching over Zoom responsibilities, so individuals should ignore the cancelation and wait for the new meeting links. L. Matus and C. Steib wished N. Johns luck with her new position.

S. Moletteri reported that there was a "Member Resources" tab available on the HIVPhilly website. If people ever had questions about meeting processes, acronyms, bylaws, etc., this portion of the website would be very helpful.

Discussion Items:

—Recommendations based on DExIS, EHE, and NHAS—

N. Johns screenshared the worksheets OHP provided in the February 2021 Prevention Committee meeting packet. These worksheets included last month's discussion around DExIS and items from the newer NHAS (National HIV/AIDS Strategy) plan.

J. Henrikson said that they would first look at the NHAS goals and how they related to Prevention Committee's work. She noted that both Goal 3 and Goal 1 were pertinent to Prevention Committee.

J. Henrikson brought up the Goal 3: Reduce HIV-Related Disparities and Health Inequities summary. Please refer to the "2021-2025 National Strategic Plan: Feedback Worksheet" for a summary of Goal 3. L. Matus suggested giving committee members a few minutes to review the summary. J. Henrikson mentioned that S. Moletteri also linked the NHAS plan in the meeting reminder email. She read the first question for Goal 3 on the worksheet: Which of the listed objectives feel most pertinent to the Prevention Committee?

K. Carter suggested the committee focus their scope to brainstorm impactful change. He explained that there was little they could do legally, but they could work with organizations like AIDS Law Project. As for Activity 3.1.2, he suggested creating measurable goals to give direction/recommendations to AACO to educate providers on stigma and bias. G. Grannan agreed, mentioning that health care professionals and front line staff needed to be receptive to the training. Receptiveness of training would indicate how effective such actions would be. K. Carter agreed, and suggested that receiving RWHAP dollars should be contingent on whether staff participates and completes their trainings. G. Grannan said that even during trainings, clinical staff may break off out of disinterest. C. Steib agreed that receiving funds could be contingent on completion of trainings. He suggested they ask AACO if trainings could be done on a yearly basis and for any new staff.

J. Williams said that sometimes training was ineffective if providers had willful bias. Conversations around training were occurring nationally, especially around racial justice. In recent RFPs, included in providers' contracts was the commitment to participate in ongoing trainings. These trainings were for all of staff, not just frontline staff. The plan was to work closely with organizations to build capacity, creating affirming services. This would be something AACO could address and put in contracts if HIPC suggested.

A. Williams said that there were organizations that may be well-intentioned and interested in improving capacity. When it comes to data collection and EMR (Electronic Medical Record), provider infrastructure may be insufficient, so implementation of policy could be difficult due to lack of proper infrastructure/technology. He suggested they look into barriers involving this topic. J. Williams responded that AACO looked into this previously and heard it was difficult to change the structure of EMR. There was notable resistance from providers to change their workflow, especially in bigger organizations.

J. Williams explained that it was important to look into sexual history taking so that providers were cued to ask certain questions. This would ensure that specific populations, such as Black MSM, could be asked about HIV, given a test, offered PrEP, etc. Then, if provider organizations applied for grant money,

AACO could offer it with the contingency that their EMR allowed for the proper treatment and appropriately cued questions. J. Williams responded that COVID-19 had proven that providers were able to change their structures and systems. M. Ross-Russell asked if it was beneficial for HIPC to provide directives specifically related to what was discussed. J. Williams said yes, it was especially helpful when communicating with PDPH leadership and other upper management, since HIPC provided leverage and their recommendations carried weight. The recommendations acted as ammunition for change. K. Carter asked if they should rephrase their conversation into a directive. J. Williams said yes. He added that all of HIPC's notes from EHE workshopping were sent to the CDC and used as community backing. The council was essential for providing community perspective and identifying needs and gaps in services.

M. Ross-Russell asked how many sole prevention providers were in the system and if most were "one-stop shops" funded for both Ryan White and prevention. J. Williams said that this answer was in flux, and once RFPs closed for Sexual Health Hubs, he would be able to offer HIPC more information. He added that, most often, people were receiving tests where they could also receive treatment. K. Carter said that this went beyond Health Center 1. J. Williams agreed, explaining that the goal was to create more Health Center 1s and to create more population-specific locations.

M. Ross-Russell said that while everything was in flux, there was still Health Center 1 receiving RWHAP money. Because HIPC had legislative mandates related to RWHAP money, provider organizations were most effective if they received both RW and prevention funds. A. Williams said priority clinics already had existing infrastructure that could easily roll this out, at least within Health Centers 1, 6, and 3. He asked why Health Center 1 was the designated STI clinic. K. Carter said that this was just an example.

G. Grannan asked who drove the structure of EMRs. He asked if there were requirements from the companies selling the software/insurers and if health centers could offer input on the data. C. Steib said that institutions typically had EMR systems in place. Within his organization, they changed their EMR system three times—it was a large undertaking, but this came directly from the top-down and depended on the institution. He suggested they administer EMR surveys for RWHAP providers, noting that some providers were better at capturing diversity. In the past, he noted that older EMR systems would not allow any preference for names/pronouns since they copied drivers' licenses. Their new EMR system was much more advanced and catered to people's names and preferred pronouns. G. Grannan felt that this would be important to look into.

K. Carter asked if there were standardized reports that could run from EMR system data. C. Steib said yes, and they had to do monthly reports for their funder with all their different departments and tests. K. Carter asked more about this process. C. Steib said he sent aggregate data to AACO and that they would also compile quarterly reports with narratives. With the structure of the EMR system, it was mildly different and did not include "notes" in the data pulling, so they needed assistance from their IT department.

L. Matus suggested that they have the providers dealing with PrEP meet quarterly to have an ongoing discussion around the issue. This could bring providers and community members together. L. Matus said that there were four strategies within one goal and that this was a coordinated effort. N. Johns agreed, noting that this would help guide HIPC moving forward. N. Johns asked if L. Matus was specifically referencing PrEP or all the plans in general. L. Matus said that she was referencing the plan in general and that Prevention Committee would continue to examine Pillars 1, 3, and 4 moving forward. L. Matus recommended creating ad-hoc committees for each of the pillars. K. Carter felt that they should instead look at the goals and strategies of the plan as Prevention Committee. K. Carter pointed out Goal 3.4 (especially 3.4.3) which related to linkage to and retention in care. He read 3.4.3. and suggested that this

would be important to their work and improving the care continuum. They could even look at cutting down the linkage of care time from 30 days to 14 days after testing, etc.

C. Steib said that while he was reviewing each of the NHAS goals, he put a check mark next to the ones he felt most vital to Prevention Committee work. After reviewing the checked portions of the plan, they could create a list and pinpoint their primary areas of interest and how HIPC could support them. M. Ross-Russell noted that the EHE Situation Analysis, NHAS, and Integrated Plan goals, all replicated the Situational Analysis goals. This is why, she noted, the committee would see overlap between EHE Pillars 0, 1, and 3. She added that their current work was directly related to Ending the HIV Epidemic. She suggested that it would be helpful to look at the EHE and Situational Analysis and note the existing initiatives and overlap that could be expanded.

C. Steib asked how they wanted to proceed today. K. Carter suggested they look further into C. Steib's checklist. He also suggested looking further into the relation between STI testing and HIV testing. They could also review housing and the way in which it improves health outcomes.

A. Williams noted the hesitancy around receiving the COVID-19 vaccine. This reminded him of people's unwillingness to receive PrEP, ART, or HIV testing due to historical medical mistrust. He asked if they were doing enough to earn back trust and to address the legacy of mistrust with access to and/or acceptance of medications.

G. Grannan felt that all of the points everyone had brought up fit well into each of the overlapping documents and were important to address. Prevention Committee is the one committee of the HIPC that deals with people at risk of HIV but do not have HIV as well as those already living with HIV. Many experiences around health issues come from social determinants of health, stigma, and discrimination. He felt that they needed to go through the goals while trying to reconcile their on-field experience, identifying the questions they needed to ask, and deciding how to proceed.

J. Henrikson reminded the committee that earlier, they discussed trainings which led them to their current conversation. C. Steib highlighted 3.1.3 of NHAS: Support communities in efforts to address misconceptions and reduce HIV-related stigma and other stigmas that negatively affect HIV outcomes. He asked if the Prevention Committee wanted to further explore this part of NHAS. G. Grannan said this was a good place to start. It would be difficult to tackle since stigma and how it negatively affects HIV outcomes could be hard to narrow down. He added that legal status of PLWH was not in HIPC's purview. D. Gana felt that they could identify notable biases and stigmas and make recommendations to AACO. K. Carter noted that stigma people faced differed from person to person.

N. Johns said that last meeting, they discussed use of language. The Prevention Committee could not erase -isms, but they could put forth recommendations and raise up best practices. They could then work with the PDPH to operationalize the goals. In the past, Prevention Committee has discussed the documented attitude and behaviors of front desk workers that may have been enforcing stigma and promoting bias. They knew that this impacted long-term outcomes for patients. She reminded the committee that they could support campaigns, advocate for change, etc., and told them not to undersell their influence as Prevention Committee. M. Ross-Russell agreed that as a Planning Body and this committee, they had an ability to support outside efforts, especially AACO in their efforts to support reduction of stigma by neighborhood, population, etc.

A. Williams concretely suggested medical industries/pharmacies benefiting from HIV patients work on a more community-based, restorative justice approach and give back to communities from which they are benefitting. A. Williams said that the ways in which pharmacies could give back would be determined by

the communities. He felt that these industries needed to take more leadership in removing barriers to services instead of simply offering information about pharmaceuticals. K. Carter was doubtful that pharmaceutical industries would actually partake in this. A. Williams said that clients had choice to continue or not continue using products. K. Carter liked A. Williams's idea.

M. Ross-Russell mentioned that AACO was moving towards a client-based model for services, and this structure change would alter the discussion. Reducing barriers to services is top priority under the structure change. For example, knowing that people typically needed services after their 9:00 a.m. – 5:00 p.m. job would be an example of a barrier to services. This was just an example of a barrier presented by a provider, and working on other similar barriers would improve the system. This would also demonstrate to the community that providers are listening which may increase trust within the system of care and improve healthcare uptake.

K. Carter said that some COVID-19 vaccination distributers were physically bringing vaccines to people so individuals receiving the vaccines did not have to miss work. This was an example of meeting the community where they were.

M. Ross-Russell asked to revisit A. Williams's recommendation and C. Steib's list of items so they could focus on possible recommendations. C. Steib said that 3.2.1. of NHAS was already under way with the DExIS project. He was unsure as to whether they could create recommendations out of 3.2.1. He noted that 3.3.1. was worth looking into for recommendations. He explained that they could look through the goals and tease out the what was relevant to Prevention Committee, create the list, and then brainstorm possible recommendations. He asked if they were on a deadline for creating NHAS-related recommendations from Prevention Committee. J. Henrikson said there was no set deadline, they were just digging into the NHAS and EHE plans. She suggested listing some items they would like to prioritize and dividing them into long-term goals vs. what they would like to prioritize quickly.

C. Steib said that as a group, they could go through all of the items and determine whether they could make any recommendations. This could be an ongoing project, going through a few goals or parts of the plan at a time. It could be similar to how they worked through the EHE plan.

J. Henrikson said that they could work this into their next meeting as well and have deeper conversations around goals or parts of the goals. K. Carter noted that their review of NHAS would also help to prepare for Priority Setting. J. Henrikson said that if they wanted to review the plan more in depth, they could come up with line items and revisit this at the next meeting. They could also specifically look at 3.4 next meeting. C. Steib agreed that this would give them more time to discuss the items in depth. J. Henrikson said that she could look over some of the things they discussed as well as A. Williams's suggestion.

N. Johns noted that the next worksheet focused on last meeting's conversation around DExIS. She asked if they wanted to discuss the DExIS worksheet or table it for next meeting. The group read over the worksheet. K. Carter said suggested adding language that encouraged providers to offer HIV tests and PrEP counseling. K. Carter also suggested holding conversations around sexual activity while people received their COVID-19 vaccinations or tests.

M. Ross-Russell said that the DExIS worksheet was based on Prevention Committee's discussion around DExIS. She said that DExIS tied directly into EHE and NHAS. The reason they assembled the worksheet was to streamline the discussion from last month to assist with direct recommendations. M. Ross-Russell mentioned how J. Williams said there may be a requirement in the current RFP for joint STI and HIV testing. K. Carter noted that there was an increase in STI infections, so there would likely be more HIV-positive tests. This would also indicate an increased need in PrEP uptake.

K. Carter said that HIV testing along with STI tests/positive results could be rephrased as a solid recommendation. He also noted that they needed to continue focusing on PWID and support certain programs. M. Ross-Russell asked if there was anyone from AACO who could speak to the STI/HIV testing relationship. A. Thomas-Ferraioli said that she was the EHE advisor and could research/bring this question back to AACO to find out the requirements as they relate to what they fund. K. Carter asked if providers were actually offering information about PrEP, and if they were not, how HIPC could ensure that providers were following through.

C. Steib said that with the EMR system, providers could do a build-in of a pop-up that could prompt them as a reminder to offer HIV tests and talk about PrEP. L. Matus said that clients may opt out of HIV tests or receiving PrEP. C. Steib said that positive STIs should prompt HIV tests, and should be a routine standard of care.

G. Grannan reminded everyone that they could not balance the entire prevention system on the assumption that everyone was willing to take HIV tests. K. Carter asked if people could go to anonymous testing centers. G. Grannan was unsure if people could test anonymously anymore. A. Williams said at-home tests were the closest people could get to anonymous tests. K. Carter said that this was a barrier to diagnosis and care. L. Matus said that anonymous tests were a double edged sword since they could not access people's information and direct them more easily to the right care.

K. Carter asked if those who were undetectable (virally suppressed) still needed to worry about the law. G. Grannan said that even if someone's viral load was at 0, they were still subject to that law. E. Thornburg said that with PA legislation, PLWH are subject to the legal reprimand, whether it make sense from a transmissibility standpoint or not. For example, if someone with HIV spits on someone else, HIV status could be a factor in sentencing. K. Carter said that science and the law had not yet merged. G. Grannan agreed, noting that the act of having sex or sharing injection equipment was not a factor for transmissibility anymore if the person was undetectable. E. Thornburg said that there was a case study where a person had revealed themselves in a lewd manner – it was discovered that the individual was newly diagnosed, and this had great influence on their sentence. This person's crime had nothing to do with exchange of fluids, but since the law open-ended, they could charge them for an HIV-related crime.

M. Ross-Russell said that, as this relates to recommendations, if HIV testing were tied to STIs, this may act as a barrier for people who are part of criminalized populations. G. Grannan said that this would not always stop someone getting an STI test. He felt that the law was so poorly written that it brought health goals into conflict with people's rights. He noted that the law needed to change since it was written in the 80's and at odds with the medical reality.

K. Carter asked if providers had the option to offer take-home tests without any requirement for them to report back with results. A. Williams said that the names or information from take-home tests did not get back to PDPH. G. Grannan noted that for Hep-C testing, if someone called the number to get their results, they would hang up if they heard themselves being transferred. This is because if someone was transferred, that meant that their result was positive. G. Grannan said that if there was an option to offer people take-home tests, it might be beneficial, because people had more control over how to handle their results.

L. Matus said that Philly Keep On Loving already offered take-home tests. G. Grannan said that if people received a positive STI test, they should get offered a take-home HIV test kit. C. Steib said that there were RWHAP providers that had been recommending to offer at-home tests if a patient was reluctant to getting a test on the premises.

K. Carter said that, as a committee, they should also look into why a provider would refuse to provide someone with PrEP. He suggested that this may be due to inherent bias on the provider side. C. Steib said that providers may feel uncomfortable because they do not have the knowledge around PrEP or did not want to deal with HIV medications. K. Carter asked if they should educate clients who receive PrEP prescriptions and notify them of their rights when seeking HIV prevention care. G. Grannan felt that this was more of an issue with the system, especially with harm reduction which was heavily stigmatized. He felt that clients should not have to bear the burden. K. Carter asked where most people received their PrEP prescriptions. C. Steib said that AACO had a PrEP directory. B. Hernandez said that AACO had a PrEP locator list on the Philly Keep On Loving website, though the list still needed updates and additions.

K. Carter asked if AACO identified providers who were refusing to administer PrEP prescriptions. A. Alex said that they were in the process of updating information for PrEP providers. They were currently working on the Philly Keep on Loving and the City of Philadelphia website from 2019. A. Alex noted that they needed to provide trainings for technical assistance. If providers were not providing PrEP, AACO would ask them if they were willing to give a referrals. She agreed with C. Steib's earlier statement, saying that many providers were comfortable with providing PrEP and were willing to teach and educate. Peer-to-peer education was being developed, especially PrEP-specific trainings. She noted that there was a State-Wide PrEP and PEP institute being publicized to all the PrEP providers. This was a 3-day institute from the PA Department of Health which would focus on barriers, resources, and network. This would be from March 23 – March 25, 2021.

J. Williams added that AACO needed to think about inclusivity and prime candidates for the prevention programs to ensure that clients want what was being offered. He noted that they had Philly Keep On Loving, preferred PrEP providers, lessons from the 15-09 navigation project, etc. However, he felt they could do better with "selling" PrEP and ensure that their priority populations were benefiting from the systems they were building. M. Ross-Russell asked if there were general doctors not part of the system who were causing barriers with PrEP distribution. G. Grannan said he knew of an instance where a primary care physician—and possibly the medical director—at a major ASO refused to administer PrEP.

M. Ross-Russell said that based on the conversation, they had rough recommendation language. She asked the committee if they would like staff to rephrase and present the recommendations based on today's discussion. Everyone said yes.

C. Steib asked if when AACO did technical assistance with PrEP providers, they could ask providers if they had any practices in their network that could benefit from the training. This could then expand the training network. K. Carter asked if there were more PrEP prescriptions administered within the city in comparison to the suburbs. C. Steib was unsure.

M. Ross-Russell asked for clarification around a rough recommendation presented by the committee earlier on in their discussion: a take-home test is offered if a person refuses an in-person HIV test. Furthermore, there would be a follow-up to offer PrEP if an HIV test came back negative. A. Williams agreed, and noted that individuals could be directed to the existing website to get more information on PrEP.

C. Steib mentioned the CTR forms required by AACO. He explained that each section had information on the agency, clients, and final test determination, etc. If a client is negative, the person filling out the CTR is prompted to go to "Section D" which contained information on PrEP referral. Therefore, counselors were prompted to discuss PrEP after negative rapid tests. C. Steib said the CTR forms changed occasionally, so they needed more information on this and improvement in general.

Any Other Business:

None.

Announcements:

G. Grannan reminded everyone that March 3rd was Sex Workers Rights Day.

Adjournment: C. Steib called for a motion to adjourn. **Motion:** K. Carter motioned, D. Gana seconded to adjourn the February 24, 2021 Prevention Committee meeting. **Motion passed:** The meeting was adjourned by general consent at 4:36 p.m.

Respectfully Submitted,

Sofia M. Moletteri, staff

Handouts distributed at the meeting:

- February 2021 Prevention Committee Meeting Agenda
- January 2021 Prevention Committee Meeting Minutes
- NHAS Feedback Worksheet
- DExIS Feedback Worksheet

Recommendations from February 21, 2021
Prevention Committee
Wednesday, May 26, 2021

Recommendations/Directives:

1. HIV tests are to be offered alongside STI tests. If an HIV test was not offered jointly with an STI test, positive STI test results are to be followed by an HIV test.

2. Providers are to offer take-home HIV test kits if a patient refuses an on-site, in-person HIV test.

3. If a patient is to receive a negative HIV test result, the provider is to offer and discuss PrEP with the patient.

More Discussion Needed:

1. Medical industries/pharmacies benefiting from HIV-positive patients are to work on community-based, restorative justice approaches to give back to the communities from which they are benefitting.

2021-2025 National Strategic Plan: Goal 3.4 Worksheet
Prevention Committee
Wednesday, May 26, 2021

Goal 3: Reduce HIV-Related Disparities and Health Inequities

This conversation will focus on Goal 3.4 of the National Strategic Plan. Goal 3.4 is outlined as follows:

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.

Questions:

1. How would we implement each subsection (3.4.1-3.4.6)?

2. Which of these goals require more attention in this EMA?

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