Meeting Agenda

VIRTUAL:
Wednesday, August 25, 2021
2:30 p.m. – 4:30 p.m.

- Call to Order
- Welcome/Introductions
- Approval of Agenda
- Approval of Minutes *(June 30, 2021)*
- Report of Co-Chairs
- Report of Staff
- Discussion Items
  - Draft Letter to Recipient
  - NHAS Goal 1: Prevent New HIV Infections
- Other Business
- Announcements
- Adjournment

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

The next Prevention Committee meeting is
VIRTUAL: Wednesday, September 22, 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

Philadelphia HIV Integrated Planning Council
Prevention Committee
Meeting Minutes of
Wednesday, June 30, 2021
2:30-4:30 p.m.
Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia PA 19107

Present: Elise Borgese, Keith Carter, David Gana, Gus Grannan, Kailah King-Collins, Erica Rand, Clint Steib (Co-Chair), Desiree Surplus

Guests: Emma Walinsky, Javontae Williams (AACO)

Excused: Lorett Matus (Co-Chair), Adam Williams

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

Call to Order: C. Steib called the meeting to order at 2:36 p.m. and asked everyone to introduce themselves with their name and what they had been doing to cool down during the hot weather.

Approval of Agenda: C. Steib presented the June 2021 Prevention Committee agenda for approval. **Motion**: K. Carter motioned, D. Gana seconded to approve the June 2021 agenda. **Motion passed**: 78% in favor, 22% abstaining.

Approval of Minutes (*May 26, 2021*): C. Steib presented the previous meeting's minutes for approval. **Motion**: D. Gana motioned, K. Carter seconded to approve the May 2021 meeting notes. **Motion passed**: 78% in favor, 22% abstaining.

Report of Co-Chair:
C. Steib apologized for being unable to attend the May 2021 meeting due to a conflict.

Report of Staff:
S. Moletteri reported that they started to put the materials for the July allocations process on the website. There was a PowerPoint, flyers for registration and advertisement by region, and other documents. They felt that the organization of the materials on the allocations tab would be clear, but if anyone had any questions, they should feel free to contact office staff. They would also like to hear suggestions on how materials were presented given that the process was virtual this year once again. It was a priority to ensure that the materials were clear and informative.

M. Ross-Russell reported that she was currently updating the Service Categories Allocations Booklet. The booklet had needs assessment information, CSU (Client Services Utilization) and MMP (Medical Monitoring Project) data, past allocations, recipient considerations, etc. The booklet also contained Medicaid information for PA and NJ. She reminded the co-chairs that they would have an Executive Committee meeting tomorrow, and some of what they discussed today might end up in the meeting tomorrow.

Discussion Item:

—Recommendation Language for Allocations—

J. Henrikson said that the language currently presented should look familiar, as it was the language they voted on within the last meeting. OHP was presenting the language to the committee once again, because with allocations coming up, they would need to decide if they wanted to include the recommendations within the process. If they were to include the language, they would have to edit it so it fell under a care lens; this was because allocations was a care-related process. J. Henrikson said they would ignore the fourth item listed, because it was not applicable for allocations. Please refer to "Recommendations Language from Prevention Committee" for the language. She reiterated that they would need to look at the first three items through a care lens.

M. Ross-Russell agreed. She said that prevention services were CDC dollars, but the RW dollars under consideration during allocations were for care services. She noted that, since participants offered directives during the allocations process, the language incorporated into the process should also be under a care lens. These recommendations, she stated, would not immediately turn into directives; allocations participants would receive the language for their consideration, deciding whether or not--and how--to include them in the allocations decisions.

She reminded the group that in previous discussions, they had talked about the relationship between the NHAS and EHE language. These two plans were inseparable and worked together in many ways. Thus, as they looked at services, they needed to consider how they could incorporate these two within their review and decision process to ensure individuals would receive care in a way that could move them towards viral suppression.They would focus on ending the epidemic while also using documented need to ensure that community needs were being met. J. Henrikson said, if it was helpful, CPC borrowed EHE language to recommend within the allocations process. She said that they were readily accessible if anyone wanted to view them.

J. Williams asked for more clarity around the role the recommendations from the Prevention Committee would play within the process. M. Ross-Russell said that they were breaking up each region into three separate meetings as they had last year. It would be virtual. Each of the three regions would consist of three meetings, making nine meetings in total. The first meeting would be to review the documents, numbers, and recommendations from committees. These care-related recommendations would be included to further discussion within the allocations process. They could decide that it would affect their funding or directive decisions, systemwide or service-specific. She reiterated that, currently, they could not be presented in allocations properly, since they were not rephrased to have direct relation to care activities.

K. Carter asked if prevention language and care activities were linked. J. Williams noted that there was a link within early intervention activities for which the EMA received funds. M. Ross-Russell said early intervention had been folded into the Ambulatory Outpatient category. As an example, she explained that a one-stop-shop provider that received both care and prevention

funding, could be taken into consideration. This meant that the recipient could ensure that these jointly funded providers were following any of the suggested prevention recommendations.

J. Williams asked what would be most helpful for the committee to focus on today. K. Carter asked what direction they should take that would be best or most effective. M. Ross-Russell said as support staff for HIPC, OHP could ensure that the committee was aware of their options for the language. If they wanted to incorporate this into the care discussion for allocations, they would need to rephrase it. If they chose not to bring it to allocations, OHP could set the language aside and eventually bring it forth to HIPC.

K. Carter asked if they had data to ensure that these recommendations were based on documented need. Additionally, he asked if they could suggest these to the recipient in some way. M. Ross-Russell said they could, with the link being providers that were jointly funded for care and prevention. They would have to keep in mind that this was related to the Situational Analysis within the EHE. J. Williams agreed. M. Ross-Russell said, based on the documented need component, this was documented since the language from the Prevention Committee was also within the EHE. She added that based on the legislative language for early intervention services, one must strongly believe that a person was living with HIV before they could provide RW services. K. Carter said that, in that case, anyone who went into a clinic who was sexually active or with an STI could potentially qualify.

K. Carter said that they should suggest this to the recipient as falling under the early intervention category. C. Steib liked this idea. He also asked if this language from the committee was also based on CDC guidelines. J. Williams affirmed that they aligned closely with the CDC's prevention strategies. He also noted that these recommendations came from the DExIS documentation. J. Williams recalled that the group felt strongly about these recommendations within the last meeting and could choose to deliver however they see fit: as a care-related directive, a formal letter to the recipient, etc. There were a few options.

K. Carter felt that the language boxed them in and that they should explore their options further. They wanted to ensure that people were being offered STI tests (as per the first recommendation) among the other recommendations. He liked the idea of writing a letter since it could offer the committee more freedom. The recommendations, he felt, all made sense in a letter since they transitioned nicely into each other. For example, someone would (1) receive an HIV test after a positive STI test, (2) be offered a take-home test if they did not want to take the test in-person, and (3) receive more information about PrEP if they tested negative for HIV.

M. Ross-Russell said that if they were to make suggestions as part of the allocations process, the language would be forwarded to the allocations participants as part of the process. The simplest way to draw the connection was to highlight EHE and how this was already the direction in which they were headed. Then, they could emphasize their point and defend their suggestion by drawing this connection. She said they could make the suggestions to the recipient completely separate (with the Executive Committee reviewing it and moving it forward as an activity) or they could present it within the allocations process. This was the committee's decision.
K. Carter suggested that they exclude the language from the allocations process. He felt it would be more complicated and that they would have to change the language they, as a committee,

already supported. They should instead draft a letter to the recipient and work on it separately from allocations. C. Steib agreed. D. Gana felt that whatever they sent to the recipient should also be sent to the Finance Committee since that committee dealt with funds. C. Steib asked if they could move forward with this or if it had to first go to the Full Council. M. Ross-Russell said it would first be a discussion within the Executive Committee. K. Carter reiterated, just to be clear, that the language would first go to the Executive Committee to determine its importance, the Prevention Committee would draft a letter, and then HIPC would approve it to be sent to the recipient. M. Ross-Russell said the Executive Committee or Prevention Committee could work on the letter, but HIPC would have the final vote.

J. Williams noted that he participated in the Prevention Committee because he wanted to hear from the committee and take back their discussions to the decision makers at AACO. While there was no CDC legislative mandate for HIPC, the committee and HIPC as a whole still had a lot of influence. He explained that 19-06 (EHE) was a CDC-funded project, and though HIPC was not drafting the plan, they still had a lot of influence in its outcome. M. Ross-Russell agreed, adding that the use of "legislative" and "contractual" was for point of clarity.

K. Carter asked J. Williams if the language would be better suited as a strong suggestion. J. Williams said whatever the committee felt was best was appropriate and would be effective. C. Steib said, in a way, the minutes for today's meeting would be a draft of the letter.

G. Grannan asked if these recommendations were not to be sent with the funding decisions. K. Carter said that from an allocations point of view, there were no RW Part A service categories that could fully address any of the current recommendations from a RW/care standpoint. G. Grannan understood, noting that those who would be tested for HIV would not be covered by RW. Additionally, if a PLWH contracted and tested positive for an STI, it would likely have zero clinical value for them to receive another HIV test if the provider and patient knew of their positive status. D. Gana agreed, saying the point of this was to test those unaware of their status and offer PrEP if the result was negative.

G. Grannan was concerned that the guidelines were too broad and could lead to overtesting in certain areas. He felt the guidelines would make sense for someone who never tested positive for HIV, but it would not for those who have. G. Grannan noted that overtesting could become an unintended outcome. He asked if they would receive data back from the recommendations. M. Ross-Russell said yes. Additionally, the recommendations came from both the EHE Situational Analysis and DExIS, so there was already existing data. M. Ross-Russell explained that, no matter what they chose to do with the language, it was also something they could incorporate into the final language once they started putting information into applications. G. Grannan was fine with the language going forward with the understanding that they would receive data back from the recipient.

G. Grannan still felt concerned about overtesting. D. Gana figured a person who knew of their positive status would deny a test or make the provider aware. K. Carter reminded that the suggestions were for providers to *offer* tests, test kits, and PrEP--not *mandate* it. C. Steib added that if a patient agreed to an HIV test and already knew they were positive but the provider did not, this was still a good opportunity to find someone lost to care. G. Grannan agreed. J.

Williams said that this was not a large issue within the system. C. Steib said that this would allow the opportunity to collect data. As a suggestion, they could monitor this as a Prevention Committee as they went through the plan. If the data suggested they move forward, they could include the language in next year's allocations process.

K. Carter noted that once you tested positive, your name was reported to the health department so you were not tested again. J. Williams agreed, noting that the health department wanted to ensure, since there were public health consequences, that people were getting linked to treatment. This was their reason behind collecting information. G. Grannan said that this was not always the case. There was a federal mandate that changed this. Therefore, it was possible that there were PLWH who were not within the system at all. M. Ross-Russell said the mandate came out around 2006/2007. K. Carter said that people's situations might be different and it was hard to say whether someone was in the system or not.

C. Steib said they would move this to the Executive Committee for discussion.

—Directives for Allocations—

J. Henrikson said they no longer had an action item since they were not moving the language to allocations.

C. Steib said that during the first allocations meetings (Part 1), they would review documents and data. The final meeting (Part 2), then, would be to create care-related directives and funding decisions. M. Ross-Russell agreed. This would all be done with the understanding that participants reviewed the website and the information listed prior to allocations. Then, they would not have to review documents in depth and could have more participation and time for people to bring their experience and expertise. She noted that there would also be a second meeting in between Parts 1 and 2. It would be on Wednesday for people to bring their questions and concerns. This meeting was optional. The process would occur over three weeks: NJ counties the first week, PA counties the second, and Philadelphia the third. J. Henrikson noted that July 12, 2021 was their first meeting.

J. Williams said that in their last meeting, someone mentioned PrEP and how transgender individuals were not indicated to access PrEP. J. Williams said he recently looked into this, and he found that the CDC had endorsed and provided episodic PrEP (PrEP 211). This was to be taken as such: two pills 2-24 hours before sexual activity, one pill after sexual activity, and one within 48 hours of the first dose. This form of PrEP was not indicated for people taking estrogen therapy. The estrogen, he said, could cause the amount of medicine within the system to fluctuate. Transgender individuals could still take regular PrEP. S. Moletteri asked if this was just for estrogen or HRT in general. J. Williams said he was not sure, but estrogen was definitely mentioned.

G. Grannan asked what it was about estrogen that made it less effective for PrEP 211 if estrogen was approved for regular 7-day PrEP. J. Williams said there were many factors that could influence the amount of medication in blood, e.g. some people taking ART could not eat grapefruit. For some, they could end up excreting it without it ever having taken effect in the

body. K. Carter asked if D. Surplus knew more about this. D. Surplus said she was not familiar with PrEP 211—she could look more into this and get back to the committee

J. Williams said that the United States had not yet officially authorized PrEP for 211. The CDC had endorsed it, but the FDA had not yet approved it. This might be why many providers had not yet received information on PrEP 211. K. Carter asked if PrEP on demand and episodic PrEP were the same. J. Williams said they were.

Other Business:
K. Carter asked about the EOB (Explanation of Benefits) J. Williams shared in the chat. J. Williams said he was sharing this as a resource, so it was not for discussion--just to look at. C. Steib said he printed it out and passed it around. He found it to be very informative.

Announcements:
None.

Adjournment: C. Steib asked for a motion to adjourn. **Motion**: K. Carter motioned, D. Gana seconded to adjourn the June 30, 2021 Prevention Committee meeting. **Motion passed**: All in favor. Meeting adjourned at 3:41 p.m.

Respectfully submitted:

Sofia M. Moletteri, staff

Handouts distributed:

- June 2021 Prevention Meeting Agenda
- May 2021 Prevention Meeting Minutes
- Recommendation Language Approved May 2021

Recommendation Language from Prevention Committee Approved May 26, 2021

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

4. Increase advocacy work around altering the HIV Felony Law to match the current science, since the current law, as is, perpetuates stigma and is not consistent with the federal and local EHE plan, particularly when addressing HIV testing in "Pillar 1: Diagnose."

2021-2025 National Strategic Plan: Goal 1 Worksheet
Prevention Committee

Wednesday, August 25, 2021

Goal 1: Prevent New HIV Infections

1.1 Increase awareness of HIV

1.2 Increase knowledge of HIV status

1.3 Expand and improve implementation of effective prevention interventions, including treatment as prevention, PrEP, PEP, and SSPs, and develop new options

1.4 Increase the capacity of health care delivery systems, public health, and the health workforce to prevent and diagnose HIV

Important Context from Goal 1 (pg. 22-23):

- *HIV treatment as prevention*. HIV treatment is now a key HIV prevention tool. Evidence has definitively shown that people with HIV who achieve and maintain an undetectable viral load by taking HIV medication as directed will not sexually transmit the virus to an HIV-negative partner. This finding has giving rise to the understanding of "treatment as prevention."

- *HIV testing and linkage to care.* People who test positive for HIV can take steps to prevent others from being exposed to the virus.49 However, nearly 40% of people with HIV are unaware of their status or are diagnosed but not receiving care.

- *PrEP.* Uptake of daily oral PrEP, which reduces the risk of getting HIV from sex by about 99% when taken daily, has climbed in recent years…EHE's nationwide Ready, Set, PrEP program is helping to increase access to PrEP by making the medications available at no cost to people who lack prescription drug coverage.

Challenges listed from Goal 1 (pg. 23):

- Many people in the United States still do not have the basic facts about HIV, including information on the latest prevention options and the effectiveness of HIV treatment.

- People at high risk for HIV are either not offered or do not receive HIV testing when visiting health care providers.

- The presence of STDs increases the risk of transmitting or acquiring HIV. Improved offering of HIV testing and prevention services, including PrEP, at STD specialty clinics would strengthen HIV prevention services

- A significant number of people with HIV are unaware of their status or diagnosed in the later stages of their HIV disease. In 2018, 14%, or about 161,800 of people with HIV, were undiagnosed,2 and nearly 21% of people diagnosed with HIV had a stage 3 (AIDS) classification at the time of diagnosis

- Despite the availability of PrEP since 2012, disparities in uptake persist.3,55,56 Though CDC estimates that 1.2 million people in the United States had indications for PrEP in 2018, only 18.1% were prescribed PrEP

- Despite overwhelming evidence that SSPs are effective prevention tools, too few people at risk of HIV through injection drug use have access to them. SSPs can reach people who would otherwise not get health care and connect them to life-saving services.

INDICATORS OF PROGRESS

Working together to pursue these objectives, the nation can achieve the following targets by 2025:

Indicator 1	Increase knowledge of status to 95% from a 2017 baseline of 85.8%
Indicator 2	Reduce new HIV infections by 75% from a 2017 baseline of 37,000
Indicator 3	Reduce new HIV diagnoses by 75% from a 2017 baseline of 38,351
Indicator 4	Increase PrEP coverage to 50% from a 2017 baseline of 12.6%

Noting this context and the overall goal of reducing the community viral load and achieving viral suppression, consider these questions:

- What can we do to normalize regular HIV testing?

- How can we increase knowledge of HIV treatment resources?