Philadelphia HIV Integrated Planning Council
Prevention Committee
Meeting Minutes of
Wednesday, May 25, 2022
2:30-4:30 p.m.
Office of HIV Planning, 340 N. 12th Street, Suite 320, Philadelphia PA 19107

Present: Keith Carter, Gus Grannan, Kailiah King-Collins, Lorett Matus (Co-Chair), Erica Rand, Desiree Surplus

Guest: Toyin Olubiyi (AACO), Javontae Williams (AACO), Melanie Mercardo

Excused: Clint Steib

Staff: Sofia Moletteri, Mari Ross-Russell, Elijah Sumners

Call to Order: L. Matus called the meeting to order at 2:34pm

Approval of Agenda: L. Matus presented the April agenda for approval. **Motion**: K. Carter motioned, G. Grannan seconded to approve the May 2022 agenda. **Motion passed**: 5 in favor.

Approval of Minutes *(April 27, 2022)*: L. Matus presented the previous meeting's minutes for approval. **Motion**: K. Carter motioned, G. Grannan seconded to approve the April 2022 meeting minutes. **Motion passed**: 5 in favor.

Report of Co-Chairs:
None.

Report of Staff:
M. Ross-Russell reported that all of the requested packets have been sent to providers. The good thing was that there have been responses coming into the office; however, OHP was behind their target, so the deadline has been extended to June 30th, 2022. There has not been a lot of participation from the Pennsylvania or New Jersey counties. Data from the Consumer Survey typically represented some of the information that was used during allocations. Historically, people in the counties were felt misrepresented when data was Philadelphia-centered, but the counties have not been participatory in this endeavor.

L. Matus asked if of the issue was not enough providers or people on-hand to facilitate or distribute packets. M. Ross-Russell stated that she was told that they were encouraging people

to complete the surveys online, but OHP has sent 400-500 packets to the counties at this point. S. Moletteri reported that as of this morning there were 86 online responses.

Discussion Items:

–AACO PrEP–

J. Williams reported that this would be informal discussion and he wanted to know what the group thought of the future of PrEP in Philadelphia. He stated that the purpose of this was to think strategically about how the different pieces of PrEP were connected. For context, J. Williams stated that this conversation came from him reaching out to M. Ross-Russell regarding the PrEP work plan that this committee participated in creating in 2019, which predated his employment to the health department. He was given this document as Caitlin Conyngham and Erica Aaron were leaving. Some of the things that AACO has done were in the PrEP work plan and there were many more things that AACO has not done. AACO now has a Clinical Prevention Associate, Dr. Toyin, who was in charge of creating PrEP activities and J. Williams wanted to help her in creating programming.

J. Williams reported that this discussion would help him determine next steps with Dr. Toyin in the creation of a workflow plan based on what members were experiencing in the field as consumers and providers. Additionally, AACO was in the process of coordinating the integrated planning process, in collaboration with HIPC and the recipient. He wanted to ensure that this process spoke to the original PrEP plan. He additionally stated that there were a lot of people who do not know about PrEP. There were even more people who did not know about the injectables that were coming out. J. Williams felt that the group could assist in developing ideas and putting together a strategy for next steps.

G. Grannan stated that he was glad J. Williams mentioned injectables and asked if there was a place that they could review information on this (prescription and administering). He also asked if there was clinical data on how the two injectables interacted? J. Williams asked to clarify which two injectables. G. Grannan clarified that he was talking about the PrEP injectable and the buprenorphine injectable that was being trialed in conjunction with substance use treatment. J. Williams stated that he has not heard of any interaction with buprenorphine, and there was a list of medications that you would want to monitor. He has not heard of any other adverse reaction/interaction with additional medication linking buprenorphine.

J. Williams answered G. Grannan's original question stating that he did not know where people could go for this medication since this type of injectable was still relatively new and the had received FDA approval in January. J. Williams reported that he knew of very few

pharmaceutical providers in Pennsylvania that actually distribute Cabotegravir. There was still very limited supply, not in the sense of being manufactured, but in the sense of getting it to the pharmacies or to medical providers. He knew of only two places in the Philadelphia area that were administering the medication to patients and those were Philadelphia Fight and AIDS Care Group.

J. Williams reported that he had spoken to the VIIV representative, identified two organizations Bebashi and Mazzoni, that were being funded to implement injectable PrEP. More places will be added, presumably, but he only knew of two places that were actively administering this.

D. Surplus reported that as far as she was aware there weren't any injectable products. Regarding Vivitrol, she noted that there were no negative interactions with other medications. Her organization was looking to actually become a site where they could provide the injectable medication, so they will be able to treat patients with both Supplicate and Vivitrol.

E. Rand reported that her organization just began administering injections of Cabenuva and then working on a roll out for PrEP. The youth in her organization were interested in injections. A lot of their youth do not like having to take a pill every day, but they were open to getting a shot every once in a while. E. Rand stated it has actually been really interesting to have these conversations and get this feedback from them. Some of the providers at the primary care sites were starting conversations about injectable PrEP with their adolescents.

L. Matus this conversation reminded her of past conversations around people using condoms. The more choices people have, especially for those who don't want to inject versus taking a pill versus putting a patch on their arm is important. The range of preventative options to meet individual needs was most important. She stated that consistent messaging was important to allow people to continuously know developments in treatment.

K. Carter stated that in health systems there were providers that have a certain opinion about PrEP and asked if there was potential for information in-services to let them know this was the reason why you might want to consider offering PrEP toward a new patient, so we re-educate the providers to get their buy-in. J. Williams asked L. Matus to speak to the Department of Public Health's PrEP Provider Application Project. L. Matus reported that the group had a meeting this morning for providers, clinicians, and everyone who involved in the service system, to understand how to implement rapid PrEP. She applauded the Department of Health and their colleagues on this endeavor because it was required as part of the current funding. L. Matus stated that the training was important, to ensure this be part of routine medical visit conversation.

J. Williams thanked her and stated that he wanted the committee to hear a perspective other than his as a representative of AACO. He stated that AACO was reaching out to providers. Currently, there are over 180 providers on their PrEP list that are emailed at least once a month as well as 30 to 40 people attending the quarterly PrEP meetings. In addition, to be listed on the phillykeeponloving website as a preferred PrEP provider, one has to participate in our quality management process.

AACO performed "secret shopper" calls: staff pretend to be people of multiple ages who are looking to get an appointment. There were some very disturbing trends amongst some providers. In some cases, it took a year or six months to get in for PrEP. There other providers who were found to be doing exceptionally well. AACO was being very intentional about trying to make sure that PrEP was accessible and easy to obtain. But more importantly, the goal was to ensure people stay on PrEP. There was a lot of national data that stated when people start PrEP, they only stay on it for seven months. After seven months, they discontinued it because no one really wants to take a pill or medication for something they don't think is important to them at the time. L. Matus stated people don't usually go to a medical provider for preventative medications. Normally people go to medical visits because something's wrong. PrEP was really a true preventative. G. Grannan added that the fact people remained on PrEP for six months doesn't necessarily mean that it was a treatment failure.

J. Williams stated in AACO's DExIS project, it was uncovered that people are not making such an informed choice. They're discontinuing PrEP and resuming sexual behavior that puts them at increased risk for HIV. Later in the data, they were a new diagnosis. The individuals interviewed about PrEP, they knew about PrEP, they were on PrEP, and then they discontinued PrEP. This was not unique to Philadelphia—it is a national trend where people, on average, do not continue treatment with PrEP, longer than seven or eight months. Informed choice and understanding risk are connected.

E. Rand stated that people who have an HIV positive scare, get really motivated to start PrEP and then they get enough distance from it and it becomes "I don't actually want to take this pill every day." That has been really interesting too, because that risk doesn't go away. The behaviors aren't changing, they were just far enough away from a scare to forget what that was like. M. Ross-Russell stated the thing that went through her mind initially with respect to injectables, related to people of color, and their feelings towards needles. She did not know if this sentiment had changed with the younger generation, but there was a fear of needles in communities of color. She did not know if this was still something that would create problems moving forward with PrEP uptake. J. Williams responded that this fear was still an issue. J. Williams reported that injectable PrEP is only administered in a medical clinic, by a nurse or other practitioner. It was not something that someone could take home and use. D. Surplus stated that she had a lot of experience with patients who were on other long acting injectables

for a variety of other conditions. In her experience, a lot of people like the idea of only getting it once a month. Nobody knew what you were prescribed, because nobody could find your pill bottle. There is more anonymity with that, and it reduces the stigma. She doesn't know how that was going to translate in terms of PrEP. For substance abuse, or even other mental health conditions, people really like the injectables for that reason. She could foresee that probably that would be an added advantage to someone who wants to be on PrEP. S. Moletteri stated that they felt injectables were normalized in queer youth circles especially as it pertained to hormone replacement therapy and people sharing their experiences online.

J. Williams asked what the group thought about the existing list of "priority populations." The list consists of people who inject drugs, Transgender Women, Black Women, Latinx folks, men who have sex with men, men who have sex with men of color, and youth ages 13 to 24. He asked the group if they felt any populations were missing M. Ross-Russell recognized the importance of the list but asked why anyone involved in *any* risky sexual behavior be excluded. J. Williams stated that the new PrEP guidelines do not exclude anyone, they still included everyone. However, when you focus on everybody, there's a lot of resources needed, so certain populations need to be prioritized—this did not inherently mean the exclusion of others. Considering the limitation of resources, something has to get prioritized and when you look at the HIV diagnosis, this was where the new diagnosis tended to cluster within these particular groups. While everyone was a candidate for PrEP, there were certain populations that needed more intense focus.

L. Matus stated that background and cultural upbringing play a big role in who's going to ask questions and "be assertive" enough to ask versus being told, that was definitely something to take into account. The Prevention Committee has discussed some hesitancy based on past history and cultural backgrounds.

J. Williams reported that AACO was in the process of reworking phillykeeponloving as they roll out telePrEP. What AACO acknowledged was that, right now, the images speak to a certain demographic. That's partly because when phillykeeponloving was rolled out, it was funded by 1509. 1509 was specifically for men who have sex with men of color, and women of trans experience, who are black or Latinx. AACO wanted to broaden the scope of who phillykeeponloving's target market was, and it's going to be everybody. In order to do that, AACO has to make sure that it was representing everyone.

Other Business:
None.

Announcements:
D. Surplus announced that her pharmacy was distributing long-acting injectables. If anybody's patients were on long-acting injectables, her pharmacy could assist with administration. She suggested interested provider representatives reach out to her to coordinate this.

Adjournment:
L. Matus called for the meeting to be adjourned. **Motion:** K. Carter motioned to adjourn. G. Grannan seconded the motion. The meeting adjourned at 3:47 p.m.

Respectfully submitted,

Elijah Sumners and Mari Ross-Russell

Additional Materials:

- May 2022 Prevention Committee Agenda
- April 2022 Prevention Committee Minutes
- AACO PrEP Presentation