# MEETING AGENDA

Thursday, June 13, 2019
2:00 p.m. – 4:30 p.m.

Call to Order

Welcome and Introductions

Approval of Agenda

Approval of Minutes (*May 9, 2019)*

Report of Co-Chairs – End the Epidemic (Coleman Terrell)

Report of Staff

Public Comment

Presentation: Client Services Unit Annual Update (Jessica Browne)

Action Item: PrEP Workgroup Report (Gus Grannan)

Discussion Items:

Priority Setting Process (Mais Diaz & Gail Thomas)

FY 2018 Year End Spending Report (Ameenah McCann-Wood)

Committee Reports

- Executive Committee – *No report*
- Finance Committee – *No report*
- Nominations Committee – Michael Cappuccilli & Sam Romero
- Positive Committee – Keith Carter & Jeannette Murdock
- Comprehensive Planning Committee – *No report*
- Prevention Committee – Lorett Matus & Clint Steib

Old Business – Racial Equity Workgroup

New Business

Announcements

Adjournment

HIV INTEGRATED PLANNING COUNCIL

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

The next HIV Integrated Planning Council meeting is scheduled for
**Thursday, July 11, 2019 from 2:00 – 4:30 p.m. at the**
Office of HIV Planning, 340 N. 12TH Street, Suite 320, Philadelphia, PA 19107

**Philadelphia EMA HIV Integrated Planning Council (HIPC)**
**Meeting Minutes of**
**Thursday, May 9, 2019**
**2:00 p.m. – 4:30 p.m.**
Office of HIV Planning, 340 N. 12th St., Suite 320, Philadelphia PA 19107

**Present:** Juan Baez, Michael Cappuccilli, Mark Coleman, Maisaloon Dias, Lupe Diaz (Co-Chair), Alan Edelstein, Gus Grannan, Sharee Heaven (Co-Chair), Peter Houle, Gerry Keys, Richard LaBoy, Lorett Matus, Nicole Miller, Christine Quimby, Erica Rand, Joseph Roderick, Samuel Romero, Terry Smith-Flores, Gloria Taylor, Coleman Terrell (Co-Chair), Gail Thomas, Lorrita Wellington, Melvin White

**Absent:** Keith Carter, Evette Colon-Street, Janice Horan, La'Seana Jones, Brian Langley, George Matthews, Dorothy McBride-Wesley, Jeanette Murdock, Eran Sargent, Jason Simmons, Adam Thompson, Zora Wesley, Jacquelyn Whitfield, Steven Zick

**Excused:** Katelyn Baron, David Gana, Pamela Gorman, Dena Lewis-Salley, Nhakia Outland, Clint Steib

**Guests:** Henry Bennett, Alvin Connelly, Ameenah McCann-Woods (AACO), Desmond Thomas

**Call to Order:**
L. Diaz called the meeting to order at 2:06 p.m. The group then introduced themselves and participated in an icebreaker activity.

**Approval of Agenda:**
**Motion:** M. White moved, G. Taylor seconded to approve the agenda. **Motion passed:** All in favor.

**Approval of Minutes:**
G. Taylor noted that she had asked to be excused from the April meeting, but that she had been marked absent in the meeting minutes. **Motion:** M. White moved, M. Cappuccilli seconded to approve the April 2019 meeting minutes as amended. **Motion passed:** All in favor.

**Report of Chair:**
No report.

**Report of Staff:**
M. Ross-Russell reported that New Jersey would host an End the Epidemic listening session that evening from 6 – 9 p.m. She went on to say that the next Brown Bag event would be held on Friday, June 7 and would include a lesson on affirming terminology. She noted that the first Brown Bag event was supposed to be on the history of the epidemic, but that it would be rescheduled due to low turnout.

M. Ross-Russell then reminded the group that they had agreed to create a racial equity workgroup in January *(see – attached handout)*. She noted that no one had signed up for the

W. Short asked what people know about the HIV cure. G. Grannan replied that there were two patients that had had bone marrow transplants, and only one was officially cured. W. Short agreed. He explained that Timothy Ray Brown, also known as the Berlin patient, was the only one who had officially been cured. He noted that they were still a couple of months out from designated the London patient cured. He explained that both patients had received bone marrow transplants from donors with mutations in their CCR5 proteins, which prevented HIV-1 from attaching to the proteins. He went on to explain that bone marrow transplants had a 30% mortality rate. M. Cappuccilli noted that this was also an extremely expensive procedure. W. Short added that there was a third person who was potentially cured.

W. Short stated that zidovudine (AZT), the first drug to treat AIDS, was approved in 1987. He noted that the second drug was dideoxyinosine (ddI). He explained that people living with HIV/AIDS had complicated drug regimens involving many pills for years, until a treatment regimen involving just one pill a day was released in 2006.

W. Short then reviewed a list of the HIV drug approvals in 2018, noting that there has been one new drug approved in 2019. He next stated that the Strategies for Management of Antiretroviral Therapy (SMART) study[1] showed that people with HIV should not stop ART after they start, and the Strategic Timing of Antiretroviral Treatment (START) study[2] showed that they should start ART right away. He stated that the START study was shut down early because there was such a large reduction in infections, heart disease, kidney, and cancers. He noted that ART can help prevent cancer, and that the longer people with HIV were off ART, they more likely they were to develop cancer.

W. Short stated that there were currently over thirty ART options available. He noted that integrase inhibitors were most commonly used today. E. Rand noted that they have better tolerability. W. Short stated that integrase inhibitors also had minimum interactions and that 90% of people were virally suppressed within two weeks. He went on to say that they were not for everyone. He stated that there were some interactions, including with Tums, and that weight gain could also be an issue. G. Grannan asked how grapefruit juice interacts with integrase inhibitors, and W. Short replied that grapefruit juice was fine. He explained that calcium and magnesium bind with the integrase inhibitors, so taking Tums and integrase inhibitors at the same time would result in integrase inhibitors leaving the body with stool.

W. Short then reviewed the Tsepamo study,[3] which conducted birth surveillance to evaluate the safety of ART in pregnancy. He noted that animal studies showed birth defects with Atripla. He then stated that pregnant women tended to be excluded from trials, so they did not have a lot of information on the effects of ART. He stated that the study found neural tube birth defects in Botswana, and that some of these birth defects were incompatible with life. He stated that they had not seen an increased signal to date in the United States, but that they would need over 2,000 exposures to assess this. He noted that the currently only had 200. He explained that he had been trying to get providers to report to their registry so they would have the necessary data.

---

[1] https://www.ncbi.nlm.nih.gov/pubmed/17135583

[2] https://www.nejm.org/doi/full/10.1056/NEJMoa1506816

[3] http://programme.ias2017.org/Abstract/Abstract/5532

W. Short next noted that breastfeeding was the one exception to undetectable equals untransmutable (U=U). He explained that the breast had two types of virus, and that breast tissue activated virus outside of the blood stream. He noted that the annual transmission rate was 6 per 100 breastfeeding parents living with HIV.

M. Cappuccilli asked if there had been research on medication implants. W. Short replied that there had been research on both implants and rings, but that this research was trailing behind injectable research.

C. Terrell stated that the federal government would not release End the Epidemic funds until the budget was approved, but that there would be a great deal of planning to do soon.

W. Short added that death rates for HIV dropped overall, but that there had been a 43% increase in deaths due to opioids among PLWH.

M. Ross-Russell stated that the PrEP pillar of the End the Epidemic initiative focused on the use of federally-qualified health centers (FQHCs). She stated that southern states did not have as many FQHCs, and asked if there was a movement toward opening more. W. Short replied that funding and access to services were extremely limited in southern states, and that people living with HIV often sought medical care after they became very sick. C. Terrell stated that the CDC would take the lead in HIV testing and diagnosis, and HRSA's HIV/AIDS Bureau (HAB) would take the lead in HIV care through Part B and Part D. He noted that the Bureau of Primary Health Care would be funded to roll out PrEP.

H. Bennett asked why a person would choose injectable ART. W. Short replied they wouldn't be for everyone. He stated that some people had a hard time taking pills, especially some people with a history of sexual abuse. He went on to say that other people found taking pills to be a constant reminder of their HIV, while still others didn't want pills in their homes due to unaware family members. He explained that it would be another option for people who don't want to take a pill, but many people will still want to take a pill.

T. Flores asked how many people with HIV had undetectable viral loads. W. Short replied that over 80% of Ryan White clients had undetectable viral loads.

H. Bennet asked for the definition of an undetectable viral load. W. Short replied that this depended on the test, but that it typically meant fewer than 50 copies/mL in a clinical setting, although "undetectable" in studies typically meant <200 copies/mL or <400 copies/mL. He noted that these levels had to be maintained for six months or longer for a person to have an undetectable viral load.

**Allocations Preparations:**

- **Legal/Other Professional Services** – *Juan Baez*

  J. Baez began with a review of the HRSA definition of legal/other professional services *(see – attached handout)*, noting that the legal services needed to be related to a person's HIV. He explained that this included issues related to benefits, such as addressing the termination of a client's Medical Assistance benefits. He stated that this also includes issues related to

M. Cappuccilli stated that dental providers provided comprehensive dental care, although emergency care is often what brings people to the dentist. He went on to say that the service covers dental care, while full crowns for aesthetics were often not covered under Part A. He explained that the primary consideration was keeping people healthy, since poor dental health led to poor nutrition. He noted that the service did require HIV care documentation, including lab results.

M. Cappuccilli stated that a dental patient should be continually treated in medical care, including labs a couple of times a year. He noted that regular patients in the dental office could be linked back to medical care through the dental office. He went on to say that oral care was very important because over half of people living with HIV (PLWH) in the EMA were over 50 years old, and older people have more dental problems. He noted that smoking prevalence was higher among PLWH, and that incidence of gum disease was higher among people who smoke. He added that gum disease was associated with cardiovascular issues.

M. Cappuccilli noted that most people receiving dental services in New Jersey and Philadelphia received services through dental schools, while Ryan White clients in the PA Counties mostly received dental services through subcontracted community-based organizations. He added that providers needed to have a certain number of unduplicated clients and visits in their programs.

M. Cappuccilli stated that dental services tended to be relatively stable from year to year, and that client cost was typically about $500. He noted that the average client would come to the provider two or three times per year. He then stated that there had been an increase in funding to dental care through Part B and Part F from the previous year to the current year.

M. Cappuccilli reviewed consumer survey data, noting that there had been 392 respondents, of which 247 had identified a need for dental care in the past twelve months. He noted that the "needed but did not get" percentage was 15%. He then stated that he had been thinking about what questions they might still have about the unmet need data, specifically asking for more information on the Medical Monitoring Project (MMP). C. Terrell replied that the MMP used structured interviews for people who were in care, while CSU Intake data would include people new to the system who might not recognize that they need dental care. M. Cappuccilli stated that this might indicate that people in medical care were getting effective messages about the importance of dental care.

- **Food Bank/Home-Delivered Meals** – *Alan Edelstein*

A. Edelstein stated that food bank/home-delivered meals was a supportive service. He then reviewed the HRSA service definition *(see – attached handout)*. He noted that vouchers primarily referred to grocery store gift cards, and that meals can include bags of food in addition to hot meals and home-delivered meals. He stated that food was a basic human need, and most people who needed the service had very low incomes.

A. Edelstein then reviewed the number of clients and units for the service. He noted that the number of clients and units had decreased from 2015 – 2017, as had the actual spending on

- **Nominations Committee**

M. Cappuccilli reported that the Nominations Committee had recommended six new applicants to the Planning Council. He stated that they were looking for more members from the PA Counties, as well as African-American males from Philadelphia. He stated that the committee was planning their summer social, which would be held immediately following the June Planning Council meeting. He noted that members who would like to contribute could bring a purchased dessert with them.

C. Terrell stated that the Planning Council had good representation from people living with HIV, but that there was room for improvement around representation from youth. He stated that young minority gay and bisexual men were disproportionately impacted when it came to new HIV diagnoses, and that the CDC often asked about representation from this group. L. Diaz replied that the Nominations Committee often talked about this, adding that one of the newly-recommended Planning Council applicants fell into this category. D. Law noted that they had had an applicant that had not completed the application because they had not supplied the tax clearance. She noted that the applicant had not responded after being asked to submit the tax clearance. S. Romero agreed that the Nominations Committee often discussed this issue, and that this was part of the reason that they were working on an online application and social media campaigns.

G. Grannan asked how the tax clearance would be addressed if an applicant was homeless. C. Terrell replied that the mayor's office had been very willing to work with the Planning Council on this. He noted that a person who was homeless would not owe property taxes. D. Law stated that QHP staff would also assist people with this issue when needed. E. Rand asked if information about an applicant's HIV status would be shared with the Planning Council, and D. Law replied that it would not. D. Law noted that the applications were blinded. H. Bennet stated that St. John's Hospice and Broad Street Ministries also provided addresses for people who are homeless.

- **Positive Committee**

B. Morgan reported that Positive Committee would meet on Monday.

- **Comprehensive Planning Committee**

No report.

- **Prevention Committee**

L. Matus reported that Prevention Committee had finished reviewing the PrEP Workgroup Report, and that they would finalize the updates at their next meeting. She asked those present to share the PDPH PrEP campaign.

**Old Business:**
None.

**New Business:**
None.

# PrEP Workgroup Report 2019

## PrEP-Related Activities in the 2018 Update to the Philadelphia EMA Integrated HIV Prevention and Care Plan 2017-2021

### Introduction

The PrEP Workgroup is a workgroup of the Prevention Committee of the Philadelphia EMA HIV Integrated Planning Council.

In compliance with the Planning Council's federally mandated bylaws, the PrEP Workgroup advises the Planning Council, through its Prevention Committee, on awareness of, access to, and uptake of pre-exposure prophylaxis (PrEP) in Philadelphia, particularly among people disproportionately affected by HIV. Members of the PrEP Workgroup include PrEP advocates, providers, and community members.

This report summarizes the PrEP Workgroup's deliberations as of its March 2019 meeting. It consists of three sections, as follows:

1. General principles for expanding access to PrEP and PEP services in Philadelphia that guided the Workgroup's discussions. *See page 2, below.*

2. A list of all 10 of the PrEP-specific activities included in the 2018 update of the Planning Council's *Integrated HIV Prevention and Care Plan, 2017-2021* by goal, objective, strategy, and page number. *See page 3, below.*
    - See Section I of the 2018 update to the **Philadelphia EMA Integrated HIV Prevention and Care Plan** for an up-to-date epidemiologic overview including detailed descriptions of emerging and special populations referenced in this report.

3. Annotations by the PrEP Workgroup for PrEP-related activities in the 2018 update of the *Integrated HIV Prevention and Care Plan 2017-2021*. *See pages 4-16, below.*
    - This section provides the context for each PrEP-related activity (labeled "Key Elements") in the *Integrated Plan*, along with a summary of the PrEP Workgroup's discussions that most closely align with the activity (labeled "Discussion").

Upon completion of this report, the Workgroup will refer the document to the Prevention Committee of the Planning Council. Workgroup participants, some of whom are also members of the Prevention Committee, will be available to provide additional input directly to the Committee. The PrEP Workgroup hopes this report will be attached to the next update of the **Integrated Plan**.

For more information about the PrEP Workgroup, including meeting minutes, visit its page on the Planning Council's website, www.hivphilly.org.

## PrEP-Related Activities in the 2018 Update to the Philadelphia EMA Integrated HIV Prevention and Care Plan 2017-2021

### Section 2. Summary List of PrEP-Specific Activities in the 2018 Update of the Integrated HIV Prevention and Care Plan 2017-2021

| # | Activity | Goal | Objective | Strategy | Plan Location |
|---|---|---|---|---|---|
| 1 | Coordinate provision of PrEP and PEP | Goal 1: Reduce new HIV infections | Obj. 1.2: Reduce the number of new infections | Strategy 1.2.2: Ensure the provision of PrEP and nPEP to at-risk populations | Page 6 |
| 2 | Develop and implement a plan to inform the public about the availability of PrEP and nPEP | | | | |
| 3 | Create online campaign Do You Philly to encourage condom use, HIV testing, and PrEP uptake in Philadelphia | | | Strategy 1.2.7: Reduce the percentage of youth, including gay and bisexual men who engage in HIV risk behaviors | Page 10 |
| 4 | Provide prevention navigation services that link MSM of color to PrEP and provide ongoing adherence support | Goal 3: Reduce HIV-related disparities and health inequities | Obj. 3.1: Reduce HIV-related disparities in new diagnoses among high-risk populations | Strategy 3.1.1: Increase access to services for MSM of color that address social determinants of HIV risk | Page 17 |
| 5 | Ensure the provision of PrEP and nPEP to at-risk populations | | | Strategy 3.1.2: Increase access to biomedical prevention interventions | Page 18 |
| 6 | Provide prevention navigations services that link MSM of color to PrEP and provide ongoing adherence support | | | | |
| 7 | Continue and expand community education activities about PrEP | | | | |
| 8 | Continue and expand clinical education about PrEP | | | | |
| 9 | Monitor population level PrEP uptake in key populations in Philadelphia | | | | |
| 10 | Educate and update clinical providers throughout the EMA on the most current evidence-based guidelines and protocols, including but not limited to routine screening and PrEP provision | Goal 4: Achieve a more coordinated response to the HIV epidemic | Obj. 4.1: Support collaboration, communication, and coordination across all sectors | Strategy 4.1.2: Continue outreach and education to clinical providers outside the Ryan White system. | Page 23 |

| PrEP Workgroup Annotations to Strategy 1.2.2 Activity A | |
|---|---|
| **Key elements** | ▪ Of the approximately 13,000 individuals with PrEP indications in Philadelphia, 12,000 are not on PrEP. *(Note: this figure does not include people with PrEP indications in the surrounding counties.)*<br>▪ PDPH estimates between 870 and 1,218 individuals in Philadelphia were on PrEP in 2016.<br>▪ Between 7% to 9% of the total population of persons with PrEP indications in the City of Philadelphia were on PrEP in 2016.<br>▪ Culturally appropriate PrEP and PEP services are available and accessible to target populations including PWID and transgender persons.<br>▪ As of March 2019, 45 individual providers are included in PDPH's PrEP provider list. |
| **Discussion** | ▪ Assuring access to PrEP training curricula to community medical practices with evidence of PrEP capacity in ZIP codes with high HIV and STD prevalence.<br>▪ Facilitating culturally appropriate PrEP-themed town halls, community events, and health fairs.<br>▪ Promoting coordination and collaboration regarding the individual-level and public health benefits of PrEP and PEP among community based clinical programs and local community and faith-based leaders.<br>▪ Integrating PrEP screenings with HIV testing and Hepatitis C testing. |

| PrEP Workgroup Annotations to Strategy 1.2.2 Activity B | |
|---|---|
| | client services, and community engagement resources/events. |
| **Discussion** | ▪ Developing and promoting PrEP campaign talking points for navigators, hotline personnel, educators, clinical staff, and other parties who interact directly with members of the target population that reinforces and leverages the campaign's information and call to action, including information on payment for medications and labs.<br>▪ Providing more information in doctors' offices and spaces where labs are drawn.<br>▪ Providing posters and waiting room materials to PrEP providers and emergency rooms, and notifying providers that these materials are available.<br>▪ Engaging support of the PrEP campaign by popular opinion leaders, public personalities, and social influencers.<br>▪ Collaborating on PrEP campaign-related educational activities with community partners such as churches, mosques, libraries, barbershops, beauty salons, school settings, health fairs, college campuses, and faith-based institutions.<br>▪ Expanding access to on-demand STI services expanded to include PrEP and PEP in order to reach under-served persons for whom PrEP and PEP are indicated (modeled on New York City's program of eight Sexual Health Clinics).<br>▪ Assuring HIV testers facilitate access to PrEP and PEP.<br>▪ Expanding access to the PrEP Dropbox folder. |

| Goal 3: Reduce HIV-related disparities and health inequities<br>Objective 3.1: Reduce HIV-related disparities in new diagnoses among high-risk populations | | | | | |
|---|---|---|---|---|---|
| **Strategy 3.1.1.: Increase access to services for MSM of color that address social determinants of HIV risk** | | | | | |
| ***Responsible parties*** | ***Activity*** | ***Target populations*** | ***Data indicators*** | ***Baseline 2016*** | ***Source*** |
| ▪ PDPH<br>▪ Navigation services providers | Provide prevention navigation services that link MSM of color to PrEP and provide ongoing adherence support | HIV-negative MSM of color | ▪ # of navigation clients<br>▪ # of linkages to behavioral health and social services<br>▪ # of linkages to PrEP in PDPH-funded programs | ▪ 83 Club 1509 clients<br>▪ 34 linkages to supportive services<br>▪ 10 linkages (4th quarter 2016 only) | Club 1509 provider data exports (CAREWare) |

| PrEP Workgroup Annotations to Strategy 3.1.1 | |
|---|---|
| **Key elements** | ▪ PDPH provides grants to seven projects funded by AACO's CDC-funded PS15-1509 cooperative agreement to conduct prevention navigation services for eligible clients. *(Note: PS15-1509 ends in 2019. Transition planning for these clients is underway. Currently, AACO funds five subrecipients for PrEP navigation services and four subrecipients for HIV navigation, which includes PrEP adherence and support.)*<br>▪ As of Year 3 of PS15-1509, 704 clients have been screened for PrEP, 545 referred to PrEP, 438 linked to PrEP, and 357 prescribed PrEP. |
| **Discussion** | ▪ Developing formal relationships among PDPH-funded navigation services, community medical providers, pharmacists, and mental health/substance abuse treatment services and plans in neighborhoods with high prevalence of HIV and STDs.<br>▪ Assessing how PDPH-funded navigator providers advertise and recruit HIV-negative MSM of color for their programs.<br>▪ Identifying lessons learned through the 1509 program and assessing its impact on the system. |

| PrEP Workgroup Annotations to Strategy 3.1.2 Activity A | |
|---|---|
| | ▪ As of March 2019, 45 provider sites are included in PDPH's PrEP provider list. *(Note: Providers with extended hours are noted in the document.)* |
| **Discussion** | ▪ Addressing barriers to accessing PrEP and PEP among uninsured and under-insured persons through initiatives that pay for uncovered costs of PrEP-related visits and labs at community medical provider sites.<br>▪ Supporting PrEP programs providing developmentally appropriate services to persons under the age of 25, particularly teens.<br>▪ Developing programs that provide evening and weekend hours to expand accessibility to PrEP services.<br>▪ Expanding access to PrEP and PEP "starter packs" for special circumstances that may occur in settings such as emergency departments with immediate linkage to PrEP providers.<br>▪ Engaging pharmacists and physicians in expanding access to PrEP and PEP, and in supporting PrEP adherence.<br>▪ Exploring possible role of 340b program financing to fill gaps in insurance coverage such as co-pays for PrEP clinic visits and laboratory costs.<br>▪ Exploring the use of telehealth to expand access to PrEP. |

## PrEP-Related Activities in the 2018 Update to the Philadelphia EMA Integrated HIV Prevention and Care Plan 2017-2021

| Strategy 3.1.2: Increase access to biomedical prevention interventions | | | | | |
|---|---|---|---|---|---|
| ***Responsible parties*** | ***Activity C*** | ***Target populations*** | ***Data indicators*** | ***Baseline 2016*** | ***Source*** |
| PDPH | Continue and expand community education activities about PrEP | ▪ MSM of color<br>▪ Community leaders<br>▪ High-risk heterosexuals<br>▪ Sexual and drug using partners of PLWH<br>▪ PWID<br>▪ Transgender women | ▪ # of technical assistance sessions provided by PDPH Clinical Advisor | ▪ 30 TA sessions | PDPH PrEP Clinical Coordination Program |
| | | | ▪ # of persons reached during TA sessions | ▪ 670 persons reached | |

| PrEP Workgroup Annotations to Strategy 3.1.2 Activity C | |
|---|---|
| **Key elements** | ▪ In 2018, the PDPH PrEP Clinical Coordinator (1) conducted 45 technical assistance visits at clinical sites, which engaged 650 persons, (2) trained 74 certified HIV testers at 7 Testing and Linkage to Care in-service trainings, and (3) participated in 6 PrEP Workgroup meetings attended by 240 duplicated individuals. |
| **Discussion** | ▪ Developing a network of Popular Opinion Leaders who can inform the community on the benefits of PrEP and PEP, how and where to access PrEP and PEP services, and the role of adherence to PrEP. |

| Strategy 3.1.2: Increase access to biomedical prevention interventions | | | | | |
|---|---|---|---|---|---|
| ***Responsible parties*** | ***Activity E*** | ***Target populations*** | ***Data indicators*** | ***Baseline 2016*** | ***Source*** |
| ▪ PDPH<br>▪ HIPC | Monitor population level PrEP uptake in key populations in Philadelphia | High-risk HIV-negative individuals<br>Transgender women<br>MSM of color<br>Youth 13-24 | ▪ # of HIV-negative Philadelphians on PrEP<br>▪ # of HIV-negative MSM on PrEP | ▪ Data to be reported in 2019 | PDPH PrEP Monitoring and Evaluation Plan |

| PrEP Workgroup Annotations to Strategy 3.1.2 Activity E | |
|---|---|
| **Key elements** | ▪ PDPH's PrEP Monitoring and Evaluation Plan was completed in 2018. *(Note: this plan identifies transgender persons who have sex with men as a target population.)*<br>▪ PDPH participated in the national PrEP-related HIV Technical Cooperation Group of the University of Washington's Public Health Capacity Building Center.<br>▪ Baseline data on PrEP uptake in Philadelphia is currently being identified and collected. |
| **Discussion** | ▪ Geo-coding (1) HIV incidence data, (2) select STI incidence data, and (3) locations of providers on the PDPH roster to identify ZIP codes that indicate disparities in access to PrEP providers.<br>▪ Addressing PrEP access gaps identified by geo-coding through such activities as (1) building clinical community-based capacity for PrEP services, and (2) linking clinical providers with available PrEP educational programs, CME courses, and other training tools.<br>▪ Implementing PrEP-related lessons to be learned by 2022 in the performance of PDPH's CDC cooperative agreement project *Demonstrating Expanded Interventional Surveillance: Towards Ending the HIV Epidemic in Philadelphia (DExIS).* DExIS is a 4-year project that began in October 2018 to address disproportionate rates of new HIV infections among gay and bisexual men of color, other men of color who have sex with men, youth of color ages 13-24, and transgender persons of color as well as to address health disparities within the HIV prevention system in Philadelphia. The project builds on Philadelphia's existing surveillance |

| PrEP Workgroup Annotations to Strategy 4.1.2 | |
|---|---|
| **Key elements** | ▪ Information on formal clinical education about PrEP is available from the Philadelphia regional partner site of the Mid-Atlantic AIDS Educational and Training Center (Health Federation of Philadelphia). |
| **Discussion** | ▪ Maintaining an online list of CME credited PrEP-related webinars.<br>▪ Providing access to PrEP and PEP best practice protocols, electronic medical record templates for PrEP and PEP, health care coverage information for HIV prevention, research articles and training programs for clinicians (the basis of which is currently available (but not easily accessible) at an online file hosting service (Dropbox.com).<br>Encouraging quality improvement projects in clinical practices on PrEP, PEP, HIV testing, and STD screening.<br>▪ Addressing barriers to and improving access to PEP.<br>▪ Encouraging Community Advisory Boards operated by service providers in Philadelphia to disseminate information on PrEP and PEP.<br>▪ Encouraging clinicians to improve services by soliciting and incorporating community feedback.<br>▪ Facilitating greater representation of racial/ethnic minorities, women, and transgender persons in PrEP-related research. |

## Service Priority Setting Worksheet 2019

Each service category will be scored according to these factors and scales using the sources noted for each factor. For the Community Voices factor each individual will vote their conscience (as informed by EMA data and committee deliberations) and the service category scores will be tallied by the average of those scores.

| Factor | Definition | Scale |
|---|---|---|
| **Consumer Survey (20%)** | Percentage of consumers who said they used or "needed but didn't get" in the last 12 months, in the 2017 Consumer Survey. The sample is geographically representative of the EMA and includes PLWH who have engaged in the RW system. | 1- no mention<br>3- >7.5%<br>5- 7.6-15%<br>8- 15.1% |
| **Medical Monitoring Project (20%)** | Medical Monitoring Project data captures unmet service needs for PLWH in care. It is a representative sample of PLWH in HIV care. The data sample if Philadelphia only. | 1 – no mention<br>3 – > 14%<br>5 - 15-44%<br>8 – 45% |
| **Client Services Unit-Need at Intake (20%)** | Self-reported service need to Client Services MCM intake. These individuals are re-entering or entering the RW service system. The data sample is not EMA-wide- Philadelphia and PA counties with very few NJ. | 1 – no mention<br>3 – >25%<br>5 – 26-51.6%<br>8 – 51.7% |
| **Community Voices (40%)** | This factor seeks to quantify community experience/expertise of delivering and receiving HIV services in relationship to emergent needs and issues, vulnerable populations, community knowledge, and other EMA data. | 1- this service is important to ensure engagement in care, retention in care and/or viral suppression<br><br>5- This service is needed to ensure engagement in care, retention in care, and/or viral suppression<br><br>8- This service is critical to ensure engagement in care, retention in care and viral suppression. |

# HIV Testing

| ACTIVITY | OUTCOME |
|---|---|
| Healthcare setting HIV testing in Model Emergency Department | Implement routinized, opt out HIV testing in emergencies departments |
| HIV testing in adolescent and pediatric healthcare settings | Increase the number of youth aware of their HIV status; PDPH estimates that 50% of youth living with HIV do not know they are positive and 26% of new diagnoses in 2017 were among youth 13-24 |
| Focused HIV Testing | Increase access to and provide low-threshold HIV testing to communities disproportionately impacted by HIV |
| HIV Testing CQI | Provide intensive 1-on-1 TA to providers conducting HIV testing |
| Site Development Process | Conduct formative research for focused HIV testing programs to ensure services are engaging populations of focus |

# PrEP

| ACTIVITY | OUTCOME |
|---|---|
| PrEP Navigation in clinical and community based settings | Increase access to PrEP by reducing barriers to uptake, adherence and retention |
| PrEP Referral List and Map | Increase access to PrEP by maintaining list of Philadelphia PrEP/ PEP provider sites |
| PrEP Quality Assurance Calls | Ensure provider sites on PrEP referral list and map are providing high quality PrEP services, Monitor wait times for new appointments |
| PrEP Media Campaign- *Philly Keep On Loving* | Increase awareness and uptake of PrEP in Philadelphia |
| PrEP Clinical Advisor/ Technical Assistance | Provide TA/ capacity building assistance to build network of PrEP providers |
| PrEP Monitoring and Evaluation Plan | Monitor PrEP use in jurisdiction |
| PrEP Data-to-care | Utilize clinic level data to maximize resources and 1) identify PrEP patients and 2) engage patients in adherence and retention activities |

| Calendar Year 2018: Client Needs at Intake (N=1903) | | | | | |
|---|---|---|---|---|---|
| | **All Clients** | **Male** | **Female** | **Afr. Amer. MSM** | **Latino MSM** |
| **Number of Intakes** | 1903 | 1286 | 545 | 461 | 103 |
| **Percent of Total Intakes** | 100% | 67.6% | 28.6% | 24.2% | 5.4% |
| **Service Category** | | | | | |
| **Housing** | 51.7% | 50.3% | 55.6% | 59.7% | 53.4% |
| **Food Bank/Voucher/ Home Delivered Meal** | 18.9% | 16.2% | 24.8% | 16.1% | 19.4% |
| **Treatment Adherence** | 45.5% | 46.8% | 45.1% | 45.8% | 43.7% |
| **Benefits Assistance** | 32.5% | 34.2% | 29.2% | 29.1% | 36.9% |
| **Medical Care** | 32.8% | 33.3% | 29.2% | 28.9% | 31.1% |
| **Transportation Assistance** | 25.4% | 24.2% | 29.0% | 23.2% | 27.2% |