VIRTUAL: HIV Integrated Planning Council
Meeting Minutes of
Thursday, October 13, 2022
2:00 p.m. – 4:30 p.m.
Office of HIV Planning, 340 N. 12th St., Suite 320, Philadelphia PA 19107

Present: Juan Baez, Mike Cappuccilli, Keith Carter, Debra D'Alessandro, Jose DeMarco, Lupe Diaz (Co-Chair), Alan Edelstein, Pamela Gorman, Gus Grannan, Julie Hazzard, Sharee Heaven (Co-Chair), Gerry Keys, Dr. Marilyn Martinez, Lorett Matus, Shane Nieves, Clint Steib, Desiree Surplus, Evan Thornburg (Co-Chair), Adam Williams

Guests: Evelyn Torres (AACO), Dr. Cheryl Bettigole, Gracie Borns, Julia Hodgson, Ahmea Branch (AACO), Ameenah McCann-Woods (AACO), Javontae Williams (AACO), A. Thomas-Ferraioli Thomas-Ferraioli (AACO), Janice Horan, Mike Frederick, Monique Gordon, AJ Scruggs, Jessica Caum, Dr. Cheryl Bettigole, Jim Garrow

Excused: Sterling Johnson

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

Call to Order: L. Diaz called the meeting to order at 2:08 p.m. and asked everyone to introduce themselves in the chat with their name, area of representation, and favorite candy.

Approval of Agenda:
L. Diaz presented the October 2022 Planning Council agenda for approval. **Motion:** K. Carter made a motion to approve the October 2022 agenda, G. Keys seconded to approve the agenda. **Motion passed:** 15 in favor, 3 abstaining.

Approval of Minutes (*September 8, 2022*)
L. Diaz presented the September 2022 meeting minutes for approval. C. Steib said he should be marked as excused for this meeting. **Motion:** G. Keys motioned to approve the amended September 2022 meeting minutes, K. Carter seconded. **Motion passed:** 14 in favor, 5 abstaining.

Report of Co-Chairs:
No report.

Report of Staff:
M. Ross-Russell reported that OHP staff was still entering the survey responses from the Consumer Survey. The goal was to have them completed by the end of the month. They encountered a brief software glitch due to a licensing issue and in turn lost a few days for entering.

S. Moletteri reported that OHP was currently in the process of conducting interviews to fill the two vacant positions in the office.

Discussion Item:

—MPV Discussion with Dr. Cheryl Bettigole—

K. Carter noted that the Positive Committee crafted a letter to Dr. Bettigole. In turn, she suggested she meet with the council to discuss non-stigmatizing language. M. Cappuccilli asked if messaging which contained the stigmatizing language came from Philadelphia or if it was coming from the CDC first. D. D'Alessandro said that Philadelphia used MPV language reflective of CDC language. J. Williams said that the Division of Disease Control was leading Philadelphia's response to MPV. Therefore, the language was coming from the federal partners' guidelines. Messaging used was not intentionally stigmatizing but there was always room for improvement. There was a weekly group that met to ensure language and approach was better. For example, a vaccine form from Philadelphia was recently tweaked to ensure it contained less stigmatizing language.

J. Williams added that Dr. Brady was also working on language – for example, they chose to use "sores" instead of "lesions" to remove stigma where they could. K. Carter was hoping that some change could take place in the near future. They were excited to step up and use their voice as a council. M. Cappuccilli asked if part of this process involved reading the full letter. In response, K. Carter read the full letter.

E. Thornburg offered to give clarification. She said that although MPV was not a STI, it was mostly transmitted sexually. There were many modes of transmission, but sexually was the most prominent mode. MPV transmissions mainly started in a population that was exchanging sexual interaction for other things. Philadelphia did not want to build excess fear or rush on a public health system and wanted to focus on the nuances. Additionally, they did not want to place the onus on one population. They must recognize that people lived intergenerationally and below the poverty rate, so they must keep this in mind that modes of transmissibility were far reaching.

Dr. Bettigole joined the meeting at 2:30 and greeted the council. K. Carter introduced himself as one of the individuals charged with writing the letter to the Health Commissioner. He reminded everyone that they were just focusing on messaging today and that they would open up a Q&A towards the end of the discussion item.

S. Heaven introduced herself and thanked Dr. Bettigole for joining the council meeting.

K. Carter read the suggestion letter. Please see the end of the meeting minutes (page 10) to read the suggestions put forth by the council. K. Carter mentioned how queer populations may have more hesitancy with MPV vaccinations, especially with the change in dosing. Queer populations might be wary and concerned that they are the "test subjects" of this vaccine.

Dr. Bettigole explained that MPV had been a difficult endeavor regarding public health messaging. Philadelphia wanted to ensure they were clear yet simultaneously not stigmatizing – the city did not have nearly enough vaccines, so they were still running into issues with this. With a city of 1.6 million, they had only about 16,000 vaccines which included those already

administered. Because of this, they wanted to ensure the vaccines were getting to those who needed it most.

Dr. Bettigole asked those joining from the Health Department to introduce themselves. J. Caum introduced herself as part of the Division for Disease Control. J. Garrow introduced himself as the Communications Director for the Health Department. The team oversaw press, website, messaging, etc. Other AACO members and Health Department employees introduced themselves.

Cheryl fleshed out the debate for communication. Some people felt there should be clear communication on who was most affected. For example, if they did not explain that Black MSM were most at risk, they would be failing their public health duties. On the other hand, others felt that singling out MSM and specifically Black MSM, might drive away these very populations, especially if Black men felt uncomfortable or did not identify as MSM/queer.

They had been working with community members to hone messaging. One idea that they had was to put vaccination clinics where high risk populations may go without any screenings or risk factors. They would not reach everybody that way, but this way they could reach people at risk without putting forth complicated communication.

K. Carter said eventually, many people would be exposed to the virus regardless of race, sexuality, etc. Currently the data showed that this was affecting mostly specific populations. However, when you start to target populations, this is when violence occurred as shown in the early days of the HIV epidemic.

A. Williams thanked Dr. Bettigole and her team for joining them. He noted that based on anecdotal and personal accounts from HIPC members, messaging and communication from individuals working the appointment hotlines and testing/vaccination services was troubling. This communication was cisgendered and heteronormative when asking questions about sexual behaviors and experienced symptoms. Those individuals who wanted to access screenings were facing difficulties unless they fit inside very specific guidelines for population demographics. Those not part of the queer risk group categories might have substantially more difficulty accessing tests. This means that results for testing/infection might be skewed and there might be artificially low numbers.

Dr. Bettigole responded that they recently changed the script for those answering the phone. Additionally, CDC had initially restricted testing but this was now wide open. They were monitoring the positivity rate among men and women.

K. Carter asked why there was not a pop-up clinic so people could get the vaccines like they did with the COVID-19 vaccine. Dr. Bettigole said they had been working on this and they were specifically working with Black Doctors. The idea was to put the pop-up clinics at clubs but they were looking at other places as well. K. Carter said this might not be the best place. Dr. Bettigole agreed but said putting them at the grocery store, for example, would not reach the high-risk populations in the same way with their limited number of vaccines. J. Horan asked about partnering with pharmacies. Dr. Bettigole said they were trying to work with independent

pharmacies, but the more partners out in the neighborhoods was likely the best mode of action. She added that partnerships seemed to be challenging given that many partners were exhausted from COVID-19 response.

E. Thornburg said she was on the vaccine distribution team. There was an RFP with 22 respondents. The team had 7 people reviewing all applications. She said they were looking for partners who had good ideas to get the vaccines out to the high-risk populations. They also looked at community trust around information, resourcing, and distribution. They also looked at if they had a distribution plan given the limited number of vaccinations. They also looked for organizations that reflected the populations at risk.

K. Carter suggested that for vaccinations, they investigate extending the hours of, and locations for availability for, receiving a vaccination. Dr. Bettigole responded that the annexes were now offering vaccines as well.

J. Horan asked if PLWH were more susceptible via other modes of transmission. Dr. Bettigole said PLWH were of higher priority for receiving the vaccine since they were immunocompromised.

D. D'Alessandro asked about availability for testing tools and whether it was still a difficult pathway for testing. Dr. Bettigole said this was much different now and that they could now do this through general labs. K. Carter asked if swabbing was just for sores or whether there were other types of swabs such as oral. Dr. Bettigole said that they would swab wherever there were sores. K. Carter asked if they were seeing many oral sores. Dr. Bettigole said that they were not seeing high rates of MPV in general and that numbers had decreased. However, for those experiencing MPV, there were still oral sores.

J. DeMarco asked about education and general knowledge around MPV within Philadelphia. He suggested getting information into places like barber shops, hair braiding salons, supermarkets, and other neutral places would be best. This way people would not be outed and still receive information. Dr. Bettigole said they were already doing this in neighborhood places. K. Carter asked if they were doing PSAs. Dr. Bettigole said they did not have specific funding to do mass PSAs.

M. Cappuccilli noted that cases had dropped nationally and asked if this was reflected within Philadelphia. Dr. Bettigole answered that peak cases were at about 70 per week and was now down into the teens. This was an encouraging trend.

K. Carter asked about the efficacy of intradermal vaccinations. Dr. Bettigole said she could share the data they had.

Dr. Bettigole thanked everyone for hosting her.

M. Ross-Russell said that J. Garrow put information on dosing within the chat that could answer some of the questions the council had.

C. Steib wondered if there was a process for individual providers to apply to distribute vaccinations. E. Thornburg said there was an RFP but it was now closed because of the limited amount of funding.

E. Torres said that her following comments were as an individual, not a representative of the Department of Public Health. She continued to explain that this meeting was specifically about messaging. The dilemma around messaging also had to consider the infection rates. The majority of those impacted by MPV were men and specifically MSM. Therefore, they had to get the language out to those who are most impacted while also ensuring nuanced messaging.

J. Horan asked if the smallpox vaccines would prevent MPV. E. Thornburg said that there was not an active smallpox virus in the public, but they were non-relational. Smallpox vaccines did not prevent against MPV. E. Thornburg also noted that a main issue with public health messaging generally was talking about the science in a consumable way. D. D'Alessandro said that the smallpox vaccine was no longer required for school entry starting in 1972.

Action Item:

—HIPC Co-Chair Election—

M. Ross-Russell said they would be holding co-chair elections at this meeting. The only person who had agreed to the co-chair position was L. Diaz. There were no additional comments. The group moved onto a vote.

It was put to a vote where 16 members were in favor and 2 people abstained. L. Diaz was reelected as Co-chair.

Presentation:

—Integrated Plan Goals & Objectives—

E. Torres introduced herself and said that A. Thomas-Ferraioli would be joining her to present on the Integrated Plan Goals & Objectives. The group received the draft goals and objectives before the meeting.

E. Torres reviewed the slide titled Background. Please refer to the presentation for more details.

E. Torres reviewed the slide titled Integrated Plan Table of Contents.

E. Torres reviewed the slide titled Section V: 2022-2026 Goals and Objectives. She explained that this plan was important because it would set the stage for 2022-2026, so they wanted to ensure that it was aligned with the NHAS plan and EHE plan. Each pillar/strategy contained their own goals and objectives. She had included the link for the plan's guidance if anyone wanted to read it.

She next looked at the slide titled Diagnosis – Draft Goals. She asked everyone to comment after the presentation. They could also send their comments to M. Ross-Russell before the plan's due date on December 9th. As for the second goal, she clarified that non-clinical HIV testing would be community-based sites. She said they had HIV testing in Philadelphia and they were tasked with testing specific populations based on incidence data. Providers could test everybody but they were focusing on the following populations: Black and Latinx MSM, Black and Latinx Trans Women, Black and Latinx heterosexual women, and PWID. As for the third goal, she said ending the HIV epidemic would not be possible without collaboration and a diverse workforce.

E. Torres next reviewed the slide titled Diagnose focusing on Goal 1: To diagnose 95% of persons living with HIV by 2026. She explained that for the third objective—implement novel HIV testing initiatives—AACO was already working toward this. They were soon putting out an RFP for HIV testing within pharmacies. They were also looking at vending machines that contained syringes and other items. Additionally, they were working with RW providers to offer syringes.

She next looked at the slide titled Diagnose, Goal 2: Eliminate disparities in non-clinical HIV testing. She said that when they looked at the data, social determinants of health impacted vulnerability to HIV and every other disease. They would not get anywhere unless they looked at other determinants of health, such as education, poverty, race, etc. Partnerships would be essential for this.

E. Torres addressed the last slide for Diagnose titled Diagnose, Goal 3: Strengthen the HIV workforce including collaboration with NJ and PA DOH (Department of Health).

A. Thomas-Ferraioli reviewed the Treatment pillar. She read the three draft goals under the slide titled Treatment – Draft Goals. She explained that the source of the goals included the EHE goals.

A. Thomas-Ferraioli next read the slide titled Treat, Goal 1: By 2026, 95% of people living with HIV will be virally suppressed. She explained that the first objective did not have a set percentage yet because they were currently working with the EPI surveillance team to establish a baseline percentage.

A. Thomas-Ferraioli reviewed the second goal under Treat on the slide titled Treat, Goal 2: Increase engagement in HIV medical care to 95% among people with diagnosed HIV. She said that part of the reason people did not engage in care was because of social and structural barriers, similar to what E. Torres had mentioned when discussing social determinants of health under the Diagnose pillar.

A. Thomas-Ferraioli next looked at the last goal under Treat on the slide titled Treat, Goal 3: Reduce HIV-related disparities in HIV outcomes.

E. Torres reviewed the prevention goals and objectives under the Prevent pillar. Please refer to the slide titled Prevent – Draft Goals. She explained that these were ambitious goals because they wanted to challenge themselves to end the epidemic. Reducing disparities was a main theme

throughout the plan. E. Thornburg was taking the lead on this and a lot of strategies were already in progress.

E. Torres referred to the slide titled Prevent, Goal 1: Use biomedical prevention strategies to reduce new HIV diagnoses by 75%. For the second objective, she noted that they had already funded an nPEP center in Philadelphia that provided the 24/7 access to PEP.

E. Torres next read the slide titled Prevent, Goal 2: Increase the number of access points for the evidence-based harm reduction. She explained that workforce/training and monitoring services was vital for delivering competent services.

She last read goal 3 of Prevent on the slide titled Prevent, Goal 3: Reduce disparities in HIV-related prevention services in priority populations. She added that they needed to focus on priority populations. She said J. Williams would be able to offer a presentation on their media campaigns and the PhillyKeepOnLoving website. She noted that the website recently added a telePrEP portion.

A. Thomas-Ferraioli next looked at the Respond pillar. She read the slide titled Respond – Draft Goals.

A. Thomas-Ferraioli read the first goal on the slide titled Respond, Goal 1: Identify and investigate active HIV transmission clusters and respond to all HIV outbreaks.

A. Thomas-Ferraioli read the second goal on the slide titled Respond, Goal 2: Ensure data sharing with the PA and NJ Departments of Health.

E. Torres thanked everyone for hearing the presentation. E. Torres noted that J. Williams had put two links in the chat about the nPEP center and the telePrEP component on PhillyKeepOnLoving.

C. Steib had asked if there was monitoring of prescribed PEP in Philly. A. Thomas-Ferraioli said this was difficult to do since prescriptions happened in many different places. Additionally, the medication was similar or identical to PrEP. They were, however, able to identify that among newly diagnosed MSM, around 20% used PEP the year before diagnosis. The Health Department identified this as a missed opportunity to have a conversation after offering PEP to then prescribing PrEP for ongoing prevention. This was from an MSM cycle of NHBS.

A. Scruggs asked why transgender men were not part of a focus group cycle included in the NHBS. E. Torres said they were focusing on high prevalence groups, especially transgender men who have sex with men. J. Williams said this would likely be an increasing population of focus, and they wanted to diversify the images on PhillyKeepOnLoving, but they would have to follow the data and trends for Philadelphia when designing interventions. A. Scruggs noted that he had presented at UCHA about the lack of data collected around transgender men. He found that transgender men, especially in the South, were at higher risk for HIV. Based on qualitative data he collected, the lack of data collection had to do with individuals assuming the way transgender

men had sex. He suggested those at AACO reach out to him. E. Torres said she would love to touch base and have A. Scruggs present this to AACO as well.

E. Thornburg pointed out that J. Williams had worked on the images within the PhillyKeepOnLoving campaign, ensuring that they represented out transgender men.

K. Carter asked about the possibility of developing relationships with pharmaceutical companies to get more data on PEP. E. Torres said that the CDC received PrEP prescription data so they could try looking further into PEP prescriptions as well. K. Carter said this was a good idea. D. D'Alessandro said that PEP was also available for purchase, though it was expensive. She said the challenge with PEP is that it could be used for treatment as well. It was difficult to know why/when it was prescribed.

C. Steib suggested they look at funding for HIV testing to receive more baseline data. For example, they could get information from emergency departments prescribing PEP. G. Grannan asked if they were able to distinguish between the PrEP and PEP based on renewal for prescription. E. Torres said they would take these suggestions into consideration and dive further into how to differentiate and collect PEP data. D. D'Alessandro, in her experience, noted that such data that G. Grannan mentioned was based prescriber identity, not the individual. A. Thomas-Ferraioli said that she could pull out more information, but it took a bit of time to develop methodology to estimate PrEP uptake, so it might be the same for PEP. She put her email address in the chat.

E. Torres asked everyone to offer their comments before the next HIPC meeting.

Committee Reports:

—Executive Committee—

L. Diaz and K. Carter reported that the Executive Committee had talked about hybrid meetings and the possibility of in-person meetings. M. Ross-Russell explained that they needed to start laying the groundwork for potential hybrid or in-person meetings. They were also still working with the social distancing rule. This meant setting up the conference room with fewer desks and discussing protocol. This meeting had occurred one day after the City's announcement around COVID protocols and next steps.

—Finance Committee—

A. Edelstein reported that the Finance Committee did not meet this month. They sent the letter regarding prevalence numbers to the State of PA. He asked if they received a response yet. M. Ross-Russell said she spoke to Dr. Brady on Friday but they had not yet received a response.

—Nominations Committee—

M. Cappuccilli reported that the committee met at the end of September to vote on new members. However, they met today to discuss how they had 34 members, meaning they were 1

below their membership and were in violation of their bylaws. They were looking into reviewing more applications and contacting other individuals. If any councilmembers knew of anyone who had interest in joining the council, he asked that they please contact S. Moletteri at sofia@hivphilly.org.

—Positive Committee—

No further report. The next meeting would be the second Monday of November.

—Comprehensive Planning Committee—

G. Grannan reported that the CPC discussed priority setting for the integrated plan. The next meeting would be a week from today at 2:00 p.m.

—Prevention Committee—

C. Steib reported that the Prevention Committee met last month to discuss plans on moving forward and worked on organizing themselves and their future work. They would meet again on the 26th of this month at 2:30 p.m.

Other Business:

M. Ross-Russell said that there were two links that she had shared in the chat. One was regarding the CDC's report on uptake of PrEP. The second was around surveillance data.

Announcements:

K. Carter congratulated L. Diaz on her Red Ribbon Award. L. Diaz congratulated J. Williams on his Red Ribbon Award.

J. Williams announced that they had launched Philadelphia telePrEP at 5:30 p.m. on Friday in partnership with Einstein Health. They were already seeing interest on the live site. He thanked B. Hernandez for his hard work on this.

D. D'Alessandro reminded everyone to vote on November 8th.

Adjournment:
L. Diaz called for a motion to adjourn. **Motion:** K. Carter motioned, D. D'Alessandro seconded. Meeting adjourned 4:17 p.m.

Respectfully submitted,

Sofia M. Moletteri, staff

Handouts distributed at the meeting:

- October 2022 HIPC Meeting Agenda
- September 2022 HIPC Meeting Minutes
- Integrated Plan 2022-2026 Draft Goals

HIV Integrated Planning Council
Suggestions for Dr. Cheryl Bettigole
Thursday, October 13, 2022
2:00 p.m. – 4:30 p.m.

Many of the members of the HIV Integrated Planning Council still remember the early days of the AIDS epidemic and the impact targeted messages had on stigmatizing the same populations we serve today. For this reason, members of the POZ committee and full planning council felt it incumbent upon us to reach out to you to express our concerns.

The following list was created to help focus the suggestions and concerns expressed by members:

1. We want to ensure that language is far reaching in that it is inclusive of warning ALL members of the public of the infection risks associated with MPV
    a. We ask that you keep messaging broad while still having conversations with specific populations that are most affected
    b. The approach to vaccination and testing for MPV has not been far reaching, inclusive, or accessible especially when compared to COVID-19 response

2. We also would like focus to be placed on one-on-one language with patients—the populations seeking assistance are diverse, training for healthcare workers should occur to ensure that the way they interact with patients is not stigmatizing or insensitive
    a. HIPC members' report this as an issue based on their own experience and the reported experiences of those they serve
        i. Patient's concerns should be taken seriously and workers helpful—not harmful—in their approaches
        ii. Providers had mixed information related to test eligibility, resources, vaccines, etc.,
    b. The reliance on Health Center 1 gave the impression that, MPV was approached as an STI even though the Department of Health did not label it as such *(meaning MPV carried the problematic stigma already attached to STI messaging)*
        i. Testing and vaccination data seem to indicate that the populations that received the majority of these services were inconsistent with the populations most infected

3. We ask that messaging remain data-focused
    a. This will help to center minority groups heavily impacted by MPV and allow Philly to train staff in a culturally sensitive way & according to data
    b. There needs to be more data about the dosage change for vaccinations and its efficacy