**HIV Integrated Planning Council (HIPC)**
**Meeting Minutes of**
**Thursday, July 11, 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, Janielle Bryan, Keith Carter, Mark C. Terrell, Evette Colon-Street, Lupe Diaz, Alan Edelstein, David Gana, Pamela Gorman, Gus Grannan, Sharee Heaven, Gerry Keys, Richard LaBoy, Dena Lewis-Salley, Lorett Matus, Nicole Miller, Christine Quimby, Eran Sargent, Jason Simmons, Terry Smith-Flores, Clint Steib, Gloria Taylor, Coleman Terrell (AACO), Jacquelyn Whitfield

**Excused:** Katelyn Baron, Michael Cappuccilli, Nhakia Outland, Erica Rand, Samuel Romero, Steven Zick

**Absent:** Maisaloon Dias, Janice Horan, Peter Houle, La'Seana Jones, Brian Langley, George Matthews, Dorothy McBride-Wesley, Jeanette Murdock, Joseph Roderick, Zsofia Szep, Gail Thomas, Adam Thompson, Lorrita Wellington, Zora Wesley, Melvin White

**Guests:** Ameenah McCann-Woods (AACO), Chris Chu (AACO), Carla Fields, Claire Burns-Lynch, Edward Campbell, Henry Bennett, Julio Jackson, Marie Jackson, Phoebe Torchia, Timothy Benston

**Staff:** Briana Morgan, Mari Ross-Russell, Nicole Johns, Sofia Moletteri

**Call to Order:**
L. Diaz called the meeting to order at 2:10 PM.

**Welcome and Introductions**
L. Diaz asked for introductions and an ice breaker. All present introduced themselves.

**Approval of Agenda**
L. Diaz called for an approval of the July 11, 2019 HIPC Agenda. **Motion:** K. Carter moved, D. Gana seconded. **Motion passed:** all in favor.

**Approval of Minutes (June 13, 2019)**
L. Diaz called for an approval of June 13, 2019 HIPC Minutes. **Motion:** K. Carter moved, J. Whitfield seconded. **Motion passed:** all in favor.

**Report of Co-Chairs – End the Epidemic (Coleman Terrell)**
C. Terrell prepared an Accelerating Strategic Planning to End the Epidemic PowerPoint to address the Ending the Epidemic Initiative (EtHE). He reported that the Health Department submitted its application for Philadelphia to the CDC yesterday, July 10, 2019. C. Terrell explained that the EtHE

money would be used for a rapid planning process on an accelerated timeline. C. Terrell differentiated between a regular Integrated Plan and EtHE by listing the mandated portions to EtHE. The EtHE must have an explicitly stated goal and must address the Four Pillars. He explained the need for an aggressive timeline and its focus on the identified counties. Ultimately, the EtHE aspires to eliminate 75% of new infections within 5 years and 90% within 10 years.

C. Terrell identified the four pillars as Diagnose, Treat, and Protect and Respond. EtHE seeks to (1) Diagnose all people with HIV as early as possible after infection, (2) Treat the infection rapidly and effectively to achieve sustained viral suppression, (3) Protect people at risk for HIV using potent and proven prevention interventions, including PrEP, and (4) Respond rapidly to detect and respond to growing HIV clusters and prevent new HIV infections.

The EtHE includes prominent short term outcomes. The short term goals are as follows: increased engagement of HIV service partners, including local care and prevention planning bodies, local providers, persons with HIV, and other community members impacted by HIV; increased understanding of epidemiological profile of the relevant jurisdictions; and increased understanding of the HIV care and Prevention context/situational for the EtHE. C. Terrell continued to explain the short term goals as engagement-focused to help individuals understand the overall plan. He mentioned that EtHE would have aggressive and specific goals—e.g. how many bisexual men of color should be on PrEP?

C. Terrell reported that intermediate outcome would involve improved ability to rapidly implement activities to meet the HIV care and prevention needs of the local jurisdictions consistent with the goals of the EtHE. He added that the intermediate outcome portion of EtHE may begin funding in fall of 2019.

C. Terrell addressed the long term goals next, reporting that they are similar to those in the current Integrated Plan. The goals are as follows: increased effectiveness of comprehensive HIV programs; reduced new HIV infections; increased access to care for PLWH, improved health outcomes for PLWH; reduced HIV-related health disparities and health inequities; and achievement of a more coordinated response.

C. Terrell listed the Seven Required Activities for the EtHE: (1) engage with existing local prevention and care integrated planning bodies; (2) prepare current epidemiologic profile for jurisdiction; (3) prepare a brief situational analysis for jurisdiction; (4) engage with local community partners; (5) engage with local HIV service provider partners; (6) reach concurrence on an Ending the HIV Epidemic plan with local HIV planning groups; and (7) prepare a final/revised Ending the HIV Epidemic plan for jurisdiction. C. Terrell expressed the importance of making sure people are engaged in all communities. There had been a proposal to work with and engage many organizations separate from normal service providers and to facilitate large, open forum town hall meetings. C. Terrell explained that he would be inviting both RWHAP providers and those who are not part of the funding system. The goal, he enforced, is to have a robust group of service providers to go over the

plan. C. Terrell lets the group know that there would be updates regarding EtHE for every HIPC meeting.

G. Grannan thanked C. Terrell for the presentation on EtHE and asked at what point of the process concurrence is expected. C. Terrell responded the current, tentative timeline. Primarily, the EPI Profile and Situational Analysis will likely be completed around the third month and then presented to the council for feedback. Then, there will be an open 30 day comment period. In addition, there will be a communications expert in attendance to break down information for greater accessibility.

C. Fields asked how the plan might spread the word to minorities or sex workers. C. Terrell said that input is needed from many different communities. He explained that there are organizations working with persons most impacted by HIV, so many demographics can get the proper representation through these organizations. C. Fields voiced her concern about people who may be too afraid to come forward to speak. C. Terrell said AACO is still working on getting to populations that are harder to reach, as that is a main concern. C. Fields encouraged reaching out to different organizations that serve these populations.

C. Terrell explained that a key part of the Pillars—routine testing—is not currently happening. He reported that less than 60% people have been tested in their lifetime.

He named the final part of EtHE as an initiative to rapidly get money out on the street to end the epidemic in a way that makes sense for the local jurisdiction. He said that some details in the timeline or approach may change post-award from CDC. R. LaBoy asked about social media outreach efforts for engaging people and different community members. C. Terrell mentioned how those outreach efforts have been enacted and fairly successful with other local campaigns.

L. Diaz reported that she and C. Steib attended the UCHAPS meeting in Baltimore. Because decisions were not finalized, they could not report on them. L. Diaz explained that she would let the council know once decisions were finalized.

**Report of Staff:**

M. Ross-Russell announced the allocations meetings would be on July 16th for NJ, July 18th for Philadelphia, and July 23rd for the PA Counties. The meetings would be from 12 PM - 5 PM, and OHP would provide food during the process. M. Ross-Russell reported that anyone who wants to attend must RSVP. M. Ross-Russell requested that the RSVP deadline be Monday, July 15. L. Diaz mentioned the RSVP on Facebook via a Google Form.

M. Ross-Russell also reminded everyone not to forget to sign in for meetings. N. Johns agreed, noting that the sign-in sheet is how OHP tracks attendance.

**Public Comment:**
L. Diaz said there are none, but if someone wanted to make one, they should make sure they write their name on the Public Comment sheet.

**Action Items:**

—**PrEP Workgroup Report—**
B. Morgan mentioned that this report was emailed to everyone, and if anyone did not receive it, they should let someone from OHP know.

G. Grannan said that the PrEP group started as a Prevention Committee subgroup. This workgroup met for about 18 months from 2017 until the beginning of 2019. G. Grannan explained that meetings involved clinicians, HIV service agencies, and interested community members. As the Prevention Committee, he said they are presenting this report as something to incorporate into the Integrated Plan. G. Grannan pointed to the first few pages of the PrEP report, identifying them as the executive summary which track well with C. Terrell's presentation earlier.

G. Grannan turned to the third page of the report to bring everyone's attention to the activities in the left column. He said the Prevention Committee expressed an interest in considering these as additions to the PrEP process. He mentioned the three goals on the page: (1) reduce new HIV infections, (3) reduce HIV-related disparities and health inequities, and (4) achieve a more coordinated response to the HIV epidemic. He explained that there are different strategies going into fulfilling each goal and how the rest of the report, starting on page 4, has a lot more detail, truly fleshing out each goal and strategy.

G. Grannan described the rest of the packet as answering the Who, What, Where, Why, and How regarding strategies and goals. G. Grannan clarified that the PrEP report addresses very broad cases and lays out guidelines for a further strategy. C. Steib listed the populations PrEP report is targeting--High risk HIV-negative individuals, PWID, Transgender women, Black women, Latinas, MSM of color, and youth 13-24. He said this including heterosexual women and heterosexual men, as this is included in "high risk HIV-negative individuals." J. Jackson asked about the number of services that were available to individuals who felt they needed to reach out. C. Terrell said there are currently 45 PrEP providing agencies which are available on Phillykeeponloving.com. A. McCann-Woods reminded individuals that if they had specific concerns about services, they can call the helpline, 1-800-985-2437.

G. Grannan continued by directing the focus to the activities column. He suggested they go through and discuss each issue. G. Grannan said that given the presentation C. Terrell gave, instead of trying to rewrite The Plan and other documents, the council might consider appending the PrEP document to The Plan. In this scenario, the council can incorporate the PrEP report into the Integrated Plan next time it needs to be rewritten. C. Terrell agreed with G. Grannan's proposal, saying it was up to the council for the deciding vote. He suggested that once people are comfortable with the issues on the

report, everyone can vote. K. Carter explained that this meeting's goal is to decide on the PrEP report, so an immediate vote would be ideal.

S. Heaven called for a vote to add the PrEP report as an addendum to the Integrated Plan:

**— 18 in favor — 0 opposed — 4 abstentions —**
The PrEP Report was passed as an addendum to the Integrated Plan.

—**Service Priority Approval—**
N. Johns started off the conversation. N. Johns pointed to the results of the Priority Setting process on the Priority Setting for Service Categories Spreadsheet. She started at the top row and pointed to the scores that the committee used to make the decision, [8, 5, 1]. 1 was the lowest score you can give a service (the service is important), 5 was middle tier (the service is needed), and 8 was the highest (the service is critical). The Community Voices portion involved informed community input based on consumer survey, EPI data, and other important data. N. Johns explained how diversity in council also benefited the decision making process, since people have their own lived experience as direction and information.

K. Carter noted that the decision making process for Priority Setting did not have to do with budget or money whatsoever. N. Johns agreed, underlining how Priority Setting includes PLWH outside of RWHP system as well. N. Johns explained that yellow service categories meant there is more than three rank change in priority.

D. Gana pointed out that the categories that increased involved Substance Abuse and Mental Health, because there had been extra focus on those topics in HIPC.

N. Johns said that the priority list would be submitted to HRSA and that it is done about once every three years. E. Colon-Street asked about bolded/blue services. N. Johns said the bolded/blue are core services. G. Grannan clarified that they are core services as defined by HRSA.

L. Diaz called for a vote to approve the 2019 Service Priorities:

**— 16 in favor — 0 opposed — 1 abstention —**
The 2019 Service Priority Setting was approved by the Planning Council.

**Discussion Items:**

**—FY 2018 Year End Spending Report— (*A. McCann-Woods*)**
A. McCann-Woods explained that she would not disperse handouts, because the information is dense. M. Ross-Russell noted that the FY 2018 Year End Spending Report was presented in full at

the June 2019 Finance Committee meeting. A. Edelstein said the committee did not have any significant concerns regarding the report.

A. McCann-Woods said the report only represented significant variants in spending 10% and higher in the FY2018-2019 ending February 28, 2019. She indicated a total of 2% underspending, translating to $408,917, all of which included MAI funding. She further explained that the December 2018 reallocation request focused on reallocating the $408,917 in underspent funds.

A. McCann-Woods mentioned service categories with underspending in Philadelphia: Drug Reimbursement Program had $140,000, Mental Health had $49,430 due to vacancies, and EFA-Pharma had $378,693 from changing prescription refills from 30 days to 2-week.

D. Lewis-Salley asked about vacancies in Mental Health. A. McCann-Woods said there was a high turnover in this service. M. Coleman asked if the information was representative of the whole EMA, and A. McCann-Woods informed the attendees that this information provided is just for Philadelphia. D. Lewis-Salley asked if clients were still getting served in spite of vacancies. A. McCann-Woods said people were still seen, and no one lost services.

A. McCann-Woods said there was also overspending for Philadelphia in EFA, Housing Assistance, Food Bank, and Transportation. This was all due to high utilization except for Food Bank which had high utilization *and* providers spending quickly at the beginning of the spending period.

C. Fields felt that funding is never present for dire need services, such as DEFA situation. A. McCann-Woods explained that DEFA is dependent on available funds. She mentioned that there are reallocations when money was needed to be moved around, but sometimes money runs out. K. Carter asked about "double dipping" and combining housing services from RWHP and a different funding stream. A. McCann-Woods clarified that this was not allowed. C. Terrell said for RWHP funding, there are many limitations for housing. There exists a recommended 2 year limit, but permanent housing does not exist in the RWHP system. He continued to say that housing may be a prominent issue for many people in Philadelphia, but due to budgets, there is only so much RWHP can do. R. LaBoy asked about the process for reallocation of funds. A. McCann-Woods said that AACO comes with a request, and Planning Council approves or denies the change. K. Carter clarified that this is only when the change is over 10%.

A. McCann-Woods transitioned to PA Counties, noting an overspending and underspending of $109,315 due to the same EFA-Pharma situation in Philadelphia. For overspending, Outpatient Ambulatory was $95,754, Mental Health was $44,566, Food Bank was $6,647, and Transportation was $3,562. A. McCann-Woods explained that Mental Health was overspent because there was difficulty filling positions with Medicaid credentialed practitioners. Practitioners need to be degreed/licensed in specific counseling and medicine or you cannot get reimbursed by Medicaid, G. Grannan elaborated. A. McCann-Woods continued to say that overspending for Outpatient/Ambulatory was due to unreimbursed lab expenses and supplies.

In NJ, there was $20,251 of overspending in Oral Health due to unreimbursed lab expenses/supplies and overspending in Transportation due to high utilization. M. Coleman asked about the opioid crisis in South Jersey, and E. Colon-Street said it was being taken care and services were being provided.

**—Allocations Preparations—**

*Mental Health services (A. Edelstein)*

A. Edelstein read the description from the Mental Health Services HRSA Definition page. Looking at the chart, pointed out that in 2014, mental health clients received 2,685 sessions, and there was underspending in that category at $261 per client. In 2015, he said that number of people served went up, corresponding with allocated dollars. He commented that cost per client increased and allocation went up by about $200,000. In 2016, he pointed out that the cost per client was similar to 2014. He then directed the group to the flip side of the page, Grantee Service Considerations which highlighted the increased utilization, corresponding with additional mental health awards and increased mental health outpatient sessions. A. Edelstein looked at projected numbers, and he said that number of clients and hours provided will increase if funds keep increasing. A. Edelstein broke down the Funding by Part A, explaining that the current allocation is around 35K more than last year. He then focused on the consumer survey; 166 people responded and only ¾ of people were getting the mental health services when needed. At the unmet need portion of the handout, he pointed out the 8.4% unmet need under the MMP and 22.7% for the Client Services Intake.

*Medial Nutritional Therapy (G. Keys)*

G. Keys referred to the Medical Nutrition Therapy handout and read the HRSA service definition aloud to the group. She mentioned that clients cannot self-refer, they have to access the service through a medical provider. G. Keys directed attention to the chart below the HRSA definition. She pointed to 2014 and the 340 Medical Nutrition Clients and how there is a significant projected increase for 2017/18/19. She noted the average cost of $171 per client based on years 2014-2016. She pointed out last year's allocation—$59,946—and the current allocation—$60,531. She noted that the consumer survey results on the flip side of the page were very similar to the Mental Health survey. G. Keys listed the unmet need as 1.8% for MMP and 22.7% for Client Services Intake. Regarding Grantee Service Considerations, she noted the slight decrease in clients served and therapy hours.

T. Smith-Flores questioned what one who receives HIV services might do when insurance companies will not pay for a service, and G. Keys responded that insurance companies unfortunately have the last word even if providers advocate for the clients and their needs.

*Local AIDS Pharmaceuticals (B. Morgan)*

B. Morgan warned that there may be confusion. She noted that this service is commonly referred to as LPAP, not to be confused with ADAP. She explained that LPAP fills in gaps that ADAP programs may have. This program, especially in other EMAs, help supplement ADAP. She continued, explaining that HRSA changed the definition in 2016, making it a bit more difficult to officially use LPAP money by mandating record keeping, an LPAP advisory board, and other such protocol. She noted that most money got shifted to EFA Medication in 2016, explaining why the allocation dropped down so much. B. Morgan stated that because of this, it is hard to look at the historical trends for the service, but based on consumer survey info, a lot of people got their needed medications. C. Terrell clarified that this service only covered HIV related medications, and SPBP (ADAP for Pennsylvania) covers almost everything.

E. Campbell asked who helped with diabetes medication. M. Ross-Russell and L. Diaz said this would fall under SPBP. E. Colon-Street said there is a diabetes foundation that can redirect anyone to a nearby service. C. Terrell suggested calling the helpline number. C. Terrell and E. Colon-Street mentioned that case managers can also provide assistance with diabetes medication. C. Terrell offered the helpline number, 1-800-985-4237. D. Gana also mentioned a website, www.givemeyourmedication.com, which gives helpful financial information about medications.

J. Jackson asked if there is an online space to give feedback on services and their funding streams. B. Morgan responded that the allocations meetings would be the time to talk about funding for RWHAP, but for other funding streams, ways to offer. C. Terrell mentioned how RWHP has caps for copays depending on the client's income level. He said that this is not often advertised, so many people do not know about it.

*Referral for Health Care and Support Services (N. Johns)*

N. Johns mentioned that this service pays for the AACO helpline. She read the definition as defined by HRSA for Referral for Health Care and Support Services. N. Johns directed attention to the chart below the definition. She noted that the top half represented the helpline and the bottom half represented the computer lab and digital health literacy. The clients and the units match up, because clients are represented by number of phone calls. In 2017, N. Johns mentioned the projection of higher units, explaining that this is because more clients will spend time learning about digital health literacy. On the back side, N. Johns pointed out that the service is funded solely by RWHAP. N. Johns then brought attention to the consumer survey, pointing out that many individuals were able to access the referral services in the past 12 months when needed at 89.2% and 10.8% were not. N. Johns noted the 9.5% decrease in clients over time, but noted that there were more hours provided at the lab.

**Committee Reports:**

—**Executive Committee**—
No report.

—**Finance Committee**—
No report.

—**Nominations Committee**—
J. Baez mentioned the meeting earlier that day, July 11, 2019, where the committee discussed the activities they were undertaking to increase representation of target populations. Targeted recruitment included brown bag events, tabling, etc. The committee is working with the office to reach out to MSM of color as well and considering more evening meetings. They are also trying to extend transportation support. They all discussed the social that had happened in June, commenting that it was a great turnout, and HIPC got 2 applicants. The tabling at the Prevention Summit was also successful, so the committee wanted to continue to do even more direct outreach. He also mentioned sending out 8 attendance warning letters and the removal of 4 members for repeated attendance violations. He commented that these members will have the opportunity to appeal. He said the committee is accepting applications for membership and asked attendees to refer people to Planning Council.

—**Positive Committee**—
K. Carter said the Positive Committee met on Monday with a nice turnout. He said the next meeting would be August 12th, 12 PM – 2 PM. Quarterly, the committee decided to change the meeting from 6 PM – 8 PM. The next evening meeting would be September 10th.

—**Comprehensive Planning Committee**—
No report.

—**Prevention Committee**—
C. Steib said the Prevention Committee discussed the PrEP report and presenting it to the full council. Their next meeting is Wednesday, July 24th from 2:30 PM – 4:30 PM.

**Old Business:**
None.

**New Business:**
None.

**Announcements:**
None.

**Adjournment:**

**Motion:** J. Whitfield motioned to adjourn the meeting, A. Edelstein seconded. **Motion Passed:** Meeting adjourned at 4:05 PM.

Respectfully submitted,

Sofia M. Moletteri, staff

Handouts distributed at meeting:

- July 11, 2019 HIPC Agenda
- Meeting Minutes from June 13, 2019
- Ryan White EMA-Wide Spending for 4th Quarter
- Service Priority Setting Spreadsheet
- HRSA Mental Health Services
- HRSA Medical Nutrition Therapy
- HRSA Local AIDS Pharmaceutical Assistance Program
- HRSA Referral for Health Care and Support Services