MEETING AGENDA

HIV INTEGRATED PLANNING COUNCIL

Monday, April 06, 2020
2:00 p.m. – 4:00 p.m.

- Call to Order
- Welcome and Introductions
- Approval of Agenda
- Approval of Minutes (*February 13, 2020)*
- Report of Co-Chairs
- Report of Staff
- Public Comment
- Action Items
  - Adoption of Special Rules of Order (Roll Call)
  - Spring 2020 Open Nominations Processes Extended to Fall 2020
- Discussion Items
  - Potential Notice of Grant Award
- Committee Reports
  - Executive Committee
  - Finance Committee – *Alan Edelstein & David Gana*
  - Nominations Committee – *Michael Cappuccilli & Sam Romero*
  - Positive Committee – *Jeanette Murdock & Kenya Moussa*
  - Comprehensive Planning Committee – *Gus Grannan & Gail Thomas*
  - Prevention Committee – *Lorett Matus & Clint Steib*
- Old Business
- New Business
- Announcements
- Adjournment

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

The next HIV Integrated Planning Council meeting is scheduled is **TBD**

HIV Integrated Planning Council
Meeting Minutes of
Thursday, February 13, 2020
2:00 p.m. – 4:30 p.m.
Office of HIV Planning, 340 N. 12th St., Suite 320, Philadelphia PA 19107

Present: Susan Arrighy, Juan Baez, Allison Byrd, Michael Cappuccilli, Keith Carter, Sharona Clarke, Lupe Diaz (Co-Chair), Alan Edelstein, David Gana, Pamela Gorman, Gus Grannan Sharee Heaven (Co-Chair), Peter Houle, Gerry Keys, Kailah King-Collins, Dena Lewis-Salley, Tyrell Mann-Barnes, Marilyn Martinez, Lorett Matus, Kenya Moussa, Sarah Nash, Nhakia Outland, Erica Rand, Samuel Romero, Coleman Terrell (Co-Chair), Jacquelyn Whitfield

Absent: Timothy Benston, Sade Benton, Mark Coleman, Evette Colon-Street, Roberta Gallaway, Janice Horan, La'Seana Jones, Richard LaBoy, Brian Langley, Joseph Roderick, Zsofia Szep, Gail Thomas, Steven Zick

Excused: Daniel Angelis, Janielle Bryan, Jeanette Murdock, Clint Steib, Gloria Taylor

Guests: Kathleen Brady (AACO), Chris Chu (AACO), Ameenah McCann-Woods (AACO), Desiree Surplus, Kristin Walker, Elise Borgese, Kate King, Joy Lander-Roe, Ebony Boswell, Kareem Mimi, Henry Bennett, John Keel, Gary Tumolo, Ronald Lassiter, John Oliver

Staff: Mari Ross-Russell, Briana Morgan, Sofia Moletteri

Call to Order:
S. Heaven called the meeting to order at 2:09 PM.

Introduction: S. Heaven asked everyone to introduce themselves with their names and area of representation.

Approval of Agenda:
L. Diaz presented the February 2020 Planning Council agenda for approval. M. Ross-Russell proposed adding the 3rd Quarter Underspending Report to the agenda. **Motion:** A. Edelstein made a motion to approve the February 2020 amended agenda, D. Gana seconded to approve the amended agenda. **Motion passed:** 17 in favor, 0 opposed, 5 abstaining.

Approval of Minutes (*January 09, 2020*)
L. Diaz presented the January 2020 meeting minutes for approval. **Motion:** J. Whitfield motioned, G. Grannan seconded to approve the January 2020 meeting minutes. **Motion passed:** 15 in favor, 0 opposed, 5 abstaining.

Report of Co-Chairs:
C. Terrell reported that there was a partial award given for Ryan White Part A. They were also expecting the EHE money to be awarded around March 1, 2020. AACO was also working on drafting the CDC EHE grant proposal to additionally receive around 3.2 million dollars for prevention services. He reported that AACO was also applying for a grant to fund STD clinics.

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Report of Staff:
M. Ross-Russell reported that there were two flyers currently out for everyone to pick up. One was for the Positive Committee, noting that the committee was working on a booklet for their 20th anniversary. The book would include interviews from past and present Positive Committee members. The Positive Committee was also looking to other HIPC members to help with locating former members who may be interested in participating. They were also planning to present the booklet at the Prevention Summit. She explained that those interested should talk to staff or Positive Committee chairs to learn more. She asked members to distribute the flyers within agencies to help get the word out.

M. Ross-Russell reported that the March 2020 HIPC evening meeting would be the first EHE Town Hall. The Town Hall would take place at OHP from 6 – 8 PM on Thursday, March 12th. There would be sandwiches and refreshments, and RSVP was required. She asked council members to spread the word about the Town Hall and bring guests for optimal feedback and attendance. She added that AACO would start accepting comments for the EHE plan on March 1st. J. Williams acknowledged HIPC as a valuable partner, explaining that the March 12th Town Hall was the first of a series of events—he noted that the mayor and other political figures would be in attendance. There would be more Town Halls that would be specific to certain topics of Pillars of the plan. He emphasized the importance of the Town Halls as a significant portion of community engagement within EHE.

Public Comment:
None.

Presentations:

—Epidemiological Update—
K. Brady introduced herself as the medical director for AACO and explained that she would to give a presentation on epidemiological updates. Most of the data included highlights of the HIV surveillance report showing a standard graph of PLWH in the city of Philadelphia per year. She noted that the number of PLWH had gone down because some individuals had moved out of Philadelphia.

In 2018, K. Brady reported on 424 newly diagnosed PLWH. Around 1 in 4 of new HIV diagnoses were from those between ages 13-24. MSM had the highest rate of new diagnoses and heterosexual and PWID rates were lower. MSM HIV infection rate still exceeded PWID even after the significant increase of PWID HIV diagnoses in 2018.

The MSM HIV infection rate, K. Brady explained, had decreased by about a quarter. For Black MSM, there was about a 1/3 decrease in infection rates. Overall, there were not any significant changes for Hispanic and white men. It was presumed the decrease in infection rates for Black MSM was due to increased PrEP uptake.

K. Brady explained that the next graph broke 2018 new diagnoses down by race/ethnicity. She gave the absolute numbers for new diagnoses: 246 Black individuals, 85 Hispanic individuals, and 78 white individuals. When looking at the infection rate as represented by the red bar, the highest rate is among Hispanic populations, showing that Black and Hispanic populations were disproportionately affected by the epidemic.

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K. Brady directed attention to the slide, "HIV Diagnoses by Census Tract, 2018." The slide showed a map of Philadelphia and concentration of new diagnoses. A. Byrd asked if there were maps for PA and NJ counties. K. Brady responded that there would be more information about the counties later, but Philadelphia ultimately had the most information.

K. Brady continued to explain that from 2016-2018 there was a 115% increase in PWID new diagnoses in Philadelphia (from 33 new diagnoses to 71 this year). K. Carter asked about the interrupted time series analysis, and K. Brady responded that the analysis took the number of new diagnoses and compared data from before and after syringe exchange implementation. G. Grannan reminded everyone that syringe exchange was decriminalized but not legal with only one organization serving the community.

K. Brady read the EMA data from the slide HIV Diagnoses in the EMA. She said that the demographic information is a bit different within the counties, but there is still a higher concentration of HIV for persons who are Black and Hispanic. There was also a higher concentration of youth infected with HIV within Philadelphia than the PA counties.

K. Brady read the slide titled, "PLWH Living in Philadelphia, 2018." Refer to this slide for more information. She noted that the number of PLWH in Philadelphia had gone down since 2017. For PWID, there was no information collected by race/ethnicity, so they were missing the rate. K. Carter recognized that according to the map, there were around 10,000 PLWH over the age of 50.

K. Brady then directed attention to the 2018 map of PLWH by Census Tract. She noted that most of the map was at least dark green, so HIV was affecting all areas of Philadelphia. Regarding the EMA-Wide map, it was clear that the epicenter of the epidemic was concentrated in Philadelphia, Camden, and Chester, and Coatesville.

She gave information for PrEP indication by transmission category and race/ethnicity (an estimated 13,900 individual total). L. Diaz asked for a comprehensive definition of indications for PrEP. K. Brady said that those with indications for PrEP are HIV negative individuals who are part of populations that are disproportionately affected with HIV. A. Edelstein asked which populations had the highest indications for PrEP. Based on the rate, K. Brady answered that more than 50% of individuals are Black and there are high proportions of Hispanic individuals. A. Edelstein added that the greatest affected population for PWID are white and heterosexual individuals, and the greatest indication for PrEP are Black individuals. K. Brady added that the greater demographic for affected heterosexual individuals are women.

K. Brady directed attention to the slide titled "Philadelphia Prevalence-Based Continuum, 2018." Refer to this slide for more information. Comparatively, Philadelphia had fewer people unaware of their HIV status than the USA as a whole as well as higher linkage to care. However, Philadelphia had a lower retention in care than the USA. In Philadelphia, about half of PLWH are virally suppressed. P. Gorman asked about the performance measure for those retained in care. K. Brady said it was based on evidence of having two or more CD4s or Viral Loads at least 90 days apart.

K. Brady explained that there was also a modified HIV continuum which could be seen on the slide titled "Modified HIV Care Continuum Philadelphia vs. the United States, 2018." Refer to this slide for more information. The continuum recognized that 4,000 PLWH had not been in care for five or more years. Some individuals may be deceased or may have moved out of the Philadelphia area.

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Based on the modified care continuum, numbers for retention in care (54.3% of PLWH) and viral suppression (60% of PLWH) were improved.

K. Brady continued to the slide titled "Philadelphia EMA HIV Care Continuum, 2018." Refer to this slide for more information. For this specific care continuum, there was a measure added which only included those with evidence of care. However, she noted that there were some limitations with the continuum due to lack of CD4 count data and other such data. New Jersey also had significant reporting delays impacting the data.

K. Brady reported on the Dashboard—refer to "Dashboard" slide for more information. She noted that areas which needed improvement were listed in red. With the new EHE (Ending the HIV Epidemic) plan, the goal was linkage to care within 7 days. There were no disparities in the care continuum except for those PWID, PLWDH (D=diagnosed). Such disparities were in both suppression and retention. K. Carter asked about the process to change from 30 to 7 days for linkage to care. Regarding that strategy, K. Brady explained that the EHE was crafting a plan specific to its funding capabilities and included the implementation of Rapid ART. C. Terrell added that delays in linkage to care would include people coming into care from a testing site, waiting for insurance to clear, and other such logistical delays. They were working with both testing *and* care sites to help people get into care. AACO would also be providing a Field Services Unit to assist with the process.

B. Rowley said that 7 days still sounds like a longer time, so 30 days is the outlier, and 7 days linkage to care was closer to the average. K. Brady responded that providers were actually shooting for 72-96 hours linkage to care. K. Carter asked which HIV medication would be the standard for Rapid ART. K. Brady said that the medication distributed would be specific to the provider.

K. Brady referred to the slide titled "Transgender PLWH" and read the data for the slide. Refer to this slide for more information. She explained that they are in the process of national HIV surveillance with a goal of interviewing 200 transgender women. Currently, they had interviewed 198, and thus far, 47.3% of the women self-reported being HIV positive. K. Walker asked what "seeds" meant within the slide. K. Brady explained that a "seed" is someone highly networked and highly regarded within the transgender community. The "seeds" do not count in the sample, just the people that the "seeds" recruit for interviews. N. Outland asked if there was data on transgender men, and K. Brady said yes, but the sample size was so small that the information was not shown within the data.

K. Brady reviewed the two slides about EHE (the first listing the goal of EHE and the second listing the four Pillars) and reviewed the slide titled "Philadelphia, 2018." She added that the information was representative of people who had evidence of care within the last five years. The information showed percentages of transmissions depending on status of care within the HIV Care Continuum. She then read all the data on the slide titled "Number and Percent PLWH Needed to Reach the 2025 Goal to End the HIV Epidemic in Philadelphia*." Refer to this slide for more information.

A. McCann-Woods asked about the NHBS transmissions. K. Brady responded that around 70% are under the age of 40 and a large proportion of that are under 30. K. Brady reported on the data from the slide titled "Goal Setting for PrEP." Refer to this slide for more information. She explained that the grey bar was representative of the current data, and the purple bar represented the goal for PrEP uptake under the EHE plan in the next 5 years. Overall, the goal was to prescribe 6,000 people PrEP, doubling the current amount of people prescribed PrEP.

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M. Cappuccilli asked about people lost to care and if there was data sharing for those who move out of the jurisdiction and continue care. K. Brady said that the CDC used some of the information to identify potential duplicates twice a year and interact within the EMA and country to identify definite duplicates. They currently had a list of 10,000 individuals who were duplicates. A. Byrd asked if those in prison counted as part of the jurisdiction or county, and K. Brady said yes. B. Rowley asked what foundation they were using for PrEP planning that might guarantee success. K. Brady said that there is a consultation line in San Francisco where individuals are recommended PEP to PrEP for same day initiation. M. Martinez asked if providers were able to contact AACO to report and confirm duplicate patients. K. Brady responded that the Philadelphia Department of Health had a Data to Care Program working with RWHAP sites, but they could involve other providers as well. The providers should reach out to get involved.

—FIMR (Fetal and Infant Mortality Rate)—

K. Brady explained that she and K. Walker would not discuss perinatal HIV infections. She added that HIV infection occurs in utero, during birth, and during breastfeeding. Since the FIMR Review process, they have been able to reduce the perinatal transmissions in Philadelphia. N. Outland asked if any of the births involved transgender men, and K. Brady said they did not.

K. Brady reported on the study done with FIMR HIV process data from the slide titled "Despite pediatric successes, mothers with HIV have poor outcomes." The data showed that retention in care and viral suppression was lower 2 years after giving birth than in the general population. She explained that there was a system in place within Philadelphia with surveillance activities, prevention coordination, and Case Management funded by RW Part D and AACO, and FIMR review process.

K. Brady read the slide titled "FIMR-HIV: The cornerstone of HIV Perinatal Prevention in Philadelphia." K. King-Collins asked if positive persons are able to deliver vaginally. K. Brady responded that they can if they have an undetectable or low viral load of less than 1,000 in the third trimester.

K. Walker introduced herself as the Coordinator of the Perinatal HIV Prevention Project. She explained that the initial purpose for FIMR was simply an initiative to monitor and assess fetal or infant death, though it had recently been adapted to women living with HIV and their infants pre and postpartum.

K. Walker explained that FIMR process: data gathering, case review, community action and data response, and improving gaps in care and systems. The team did not review every mother's history who gives birth and living with HIV in Philadelphia. The mothers instead had to match a certain criteria. Regarding the criteria, they looked at case management, providers caring for the mother, postpartum delivery, infant care, and data about the mother and anyone who cares for her. The reason they look at information for the woman and care around her is to identify gaps in care and the process around her care.

K. Walker reviewed the specific criteria for the cases reviewed. K. Carter asked about the HIV testing process for pregnant women. K. Walker explained that there needs to be two HIV tests with the second test during the third trimester to gauge the method of labor. She added that Philadelphia never missed a second test. Though the second test was a standard for the whole state of PA, providers outside of Philadelphia may miss the step.

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K. Walker noted that women who are later in pregnancy are at higher risk for HIV acquisition. Regarding the CAT (Community Action Team), the idea was to initiate systems change based on findings and recommendations. They take recommendations from CRT (Case Review Team) to make further improvements to the team.

CAT had four committees: Contraception Committee, Emergency Department Protocol Committee, Engagement in Care Committee, and Behavioral Health Committee. There had been identified issues and action items since CAT's inception in 2010. Issues involved lack of preconception counseling for HIV-positive women, continuity of/engagement in care for those with MH/SA issues, and lack of connection to prenatal care from ER.

K. Walker added that the average of pregnant, HIV positive women had a higher percentage of unintended conception, with 50% being the national average. Based on the recommendations, one key question that was now being asked of clients was if the woman wanted to become pregnant within the next year. This allowed the provider to talk about preconception counseling or contraception with the client. K. King-Collins asked if the program had seen any transgender individuals, and K. Walker responded that it had not.

D. Surplus noted that pharmacists within Delaware were able to prescribe birth control and asked if this was also the case within Philadelphia. K. Walker responded that that needed to be further researched and she was not sure. N. Outland asked about the prison system and if they covered people's contraceptive care. K. Walker said that the issue of contraceptive was a policy issue that had been only somewhat addressed. K. Brady added that the contraceptive should continue, but injectable contraceptive was not allowed. K. Walker said that individuals cannot start new forms of contraceptive once they had entered the prison system either.

Regarding the Prenatal CRT recommendations slide, K. Walker emphasized the importance of knowing their partner's status, offering PrEP, and raising awareness. Testing pregnant women in the emergency room who are not in prenatal care was also an important step. Women who had entered the ER must also be referred out of prenatal care to postnatal and to perinatal case management. Intensive case management would improve retention in postpartum care. Getting the word out to providers and agencies would help to increase the efficiency of the process. K. Walker added that women and providers both faced a discomfort around continuing mental health medication through and after pregnancy. However, it was important to emphasize that the mother should continue psychiatric medication.

For CAT Action Items, they were to develop new and creative solutions; enhance credibility and visibility of issues related to parents, infants, and families; work with the community to implement interventions to improve services and resources; determine if the needs of the community are changing over time and decide which interventions should be added or altered to meet the needs; safeguard successful FIMR system changes from being discontinued in the future.

K. Walker explained that one of the main goals was to ensure that the mother was still being cared for after birth, not just the child. This involved helping women to get postpartum care appointments before even leaving the hospital. The committees had made a checklist of procedures a hospital must follow before discharging a mother, post birth. They were specifically working with social work

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teams to overlook checklists and distribute tasks and roles to particular people within the hospitals, keeping the process organized and effective.

K. Brady added that they had created an online course for DHS social workers which would assist with the process. She said Ongoing Questions and work would involve increasing knowledge around SPBP. She noted that there was also work with WIC (Women, Infants, and Children), a no-cost Nutrition Education Program.

K. Walker said that there was more information on FIMRHIV.org.

Discussion Items:

—Assembly of EHE Workgroup—
M. Ross-Russell explained that HRSA and the CDC wanted to have more involvement of the Planning Body in the EHE process. They wanted Planning Body members to form an ad hoc committee. Members of the Prevention Committee and Comprehensive Planning Committee (CPC) would be the most heavily involved. The final EHE plan would be submitted in September of 2020. All of the work and input would have to happen between now and September.

M. Ross-Russell noted the group would be named EHE Workgroup. Formation of a new committee would require a change within the bylaws, so this will be an ad hoc workgroup. EHE included two pillars related to care (central to CPC's purpose) and 2 of which are related to prevention (Prevention Committee's purpose). P. Gorman asked what the commitment would be for the meeting times. M. Ross-Russell responded that the committees would have one meeting per month for about two hours. After the finalization of the EHE plan, the workgroup could choose to meet quarterly.

J. Williams explained that the formation of a workgroup would be helpful to create more ambassadors within the field to spread more awareness around and information regarding the plan. He suggested that the workgroup continue their work for as long as the EHE exists—this would allow the workgroup to assist with implementation and work closely with EHE activities.

A. Edelstein asked if it would be beneficial to have members from each of the six HIPC committees. He asked if the workgroup would only focus on Philadelphia for the purposes of the EHE plan. M. Ross-Russell responded that EHE planning only included the City of Philadelphia. However, elements of the EHE could inform the Integrated Plan for the rest of the EMA. M. Ross-Russell added that the addition of other members from each committee would be beneficial.

J. Williams explained that Philadelphia was a Phase 1 Jurisdiction while the other EMA counties were Phase 3. Philadelphia would act as the starting point before more comprehensive planning for the other counties. C. Terrell added that AACO would be implementing many activities and strategies (e.g. Rapid ART) from the Philadelphia EHE plan in the rest of the 9-county region.

L. Matus asked if members from CPC and Prevention Committee would be excused from their committee meetings due to involvement in the EHE Workgroup. B. Morgan said that the current bylaws would still be in place: the member would inform staff of their excused absence, but the member was still not allowed to exceed 5 excused absences over the course of the year. She added that CPC and Prevention Committee could take turns hosting the meetings during their regular meeting times to lessen the amount of meetings.

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Motion: A. Edelstein made a motion to create an ad hoc EHE Workgroup, D. Gana seconded.
Motion passed: 19 in favor, 0 opposed, 3 abstaining.

—3rd Quarter Underspending Report—
A. Edelstein announced that the 3rd quarter spending report had already been reviewed by the Finance Committee. A. McCann-Woods explained that the report reflected spending in the third quarter through 2019. The fiscal year would be ending at the end of February 2020. She reminded everyone that AACO only reports back to the council on underspending and overspending exceeding 10%.

A. McCann-Woods addressed the 3rd Quarter Spending report. She read the first slide in whole. Please refer to Recipient FY2019 Underspending Report, slide titled 3Q Underspending Summary" for more information. She explained that late invoices were typical in every quarter's underspending report and would be a continuing theme. A. McCann-Woods noted that there was also a packet of spreadsheets with details on total allocation, 3rd quarter allocation, spending, balance, and under/overspending percentage. The packet was broken down by county and service category.

A. McCann Woods asked everyone to refer to the underspending slide for Philadelphia. She noted that Substance Abuse Treatment – Outpatient was underspent at $171,588 (due to vacancies and leveraging other funding sources). Regarding the vacancies, credentialing for therapists and counselors was a barrier to the hiring process. EFA-Pharma was underspent by $90,213 based on demand, Food Bank was underspent by $54,150 from leveraging other funding sources, and Referrals to Healthcare was underspent by $24,638 because of delayed spending.

A. McCann-Woods then read the overspending for Philadelphia. The following services were all overspent due to high utilization: EFA (by $34,591), Housing Assistance (by $66,935), and Transportation (by $1,406). However, it was important to note that EFA and Housing Assistance were overspent at that point in time, but it had now leveled out due to proactively approved reallocations.

A. McCann-Woods continued to the PA counties underspending. Outpatient/Ambulatory Health Services was underspent by $52,229 (due to late invoicing, delayed spending, and leveraging other funding sources), Substance Abuse Treatment – Outpatient was underspent by $70,742 (due to vacancies and leveraging other funding sources), EFA-Pharma was underspent by $27,536 (based on demand), and Transportation was underspent by $44,076 (due to delayed spending and leveraging other funding sources). She noted that the underspending at that point in time had likely leveled out of been recaptured and reallocated.

A. McCann-Woods read the underspending for New Jersey. Mental Health Therapy/Counseling was underspent by $18,183 due to vacancies, and Food Bank was underspent by $16,366 due to delayed spending and lower utilization. She noted that the identified underspending for Mental Health services was likely on target now or had been recaptured and reallocated. During the Finance Committee, there was discussion about Food Bank. AACO was researching possible barriers to access, though they had not received any grievances about the service.

A. McCann-Woods read overspending for New Jersey. Transportation was overspent by $26,023 due to higher utilization and Oral Health Care was overspent by $20,941 due to early overspending. NJ

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Transportation and Oral Health were reallocated additional funds due to higher utilization. She said that that happened after November 2020, so it was not reflected but had leveled out.

She read Systemwide allocations underspending. She said that this is all administrative below the line spending. All is late invoicing, except capacity support and grant administration which is typically also vacancies.

A. McCann-Woods directed attention to page 5 in the RW EMA-Wide Spending packet containing spreadsheets and number data. She noted that on this page, there was regarding Systemwide Allocations. She read that there was underspending for Information & Referral ($405,744), Quality Management Activities ($130,309), Capacity Building ($64,997), Planning Council Support ($49,241), Grantee Administration ($540,876). She reported that most of the underspending was mostly due to vacancies or late invoicing. Due to the cumbersome hiring practices, especially at the Recipient level, underspending was unresolved. However, any remaining underspending had either leveled out or was/will be redirected to direct service categories.

Action Item:

—Reallocation Request—
A. Edelstein reported that the Finance Committee would be presenting the next action items. He explained that the Finance Committee had already reviewed the reallocation request from the Recipient. The committee brought the request forward with a recommendation for approval. He reminded the HIPC that during the November 2019 HIPC meeting, there had been a Recipient request put forward and the approved by HIPC which allowed the Recipient to reallocate any remaining of the following direct service categories: Emergency Financial Assistance (EFA), Food/Bank/Home Delivered Meals, Medications, Oral Health Care, and Medical Transportation Services.

A. Edelstein read the Recipient Philadelphia Region Reallocation Request & Notice of Grant Award (Partial) handout. Refer to this sheet for more information about the reallocation request. He added that the current reallocation request reflected the changes made in November 2019. Since the request was asking for a reallocation exceeding 10%, HIPC approval was required.

Since the request was asking for a sizeable reallocation (moving $149.328.00 from EFA/Pharma to Other Professional Legal Services), the Finance Committee suggested a future presentation on the nature of the legal services and on the full purpose of the reallocation. Such a presentation would be helpful for planning for the next year to see if the reallocated dollars would need to be kept in Other Professional Legal Services.

K. Carter asked if there was overspending in the Legal service category. A. Edelstein said there was no overspending. A. McCann-Woods added that legal services had already been rendered to consumers within EMA, but the providers did not have another funding mechanism to reimburse the costs. She explained that AACO had already identified underspending within EFA-Pharma, so providers within the Legal service category requested more money for the Ryan White eligible clients within the EMA. E. Rand asked if providers within the Legal service category had made such a request in the past. C. Chu responded that underspending had been reallocated to Legal Services in the past, but never this much.

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A. McCann-Woods added that Legal Services (especially for benefits, housing, and immigration purposes) had a significant increase in utilization. She added that AACO would present to the full Planning Body on Other Professional Legal Services. K. King-Collins asked if need was being met for EFA-Pharma. A. Edelstein explained that providers went from a 30-day fill to a 15-day fill—the change did not affect consumers in acquiring medication, and SPBP was more effective, causing continual underspending.

A. Edelstein called for a vote to approve the reallocation request (reallocate $149,328.00 from EFA-Pharma to Other Professional Legal Services) from the Finance Committee.

22 in favor, 0 opposed, 4 abstaining.

Reallocation Request Approved

—Continuing Resolution Level Funding Budget Review—

A. Edelstein explained that the Recipient had received a partial Notice of Grant Award for Part A Formula funding at 25% of the overall award. To prevent disruption of service delivery, the Recipient was seeking approval to issue provider awards at a level funding budget scenario for the rest of year. He asked everyone to look at the spreadsheets within the meeting packet. The spreadsheets showed the level, 5% decrease, and 5% increase budgets for PHL, PA, NJ, and EMA-Wide.

A. Edelstein explained that the Finance Committee recommended that the Planning Body approve the budget based on the level funding amount approved in the August 2019 allocations process. The Finance Committee approved the budgets for funding as the continuation of the current level of funding. The level funding budget was reflected in blue text which reflected the level funding budget decision made in August 2019.

M. Ross-Russell explained that the federal budgets were typically approved in September. If they were not approved by the beginning of the contract year, RWHAP follows a continuing resolution process and jurisdictions are given a partial award. The 25% which was discussed in the Recipient Philadelphia Region Reallocation Request & Notice of Grant Award (Partial) handout is part of the partial award to sustain programs and services until the full budget is awarded. She noted that even within the level funding budget, because percentages of people living with HIV changes within the EMA, the percentage of funding within regions changes as well.

A. Edelstein added that within the last few years, the Planning Body adopted a standard which allocated certain percentages of Ryan White dollars to certain regions based on PLWH within the area. M. Ross-Russell explained that the Recipient awards contracts and grants but first receives approval from HIPC for allocations. She added that the Planning Council typically started with the Level Funding budget for the Partial Award. When they are awarded the Full Award, the Planning Body reviews budgets again (5% Increase, 5% Decrease, or Level Funding Budget) to choose which to approve.

A. Edelstein called for a vote to approve of the Continuing Resolution Budget beginning in March 1st based on Level Budget passed in August 2019 and accounting for changes in PLWH percentages within the EMA.

Vote: 22 in favor, 0 opposed, 3 abstaining

Continuing Resolution Level Funding Budget Passed

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Committee Reports:

—Executive Committee—
None.

—Finance Committee—
No further.

—Nominations Committee—
M. Cappuccilli reported that anyone who is a new member should see him after the meeting to sign up for a subcommittee. On March 12th, the Nominations Committee hoped to recruit new members, so they were asking members to bring people from the community to the HIPC evening meeting.

—Positive Committee—
K. Carter reported that the Positive Committee was working on their 20th anniversary project. At their last meeting, they had a presentation on social determinants and discussed having a workshop for the Prevention Summit. Their next meeting would occur on Monday, March 9th from 12-2 PM. He directed those attending to contact the office so they could order the proper amount of food and transportation reimbursements.

—Comprehensive Planning Committee—
G. Grannan reported that the Comprehensive Planning Committee was still reviewing the EHE plan. They would also be participating in the EHE Workgroup.

—Prevention Committee—
L. Matus reported that the Prevention Committee reviewed Pillar 3 of EHE plan.

Old Business:
None.

New Business:
None.

Announcements:
P. Houle announced that he was retiring and would be resigning from the Planning Council. He had been a member for the past 15 years.

Adjournment:
L. Diaz called for a motion to adjourn. **Motion:** L. Diaz motioned, D. Lewis-Salley seconded. **Motion passed:** Meeting adjourned 4:27 PM.

Respectfully submitted,

Sofia M. Moletteri, staff

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Handouts distributed at the meeting:

- February 2020 HIPC Meeting Agenda
- January 2020 HIPC Meeting Minutes
- PA Counties FY2020-2021 Allocations Examples
- NJ Counties FY2020-2021 Allocations Examples
- Philadelphia Counties FY2020-2021 Allocations Examples
- Philadelphia EMA FY2020-2021 Allocations Examples
- QM Activities and Administrative Allocations Examples
- Recipient Philadelphia Region Reallocation Request & Notice of Partial Grant Award
- Ryan White EMA Wide Spending as of 11.03.19
- February/March 2020 HIPC Meeting Calendar

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